FROM POLICY TO PRACTICE - 1

THE DYNAMICS OF IMPLEMENTING THE MAMATA SCHEME IN ODISHA:

PATTERNS IN THE USAGE OF MAMATA SCHEME MONIES AND THE IMPLICATIONS FOR WOMEN'S HEALTH AND AGENCY

INDUS ACTION

About Indus Action

At Indus Action, we are at the frontline in solving the entrenched challenge of poverty and systemic barriers that keep large sections of the Indian population unable to access their welfare entitlements. Our guiding beacon is a simple yet powerful conviction: every family in India, particularly those subsisting on an income of less than Rs. 10,000 ($135) per month, should have unrestricted access to their welfare entitlements, entitlements that grant them a path to quality education, robust health, and secure livelihoods, amongst others.

As we navigate the intricate web of policies and regulations, we are faced with the towering figure of 890 million citizens, a segment that continues to live below the poverty line, trapped in a maze of systemic inefficiencies that hinder access to welfare rights anchored in education, health, and livelihood security. The journey to upliftment is anchored to over 500 schemes, a wide range of opportunities that unfortunately culminate in low-impact delivery, leaving a substantial portion of the populace grappling with poverty.

At the core of our work lies the transformative Portfolio of Welfare and Entitlement Rights (PoWER). It is not just a portfolio but a testament to our unwavering commitment to redefining the boundaries of welfare in India, translating the 500+ fragmented low-impact schemes into a consolidated set of 5-10 high-impact, accessible welfare schemes. Through PoWER, we aspire to unlock welfare benefits across various dimensions, assisting 1,000,000 families and helping them reclaim their entitlements and navigate their way out of poverty by 2025.

Since 2013, our work has contributed towards:

1. Facilitating 611,432 admissions under the Right to Education Act.
2. Empowering 172,446 mothers with maternity benefits under the National Food Security Act.
3. Supporting 137,713 workers to avail entitlements per state-specific labour welfare provisions.

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Executive Summary

Introduction: The state of Odisha has made significant strides in improving maternal and child health. The Mamata scheme, introduced in 2011, is a conditional cash transfer (CCT) programme aimed at alleviating financial burdens on pregnant and lactating mothers, promoting health service utilisation, and enhancing mother and child care practices. This study aims to delve into the intricacies of intra-household gender relations and women's agency to understand the effectiveness of the Mamata scheme in addressing the objectives it was launched for.

Methodology: This cross-sectional qualitative study investigates the utilisation patterns of welfare funds allocated through the Mamata scheme in two Gram Panchayats - Gobindapur and Gengutia - within the Dhenkanal district in Odisha. Twenty-eight participants, consisting of 7 pregnant women and 21 lactating mothers, were included in the study.

Key Findings:

1. **Labour and Wage Compensation:** None of the respondents when contacted, were engaged in any regular income-earning work either from home or outside during their pregnant or lactating state. However, they were actively engaged in unpaid household work, including responsibilities such as fetching water and tending to livestock. Considering that a significant portion of the study cohort had no employment history before marriage or before pregnancy, it was not possible to assess the Mamata scheme's aim of addressing income loss during pregnancy and lactation.
2. **Women's agency and household dynamics:** The survey findings revealed that a significant majority of beneficiaries do not directly receive cash from their husbands for general household expenses, nor do they have a say in determining how the overall household income is allocated for major expenditures. Concerning the Mamata funds, beneficiaries indicated that they do not transfer the money to other household members. However, many respondents admitted not exercising independent financial decision-making regarding utilising the Mamata funds. In joint families, intragenerational power dynamics may be a prominent factor constraining women's agency in engaging in financial decision-making, with mothers-in-law and other elders playing key roles in decision-making. In nuclear families, husbands and wives jointly make decisions in utilising the Mamata funds received.
3. **Use of funds:** It was found that the respondents utilise the funds in various ways, including saving, directing them towards the future of their children, or utilising them for household and health-related expenses. While the Mamata scheme aims to enhance health and nutrition outcomes for both mothers and children, the majority of households being in the BPL category and having constrained resources means that, in situations where a choice must be made between the mother's health and the child's future, the child's needs are typically prioritised. Despite the scheme's consideration of women's needs, societal

norms and family dynamics often hinder women from prioritising their own rest, health, and well-being.

4. **Nutrition intake:** Our small-scale research indicates that within joint-family households, mothers-in-law predominantly wield authority over food purchases. The male members of the household were responsible for grocery shopping. While most respondents expressed the belief that food should be distributed equitably amongst family members, when probed further, several respondents attested that men and boys should consume more food than female members because they believed that men did more strenuous labour. Also, all respondents in the present study reported receiving eggs and *chhatua* through the Take Home Ration scheme, and they all mentioned sharing both items with other members of their families.

Conclusion: While the *Mamata* scheme is designed to achieve several objectives - including providing wage compensation for pregnant and nursing mothers to ensure adequate rest, increasing the utilisation of maternal and child health services, and improving mother and child care practices such as breastfeeding and complementary feeding - it's essential to recognise that broader societal factors influence its effectiveness. Gender norms and social structures significantly shape the interactions between the scheme and its beneficiaries. To empower women and positively impact maternal and child health outcomes, we must adopt a more holistic approach that extends beyond individual responsibility. This entails investing in a broader support network around women, leveraging the roles of Anganwadi Workers (AWWs) and state institutions to influence behaviours and purchasing decisions related to food and meal habits within the household.

Policy Recommendations:

- Implement programmes and policies that recognise and address intergenerational power dynamics within households
- Active engagement of pregnant women and their husbands (and other family members) during pregnancy and lactation can enhance awareness programmes on nutrition and maternal health.
- Establish robust and continuous monitoring and evaluation mechanisms to assess the effectiveness of interventions in promoting women's empowerment and improving health and nutrition outcomes with a gender-inclusive perspective

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This summary encapsulates the study's aims, methods, findings, and policy recommendations. For detailed insights, refer to the full report.

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Abbreviations

AWW	Anganwadi Worker
AWH	Anganwadi Helper
ANM	Auxiliary Nursing Midwifery
ASHA	Accredited Social Health Activists
BPL	Below Poverty Line
BIL	Brother-in-Law
CCT	Conditional Cash Transfer
FIL	Father-in-Law
FLW	Front Line Workers
IYCF	Infant and Young Child Feeding
IFPRI	International Food Policy Research Institute
MIL	Mother-in-Law
NFHS	National Family Health Survey
OBC	Other Backward Class
PHH	Priority Household
SC	Scheduled Caste
ST	Scheduled Tribe
SEBC	Socially and Economically Backward Classes
SIL	Sister-in-Law
UNDP	United Nations Development Program
UNICEF	United Nations International Children’s Emergency Fund

Introduction

In the realm of maternal and nutrition and child welfare, the state of Odisha in India has garnered acclaim as a 'nutrition champion', marking notable progress in enhancing the well-being of its women and children, as highlighted by IFPRI (2016). Over the span from 2005-06 (NFHS 3) to 2019-21 (NFHS 5), the state has observed notable advancements in maternal and child health and nutrition indicators. For instance, the infant mortality rate has dropped from 65 to 36 per 1000 live births, while the prevalence of stunting among children under the age of 5 has decreased from 48.2% to 31.0%. Moreover, the percentage of underweight children has declined from 53.3% to 29.7%, and the incidence of wasting[1] among children has slightly decreased from 19.6% to 18.1%. Antenatal care coverage has seen a substantial increase, rising from 48.3% in 2005 to 76.9% in 2019-20. The institutional delivery rate in the State has also significantly risen from 35.6% to 92.2% during the same period, surpassing the national average of 88.6% (IIPS, 2019-21; IIPS 2005-06).

The Government of Odisha has taken proactive measures to improve maternal and child nutrition outcomes, including implementing supplementary nutrition programmes, expanding Anganwadi services, introducing pre-school education initiatives and enhancing health infrastructure. These efforts have promoted Infant and Young Child Feeding (IYCF) practices and built the capacity of Accredited Social Health Activists (ASHA), Anganwadi Workers (AWW) and Auxiliary Nursing Midwifery (ANMs) at community and facility levels (Government of Odisha, 2023). The frontline ASHA, Anganwadi and ANM workers counsel pregnant and lactating mothers on breastfeeding and complementary feeding practices with the aim of improving the nutritional status of both children and mothers. Despite these efforts, nutritional indicators of women and children remain a concern in the state.

A recent study conducted in six states in India - North (UP, HP), Central (BH, JH, MP) and East (OD), found that pregnant women's fundamental requirements for nutritious food, adequate rest, and healthcare are frequently unmet. Among those who recently gave birth, approximately half reported consuming less food than usual during pregnancy, and nearly 40% expressed dissatisfaction with the amount of rest they received during that period (Dreze et al., 2021). According to the National Family Health Survey 5 (NFHS-5), two in every three children aged six months to 5 years and women aged 15 to 49 years respectively in Odisha are anaemic. The percentage of anaemia in children aged six months to 5 years and pregnant women aged 15-49 increased from 44.6% to 64.2% and 47.6% to 61.8%, respectively, between 2015-16 and 2019-20 (IIPS, 2019-21).

[1] Wasting is defined as a form of acute malnutrition characterised by a low weight-for-height/length. A child is considered wasted if their weight-for-height/length Z-score falls below a certain threshold, typically -2 standard deviations, based on the WHO standards.

Upon examining the health and nutrition data from NFHS 5, the immediate factors contributing to the high prevalence of anaemia in mothers in Odisha can be linked to the low proportion (34%) of mothers who adhered to consuming iron-folic acid supplements for 180 days or more during pregnancy. The primary determinant for anaemia in children in Odisha appears to be the low percentage (20.3%) of breastfeeding children aged six to twenty-three months, who receive a nutritionally adequate diet (IIPS, 2019-21). Additionally, there is a lack of dietary diversity among this age group in Odisha. Research conducted by Gune et al. (2022) indicates that only 40% of children in Odisha aged six to twenty-three months are fed a diet that meets the minimum dietary diversity requirements. As Gune et al. (2022) outlined, the above indicators appear to be the immediate factors. However, the underlying and basic determinants impacting optimal foetal and child nutrition and development in Odisha encompass women's status, sanitation and hygiene practices, food security measures, and socioeconomic conditions. Addressing these foundational determinants involves implementing interventions aimed at empowering women, improving sanitation infrastructure, enhancing agricultural practices, and establishing social safety net programmes.

Studies conducted in East African countries have found that the empowerment of women correlates with healthier body weights and blood haemoglobin levels, which serve as significant indicators of good nutrition (Jones et al., 2019). Further, a systematic review conducted by Lufuke et al. (2022) on nine studies in Africa found that when women are empowered, it often leads to improved nutrition for their families. This improvement encompasses both the overall household nutrition and the specific nutritional well-being of children or women themselves. Similarly, in South Asian countries, including India, the prevalence of stunting among children under five is closely linked to maternal nutritional status and education levels, as noted by Wali et al. (2020).

Compared to men, females in low and middle-income countries generally possess fewer opportunities for choice, limited control over their lives, minimal influence in household decision-making, and lower levels of life satisfaction (Jayachandran, S., 2015). Enhancing agency is a pivotal aspect of empowering individuals, particularly women, to foster gender equality and bolster women's economic empowerment (Anand et al., 2019). When women possess agency, they can make well-informed financial decisions aligned with their aspirations, benefiting both themselves and their families. Moreover, the intergenerational impact of agency is significant, as a mother's empowered choices positively influence her children and subsequent generations (Anand et al., 2019).

According to the latest UNDP Report (2024), India's ranking of 108 out of 193 countries in the Gender Inequality Index underscores the pervasive gender disparities in reproductive health, empowerment, and labour participation. Existing policies addressing food and nutrition security

often fail to adequately consider gender differences, highlighting the need for more inclusive policies that empower women in decision-making related to food and nutrition.

The Women and Child Development Department of the Government of Odisha in September 2011 introduced *Mamata,* a conditional cash transfer (CCT) scheme that seeks to alleviate the financial burden on pregnant and lactating mothers by providing partial wage compensation, facilitating adequate rest during pregnancy and after childbirth. Additionally, it aims to increase the utilisation of maternal and child health services, focusing on antenatal and postnatal care, and immunisation. Furthermore, the scheme aims to improve mother and child care practices, including promoting exclusive breastfeeding and appropriate complementary feeding for infants. By implementing these measures, the program endeavours to support the overall well-being of mothers and children, thereby contributing to healthier communities.

Under this programme, eligible women receive partial wage compensation through CCT, amounting to a total disbursement of INR 5,000 in two instalments directly into their bank accounts. Beyond the logistical framework of financial support lies a complex tapestry of gender dynamics, healthcare decision-making, and women's agency within beneficiary households.

This cross-sectional qualitative study investigates the utilisation patterns of welfare funds allocated through the Mamata scheme in two gram panchayats - Gobindapur and Gengutia - within the Dhenkanal district in Odisha. It aims to delve into the intricacies of intra-household gender relations and women's agency to understand the effectiveness of the Mamata scheme in addressing women's nutritional needs.

In more concrete terms, the questions that motivate this study are:

- Does the Mamata scheme compensate for women's wages, as intended, to facilitate rest for pregnant women and support breastfeeding for lactating women?
- How do women allocate and utilise funds, especially those received through the Mamata scheme?
- What are the existing gender dynamics within the households of pregnant and lactating women who are beneficiaries of the Mamata scheme with conditional cash transfers?
- Does the financial support from the Mamata scheme influence or alter the existing intra-household gender dynamics?

Literature Review

Various studies have shown the existence of a positive relationship between women's empowerment and household nutritional improvement (Lentz E et al., 2021; Onah et al., 2021; Galie et al., 2015). UNICEF (2017) defines women's empowerment as the process by which they attain power and autonomy over their lives. This involves raising awareness, fostering self-confidence, expanding choices, enhancing access to and control over resources, and taking action to transform societal structures and institutions that perpetuate gender discrimination and inequality.

At the heart of empowerment is the capacity of individuals to shape their own future. This means that for women and girls to be truly empowered, they require not only equal capabilities (such as education and healthcare) and equitable access to resources and opportunities (such as land and employment), but also the agency to utilise these rights, capabilities, resources, and opportunities to make strategic choices and decisions (UNICEF, 2017).

Political economist Naila Kabeer's definition of agency as the 'capacity to define one's goals and act upon them' (1999) is deeply relevant to understanding the importance of women's agency in improving health-related decision-making within households. When women have agency, they are empowered to actively participate in decision-making processes regarding their own health and that of their families. Agency involves increased participation, voice, negotiation, and influence in decision-making about crucial life choices. Rather than being passive recipients of decisions made by others, women with agency can articulate their health concerns, preferences, and aspirations. This can involve accessing healthcare services, adopting preventive measures, and making lifestyle choices that promote well-being. Moreover, when women are able to define their own goals and aspirations, they are more likely to be motivated to pursue behaviours and practices that contribute to their well-being. This intrinsic motivation can lead to sustained efforts to maintain good health and prevent illness.

A more comprehensive view of women's agency is given by J-PAL's (2020) 'review paper on interventions that improve women's agency'. It adapted existing frameworks by Laszlo et al. (2017); Kabeer, N. (1999); Malhotra and Schuler (2002); Ibrahim and Alkire (2007); Alkire et al. (2013); and Quisumbing et al. (2016) to develop a list of direct and indirect indicators of agency. The review identified four direct indicators of women's agency - power within, household decision-making, freedom of movement and freedom from violence; and seven indirect indicators, which are outcomes that may result from women exercising agency - timing of marriage and childbearing, contraceptive use, labour force participation, income generation from entrepreneurship, participation in politics and community decision making, voting behaviour and participation in groups and ties in the community. Enhancing women's agency across these

indicators is crucial for progressing gender equality, empowering women, and enhancing the well-being of individuals, families, and communities.

A 2018 analysis of surveys from 54 countries observed that in critical aspects of family relationships, four out of five women did not hold agency, emphasising the importance of addressing women's empowerment within the household context (Haymann, J. et al, 2018). Cunningham et al. (2015) highlight that women not only face resource constraints hindering their ability to make impactful decisions for better health and nutrition outcomes but also, when disempowered, experience a lack of autonomy and decision-making authority within the household. This absence of empowerment has multiplier effects on both family and community well-being.

Studies on cash transfers to women and their usage find that when transfers are provided to women, they tend to spend more money on children, leading to increased investments in children's health and education (Fiszbein et al. ,2009; Yoong J et al., 2012; Hidrobo et al., 2018; Hagen- Zanker et al., 2017). Evidence also suggests that directing transfers specifically to women can influence spending patterns, particularly by enhancing expenditures on food (Schady and Rosero, 2008). Studies have also shown improvement in dietary food consumption quality in various countries where transfers are typically provided to women, such as Mexico (Hoddinott and Skoufias, 2003), Colombia (Attanasio and Mesnard, 2006), Nicaragua (Maluccio and Flores, 2005), Nepal (Gram et al., 2019). However, it remains uncertain whether gains from cash transfers primarily result from increased financial resources within households or from women gaining more influence over expenditure decisions.

As per the Lancet 2019 series on Gender Equality, Norms, and Health, gender inequality and restrictive gender norms are identified as potent yet distinct factors influencing health and overall well-being. Programmes that target women with blanket approaches often operate under the assumption that providing cash or empowerment initiatives will automatically lead to gender benefits. However, social norms related to gender limit the effectiveness of many interventions that target women (J-PAL, 2020). Information interventions may also fail due to restrictive social norms that prevent women from acting on information. For example, a qualitative assessment study of family barriers and facilitators to implement recommended nutrition practices in two Mumbai slum communities in India found that mothers' status in the family and their fear of disrespecting elders outweighed their ability to implement the nutrition experts' recommendations for caring for their child's nutrition and health (Athavale et al., 2020).

Despite the potential of cash transfers to empower women and enhance their agency, the evidence regarding their efficacy remains mixed. Providing access to financial resources, without addressing household dynamics or gender norms, does not reliably enhance women's agency. For example, women in Indonesia who received conditional cash transfers (CCT) under *Program*

Keluarga Harapan (PKH) to improve their and their children's education and health outcomes did not experience any gain in their bargaining position in the household**.** Even after two years of implementation, the programme had neither affected intra-household gender relations nor the relative position of women within the household (Sirojuddin Arif et al., 2013).

In Egypt, CCTs to women under the *Takaful and Karama Program (TKP)* to support impoverished families with school-age children, the elderly, and people with special needs had no effect on the aggregate index of women's control over decision-making due to the persistence of cultural norms where men are expected to be perceived as primary decision-makers. Even if women participate in decision-making, many believe that men need to retain the primary decision-maker role for cultural reasons (El Enbaby et al., 2021). Vaz and Alkire (2019) study on measuring autonomy in Bangladesh, although not exclusively centred on cash transfers, revealed unexpected gendered patterns in motivation sub-scales, hinting at the potential influence of economic factors such as financial rewards, on women's autonomy. The study speculates that cultural influences may lead Bangladeshi women to internalise societal norms, emphasising the need for qualitative exploration to understand this phenomenon.

Similarly, in Columbia, an evaluation of the CCT scheme - *Familias en Acción* - showed increased health service use and dietary improvements but did not lead to increased women's involvement in decision-making processes, potentially due to avoidance of domestic conflicts or violence (Fernandez V., 2022). In India, due to the historical exclusion from income opportunities and subsequent limited access to financial services, many women surveyed across Bihar, Uttar Pradesh, and Chhattisgarh had internalised the belief that it is preferable to defer money matters to male household members. They felt they did not require independent control over their income (Sabherwal R., 2019).

The internalisation of this belief reflects broader societal norms and expectations regarding gender roles and decision-making authority within Indian households. Women may perceive themselves as lacking the necessary knowledge, skills, or agency to independently manage finances, potentially due to limited educational opportunities or cultural barriers that prioritise male authority in financial matters. According to 2017 Financial Inclusion Insight (FII) data, 45.39% of women who held a bank account or had the ability to use someone else's account either believed they did not need it or had never considered using it (Sabherwal R., 2019).

In contrast, cash transfers did increase women's agency in some domains. For example, access to CCTs enhanced women's decision-making power in Mexico's *PROGRESA* programme (Adato et al., 2000). In Zambia, Bonilla et al. (2017) found that women in households receiving benefits from cash transfer programmes experienced an increase in both sole and joint decision-making roles. However, the actual impact of these changes resulted in relatively modest expansions in the number of decision areas women were engaged in.

A recent investigation conducted by Amartya Sen's Pratichi Trust revealed a favourable influence of the Lakshmir Bhandar program, a prominent CCT initiative of the West Bengal government in India, on the financial decision-making of women recipients. Approximately 62% of the female beneficiaries recognised that the monetary transfers have improved their status within their households, while 85.55% of women independently decided how to allocate the funds and joint decision-making with husbands accounted for 10.76% (Pratichi Trust, 2023)

The impediments to women's economic empowerment stem not only from gender-based power dynamics but also from the oppression of women by women themselves (Cornwall, 2007; Vera-Sanso, 2008). Specifically, anthropological research has highlighted the significant impact of intergenerational power struggles, particularly between daughters-in-law and mothers-in-law, on household dynamics in South Asia (Allendorf, 2017; Kandiyoti, 1988; Mandelbaum, 1993; Minturn and Kapoor, 1993; Vera-Sanso, 1999). However, there remains a scarcity of literature utilising this framework to examine women's economic empowerment.

Senarath and Gunawardena (2009) conducted research on women's autonomy in healthcare decision-making and its influencing factors across three South Asian nations: India, Sri Lanka, and Nepal. Their findings revealed that the majority of households in Nepal (72.7%) and approximately half of households in Bangladesh (54.3%) and India (48.5%) made decisions regarding women's health care without their involvement. Singh and Bhandari (2012), in their study of money management and control in middle-income nuclear and joint-family households in North India, found that within the joint Indian household, the decision-making power usually rests with the husband’s parents.

Gram et al. (2018) examined intergenerational power dynamics in money management within rural Nepalese households and found that junior wives and husbands often formed clandestine alliances to gain financial independence from their in-laws. Their study underscores the importance of intergenerational power relations, alongside gender-based ones, in women's economic empowerment, suggesting that familial dynamics significantly influence women's financial autonomy. Another study in Nepal found that the mother-in-law had both a direct and indirect influence on the daughter-in-law’s food consumption, such as food quantity, types of foods, and frequency of consumption (Negin et al., 2016).

An impact evaluation conducted in 2017 on the Bihar Child Support Programme (BCSP) in India revealed that CCTs to women increased expenditure on food items as well as improved women's self-esteem and physical mobility, however, it did not significantly influence household decision-making dynamics. Husbands and in-laws retained primary decision-making authority regarding health expenditure and family planning (Oxford Policy Management, India, 2017). In the Indian context, there is limited available information on the effectiveness of cash transfer

programmes in accomplishing their predefined objectives and attaining desired outcomes (Narayanan., S., 2011; UNFPA India, 2015).

It is evident that the impact of cash transfers on women's spending patterns is multifaceted and context-dependent. To truly understand the impact of cash transfers on women’s agency i.e. her decision-making ability in the household, it's crucial to delve into the realities of women's lives. This requires a context-specific approach. Without conducting a gender analysis to comprehend how money is allocated, controlled, and utilised within households, it remains uncertain whether providing funds directly to women will enhance overall household welfare and foster improved gender relations and women's status.

The literature underscores the need for nuanced approaches that consider the socio-cultural context and gender dynamics shaping women's agency and autonomy. Context-specific interventions that prioritise women's empowerment alongside complementary services are essential for realising enduring positive changes in intra-household gender relations and achieving meaningful outcomes in terms of poverty reduction, maternal health, and overall well-being (De Brauw and Peterman A., 2020; Hagen-Zanker et al., 2016; Cunningham et al., 2015).

This study in Odisha aims to contribute to this body of literature by examining the utilisation patterns of welfare entitlements allocated through the Mamata scheme and exploring the dynamics of intra-household gender relations and women's agency. By investigating how women allocate and utilise funds received through the Mamata scheme, the study seeks to shed light on the effectiveness of the cash transfer scheme in addressing women's nutritional needs and agency within beneficiary households.

Methodology

The fieldwork was conducted in the villages of Gobindapur and Gengutia in Dhenkanal District, Odisha, using convenience sampling. Dhenkanal district, situated in Central Odisha, shares its boundaries with Keonjhar district to the North, Cuttack district to the South, Jajpur district to the East, and Angul district to the West. The district's economy heavily relies on agriculture and forest products. According to the 2011 Census, 9.85% of Dhenkanal's population lived in urban areas, while 90.15% resided in rural regions. Gobindapur and Gengutia villages had approximately 330 and 58 families, respectively.

From 2015-16 to 2019-20, Dhenkanal district witnessed an increase in the percentage of stunted, underweight, and wasted children under 5 years. Additionally, a significant percentage of children and pregnant women were found to be anaemic. Only 25.3% of breastfeeding children aged 6-23 months received a sufficient diet (IIPS, 2019-21).

A small-scale rapid study was conducted from November 30 to December 2, 2023. Twenty-eight participants, consisting of 7 pregnant women and 21 lactating mothers, were included in the study. The sample size was determined based on practical considerations like time constraints and human resources, considering the depth of the interview process. Each participant underwent a comprehensive questionnaire session, lasting an average of 30 minutes. Cross-sectional qualitative research techniques, including in-depth interviews and observations, were utilised.

Two female researchers interviewed the Mamata beneficiaries. Although the questionnaire was in English, both surveyors were proficient in the local Odia language, ensuring effective communication. During interviews, it was observed that daughters-in-law, particularly those newly married or experiencing their first pregnancy, exhibited hesitancy or nervousness when discussing household matters in front of their mothers-in-law. Interviews mostly took place outside the respondents' homes in a verandah or in their drawing rooms. Some respondents hesitated and refrained from answering certain questions, particularly regarding household financial matters.

Ethical guidelines were followed throughout the research process, ensuring informed consent, confidentiality, and respect for participants' autonomy and cultural sensitivities. Detailed and organised field notes provided a foundation for robust data analysis. In-depth interactions with respondents ensured a nuanced understanding of their experiences.

This paper is structured around five central themes: Demographic Profile and Household Composition of Respondents, Mamata Scheme and Labour and Wage Compensation, Mamata scheme money and Women’s Agency, Nutrition information from Anganwadi Centres and Feelings of Empowerment.

<u>Demographic Profile and Household Composition of Respondents</u>

Annexure-I shows the characteristics of the 28 female respondents interviewed. The average age of the participants was found to be 24 years old. Notably, eighteen beneficiaries were receiving Mamata benefits for their first child, while eight beneficiaries were availing themselves of the program for their second child. All respondents identified as Hindu.

Caste distribution reveals a heterogeneous sample, showcasing participation from various social backgrounds. Among the 28 respondents, 8 hail from the General Category (GC), 10 from Other Backward Classes (OBC), 5 from Scheduled Castes (SC), 4 from Scheduled Tribes (ST), and 1 from Socially and Educationally Backward Classes (SEBC). The educational backgrounds of participants vary widely, showcasing disparities in access to formal education. While 21 respondents have attained secondary education or higher, 7 possess primary or middle school education levels.

The socio-economic status of the respondents was evident through the types of ration cards held by their families. In India, ration cards serve as indicators of economic circumstances, with Below Poverty Line (BPL) and Priority Household (PHH) cards typically issued to those facing financial challenges. Out of the 28 respondents surveyed, 14 belonged to the BPL category, while 11 were classified as PHH. Additionally, 2 respondents did not have a ration card, and 1 was unsure about their ration card status. Joint families emerge as the predominant household type, comprising 22 households, while nuclear families constitute 6 households. The dominance of joint families reflects a preference for multigenerational living arrangements. This can be linked to the principles of the Hindu joint family system, where multiple generations - fathers-in-law (FIL), mothers-in-law (MIL), brothers-in-law (BIL), sister-in-law (SIL) etc, cohabit under one roof, sharing resources and responsibilities (Chandrasekhar S., 1943).

Further, in terms of household headship dynamics, the majority of beneficiaries (25 of 28) were not household heads. According to the National Food Security Act (NFSA) of 2013, the eldest woman aged 18 or above within the beneficiary household is designated as the 'Head of Family' for ration card issuance. Within our study cohort, only two respondents took on the position of household heads as they lived in nuclear family arrangements without the presence of a mother-in-law. In four instances, the respondent indicated living in a nuclear setup but did not identify themselves as the head of the household. This discrepancy might stem from a lack of understanding on the part of the respondents that the eldest woman aged 18 or above within the beneficiary household is designated as the 'Head of Family' for ration card issuance.
An examination of earning dynamics within households reveals a rich diversity of arrangements. Among them, seven households rely on a single earner, while the rest have two or more

individuals contributing to the family’s income. Typically, husbands take on the primary breadwinning role, participating in a range of formal and informal occupations such as driving, labouring, working in factories, engineering, weaving, and owning grocery shops. Notably, in joint family setups, additional male members, including brothers-in-law (BIL) and fathers-in-law (FIL), actively contribute to labour or hold specific occupations. Furthermore, in five instances, the mother-in-law (MIL) also contributes to earnings, undertaking tasks that vary from cooking to weaving and labouring.

When asked about their household's monthly income and expenses, thirteen respondents admitted to being unaware of the income, while eighteen were uncertain about the expenses. This underscores women's limited involvement in managing household finances in this community. The distribution of monthly earnings and expenditures varied significantly among households: five earned between Rs. 7,000 to Rs. 10,000 monthly, six earned between Rs. 10,000 to Rs. 20,000, and four earned above Rs. 20,000. Similarly, monthly spending patterns also exhibited diversity, with three households spending less than Rs. 10,000 monthly, five spending between Rs. 10,000 to Rs. 20,000, and two spending above Rs. 20,000.

Results and Discussions

1. Mamata Scheme and Labour and Wage Compensation

One of the aims of the current study is to determine whether the Mamata scheme effectively supplements women's wages, as intended, to enable rest for pregnant women and provide support for breastfeeding among lactating women. The questions were formulated to ascertain the employment status of the respondents prior to marriage, three months prior to pregnancy/lactating and during the pregnancy/lactating period. None of the respondents were presently engaged in any regular income-earning work either from home or outside during their pregnant or lactating state. Further analysis reveals that within the last three months preceding pregnancy or lactation, only one respondent had worked prior to childbirth. This respondent, a 30-year-old lactating mother with a B.Ed degree and professional experience as a teacher in a private school, is presently on maternity leave and also holds the designation of the head of the household since she lives in a nuclear set-up.

Further, the study finds that only five respondents had worked prior to marriage. They were employed in professions including teaching, tailoring, and nursing at private institutions. Two of these respondents were graduates, while the remaining three had completed secondary education. Across all five cases, marriage was cited as the main cause for leaving their jobs. Two lactating mothers, aged 33 and 22 respectively, who had worked as tailors before marriage, expressed their intention to return to work once their children reach a certain age. The surveyors observed that their decision was not driven by financial pressure but rather by their own interest in doing so.

When asked about their daily household tasks, the majority of respondents mentioned cooking most or all meals for all household members, washing utensils and clothes, cleaning floors, and caring for children and elderly family members. Additionally, some respondents mentioned responsibilities such as fetching water and tending to livestock, with two noting that their mother-in-law handles firewood collection. Interestingly, one respondent - teacher on maternity leave, mentioned hiring a maid for washing and cleaning. When questioned about engagement in non-remunerative work beyond household chores, only one respondent mentioned involvement in agricultural activities on family owned land.

Considering that a significant portion of the study cohort had no employment history before marriage or before pregnancy, it's imperative to thoroughly assess the Mamata scheme's aim of addressing income loss during pregnancy and lactation. While it is not within the scope of this paper to elucidate on the issue, it is imperative to understand the percentage of female workforce participation by itself and also in the context of the Mamata scheme.

While the sample size is limited, it sheds light on broader issues concerning women's education, employment opportunities, social-cultural norms, and geographical location. According to the NFHS-5 (2019-21) data for Odisha, a substantial percentage of women (71%) aged 15-49 were not employed in the last 12 months preceding the survey. While a small percentage of women (3%) were engaged in agricultural occupations, a larger proportion (25%) were employed in non-agricultural sectors. This data underscores the complexity of the employment landscape for women in Odisha. Understanding the factors contributing to women's exclusion from both formal and informal employment sectors is crucial, particularly since wage loss compensation is a primary objective of the financial assistance provided. However, it's important to note that delving into these reasons falls beyond the scope of this study and warrants separate attention.

2. Mamata Scheme Money and Women's Agency

2.1 Impact of the Mamata Scheme Money on Women's Financial Decision-Making

The survey findings revealed that a significant majority of beneficiaries (61%) do not directly receive cash from their husbands for general household expenses, nor do they have a say in determining how the overall household income is allocated for major expenditures. Concerning the Mamata funds, beneficiaries indicated that they do not transfer the money to other household members. However, a significant portion of respondents admitted to not exercising independent financial decision-making regarding the utilisation of the Mamata funds. Specifically, 39% respondents stated that they are obligated to seek permission before spending the Mamata money, either from their husbands or their mothers-in-law. Annexure 2 outlines the individuals responsible for financial decision-making within the households, both in general and concerning the Mamata funds specifically.

In this study, the prevalence of joint family households (79%) highlights the significant influence of intragenerational power dynamics, which may be a prominent factor constraining women's agency in engaging in financial decision-making within the household. Kandiyoti (1988) is renowned for suggesting that women who live in households following a patrilocal-patrilineal structure, extending from North Africa through the Middle East to South and East Asia, strategically navigate their decisions within a set of constraints known as the 'patriarchal bargain.' Under this framework, young brides are obligated to endure challenges, hardships, and subordination to their husbands and mothers-in-law. In exchange, they gain economic security facilitated by their husbands.

Furthermore, our analysis revealed that participants exceeding the age of 25 (8 respondents) do not seek permission from their mother-in-law regarding financial decisions concerning themselves or the utilisation of Mamata funds. Within this subset, only four individuals mention consulting with their husbands, while the remaining four perceive spousal permission as unnecessary in their decision-making process. One rationale for this lack of MIL consultation is the absence of the MIL herself, as six out of these eight respondents reside in nuclear family setups. This could suggest that as women age, they are more inclined to separate from joint family arrangements, thereby gaining increased autonomy in financial decision-making or in general, as women age they gain greater autonomy. Research conducted in Nepal, Bangladesh, India, Pakistan, and Kenya indicates that women's age correlates with higher levels of agency, autonomy, and decision-making authority (Senarath and Gunawardena, 2009; Akram, N., 2018; Acharya et al., 2010). Studies have also found that women's autonomy in decision making is positively associated with their employment (Acharya et al. 2010; Senarath and Gunawardena, 2009), education (Adato et al. 2000); El Enbaby et al. 2021) and household size (Batura et al. 2022).

Notably, a substantial proportion of respondents privately consult with their husbands regarding the utilisation of funds from the Mamata scheme. One respondent mentioned that the cash benefits received for both her first and second daughters through the Mamata scheme were deposited into a savings account, a decision jointly made by her and her husband. Upon asking the respondents about discussing general household finances privately with their husbands, 36% confirmed engaging in such conversations, while 25% mentioned occasional discussions, and remaining denied partaking in such talks. To further investigate the bargaining power of the respondents, they were probed regarding their involvement in discussions, negotiations, or bargaining with their husbands regarding expenditure decisions, including which items or for whom expenditures should be made. Twelve respondents affirmed actively participating in these discussions, while an equal number denied such involvement. Furthermore, three respondents clarified that although they do not deliberate on household spending, they do engage in discussions specifically related to their children's expenses.

A recent survey by Pew Research Centre, which surveyed nearly 30,000 adults across India found a divergence in attitudes towards gender roles and decision-making within Indian households. While a majority of respondents believe that both genders should participate in family financial decisions (73%), there is still a strong adherence to traditional gender norms, with a significant proportion (67%) endorsing the idea that wives should always obey their husbands (Evans et al., 2022). The Pew survey's identification of a divergence in attitudes towards gender roles echoes the varied responses obtained from the Mamata scheme survey regarding respondents' involvement in household financial decisions. While some respondents actively participate in discussions and negotiations with their husbands, others report occasional involvement or complete exclusion from such conversations. This diversity in responses underscores the complexity of gender dynamics and decision-making processes within the beneficiary’s households, where traditional beliefs coexist with evolving attitudes towards gender equality.

Contrary to the findings of several studies (Galie et al., 2015; Hoddinott and Skoufias, 2003; Attanasio and Mesnard, 2006; Maluccio and Flores, 2005; Gram et al., 2019), which have shown that greater autonomy over finances and resources for women is associated with healthier eating habits and improved overall nutrition within families, our study finds that cash transfers to women beneficiaries under the Mamata scheme did not significantly impact women's agency within the household. Additionally, there was no significant change observed in their overall authority in financial decision-making or financial control at home.

The lack of impact of CCT on women’s agency observed in our study suggests that factors beyond mere cash transfers may influence women's agency and decision-making within households. While cash transfers can be an important intervention, their effectiveness in

enhancing women's empowerment may be contingent upon various contextual factors, such as gender norms, cultural practices, and the distribution of power within the household, specifically, joint families. Therefore, future interventions aimed at improving women's agency and decision-making through CCTs in the context of household nutrition and food security may need to consider a more comprehensive approach that addresses these underlying factors.

2.2 Mamata Beneficiary and Usage of Mamata Money

Regarding usage of the Mamata money, it was found that the respondents utilise the funds in a variety of ways, including saving, directing them towards the future of their children, or utilising them for household and health-related expenses. Six respondents chose not to utilise the funds, instead opting to save them for their children's future. This observation resonates with IFPRI's 2015 research conducted in Odisha, which found that most households receiving funds from the Mamata scheme either saved the money for future use or directed it towards their child's healthcare needs (Avula et al., 2015).

All the respondents who saved Mamata money for future use, live in a joint family set up. A 22-year-old respondent pregnant with a third child said, ‘*deposited some money in the bank for Sukanya Yojana as well as used some for household expenses’*. A 27-year-old lactating mother mentioned, ‘*her husband made the decision to save the money for the future use of their two children’*. Another respondent stated, ‘*Money not yet used and kept as savings for their son’*.

Huda et al. (2018) also emphasised the trend of saving or investing transfer funds for future use. They investigated the impact of an unconditional cash transfer programme on nutrition during pregnancy and the first year of a child's life in rural Bangladesh. Their findings indicated that while there was a predominant focus on obtaining food among low-income families, some recipients chose to allocate funds toward healthcare or opted to save and invest. Moreover, households experiencing a slight improvement in economic status tended to prioritise saving or investing in income-generating activities.

Further, five respondents mentioned using the Mamata funds for household expenses and two respondents said, *‘Do not remember how Mamata money was used’*. As discussed in the previous section, the limited control beneficiaries have over decision-making regarding the use of Mamata funds leads to other household members, mainly mothers-in-law and husbands, determining their allocation. While the Mamata scheme aims to enhance health and nutrition outcomes for both mothers and children, the majority of households being in the BPL category and having constrained resources means that, in situations where a choice must be made between the mother's health and the child's future, the child's needs are typically prioritised. Despite the

scheme's consideration of women's needs, societal norms and family dynamics often hinder women from prioritising their own rest, health, and well-being.

Some beneficiaries reported using the Mamata funds for health-related purposes, particularly emphasising food and nutrition. Their choice to prioritise spending the Mamata money on health during pregnancy and childbirth has led to an increase in dietary diversity. This is evident from their responses, which include purchasing items such as fruits (specifically pomegranates and oranges), dry fruits (almonds), biscuits, bread, Horlicks, fish, chicken, meat, eggs, and green vegetables, indicating an improvement in overall nutritional intake.

However, the limited control over fund allocation among women beneficiaries highlights broader challenges in women's agency within household decision-making processes, which are often exacerbated by poverty. In many impoverished households, entrenched gender norms and power dynamics may restrict women's ability to assert their preferences or make independent financial choices. This lack of agency can perpetuate cycles of poverty and inequality, as women are unable to fully participate in economic decision-making or leverage resources to improve their families' well-being. By aligning cash transfer programmes with comprehensive poverty alleviation measures, policymakers can foster economic empowerment, social inclusion, and sustainable improvements in maternal and child health outcomes.

2.3 Mamata Beneficiary and Existing Household Dynamics (Food)

Our research indicates that within joint family households (79%), mothers-in-law predominantly wield authority over food purchases. While husbands may occasionally participate in decision-making regarding purchases, there were no instances observed where daughters-in-law have sole discretion over food procurement decisions.

Additionally, the primary grocery shoppers in all the surveyed households are male members, primarily husbands, with fewer cases involving fathers-in-law and brothers-in-law. Nutritional awareness programmes often focus on pregnant and lactating women, yet the fact that husbands are typically responsible for purchasing food from the market raises doubts about the programmes' effectiveness in achieving their goals of improving maternal nutrition outcomes. This is because if husbands were knowledgeable about nutritious food options, they would likely purchase foods in line with dietary recommendations (Jhaveri et al., 2023). Further, an extended family structure is also linked to women having difficulty applying nutrition knowledge gained from awareness programmes during pregnancy and the postpartum period, as highlighted by Skordis et al. (2019) in their study in Nepal.

Further, we find that in these joint family setups, food preparation decisions as to what to cook also predominantly involve the mother-in-law. Only in a few cases, a collaboration between the

mother-in-law and the daughter-in-law is found. Interestingly, the analysis of food-related decisions within the nuclear families of the study cohort found that the majority either make decisions independently or seek input from their husbands. Annexure 3 shows the responses related to decision-making in food purchases and preparation in Mamata beneficiary households.

In exploring the perceptions of respondents regarding general eating practices within their households, the question was posed: "What should be considered their (the respondents') fair share of food in the household?" Respondents were given the options of eating more, less, or an equal amount compared to other family members. A notable number expressed the belief that their fair share should align with their needs or be equal to that of other family members. This suggests a prevailing sense of fairness and equity in the distribution of food among the respondents.

However, when probed further about whether boys and men should consume more food than female members, eleven respondents affirmed this notion. Two respondents elaborated that this belief stemmed from the belief that men engage in more strenuous labour than women, thus justifying a greater intake. This revelation sheds light on entrenched gender norms and self-sacrificial behaviour of women regarding food consumption. Anthropological research has uncovered that many South Asian women internalise prevalent cultural norms that promote male privilege. They find satisfaction in nurturing their families and willingly embrace self-sacrificial behaviours (Messer, 1997). This tendency suggests a lower prioritisation of their own well-being, echoing concerns expressed by several scholars (Sen, 1987). Nevertheless, when provided with the opportunity, women generally allocate more food to themselves as highlighted by Harries et al. (2021) in their study in Nepal where the majority of pregnant women receiving cash transfers maintained control over the funds and reported active involvement in decisions regarding the allocation of these resources. This phenomenon can be attributed to a combination of factors, including increased feelings of empowerment among recipients and the program's design, which earmarked the transfers for their specific use.

Further, when asked if they partake in any meal of the day together as a family, some respondents outlined specific conditions, such as eating after elders or only alongside female members. A 22-year-old respondent residing in a household with a joint family structure, consisting of eight family members, including their father-in-law, mother-in-law, and brother-in-law, noted that she is the last to eat, waiting until everyone else has finished their meals. This reflects a common cultural or familial norm observed in many families in India, where women of the household prioritise the needs and schedules of others before their own.

Also, these observations contradict the initial perceptions expressed by respondents regarding the fairness and equity of food distribution within the household. This underscores the conflict between the belief of fairness and accepted practices within the household, revealing the

complexities of intergenerational dynamics and power struggles.Those who acknowledged eating meals together typically referred to dinner as the primary occasion for familial dining.

Further, most respondents informed that they ate more during pregnancy/lactation period, although some experienced a decreased appetite. Four respondents indicated that when feeling hungry or weak during pregnancy or lactation, they refrained from eating lunch or dinner until after other family members have finished. One respondent stated, '*She ate whenever she felt hungry but after her father-in-law and mother-in-law have eaten*'.

Under the Take Home Ration (THR) scheme in Odisha, eggs and *chhatua*[2] are provided to both normally nourished and severely malnourished children aged between 6 months and 3 years, as well as to pregnant and lactating mothers. All respondents in the present study reported receiving eggs and *chhatua* through THR scheme, and they all mentioned sharing both items with other members of their families. Eight respondents noted that their mothers-in-law consume *chhatua*, while the rest shared it with either their husbands or children. A 22-year old lactating mother from a Socially and Economically Backward Community (SEBC) said, '*Most often, the mother-in-law visits the Anganwadi Centre to collect eggs and chattua, which are then consumed by all members of the family'*.

Anthropological studies propose that the distribution of food within households is influenced by intergenerational negotiations among women (Cornwall, 2007; Vera-Sanso, 1999). In certain situations, intergenerational bargaining power may exert a more significant impact, especially in cases where mothers-in-law are in charge of daily food-related decisions, including purchasing, preparation, and distribution, within shared households (Harris et al., 2021; Aubel, 2012; Morrison et al., 2017), thereby affecting daughter-in-law's agency in making decisions herself. It is surprising that most interventions related to nutrition, health, and social welfare fail to consider these intergenerational power dynamics in their design and evaluation processes (Harris et al., 2021).

3. Nutrition Information from Anganwadi Centres

This study found a significant overall awareness among respondents regarding the purpose and utilisation of Mamata money, largely guided by the insights provided by Anganwadi workers. All beneficiaries acknowledged that Anganwadi workers told them that Mamata money's purpose is to enhance the nutritious diet for both the mother and child. While many could identify specific food items recommended during pregnancy, there was a notable lack of detailed information on quantities. While respondents generally mentioned categories of items such as "healthy food," "nutritious food," "milk," "fruits," and "Horlicks," there was lack of specificity regarding the

[2] *Chhatua* is a dry mixture made of wheat, Bengal gram, peanuts and sugar.

quantity or proportion of the Mamata money to be allocated to each item. Further, none of the respondents mentioned multiple food groups such as grains, pulses, etc.

Interestingly, not all respondents adhered to the spending instructions given by Anganwadi workers. Some intentionally saved the money for future use, emphasising the necessity for tailored interventions and support mechanisms. It's crucial to recognise that despite health workers providing nutritional information, various barriers — individual, household, cultural, economic, and environmental — hinder translating this knowledge into practice (Jhaveri et al., 2023). Women face barriers in implementing expert recommendations, be it due to seasonal availability, dietary restrictions, or familial obligations. A qualitative assessment study of family barriers and facilitators to implementing recommended nutrition practices in two Mumbai slum communities found that mothers' status in the family, and their fear of disrespecting elders, outweighed their ability to implement the experts' recommendations for caring for their child's nutrition and health (Athavale et al., 2020).

Our study found the presence of intergenerational power dynamics and deeply ingrained patriarchal norms, among interviewed women within households. The inclination of beneficiaries to prioritise other family members over themselves adds complexity to the situation. Our findings underscore the imperative to move beyond mere observation of these intergenerational and patriarchal dynamics. A critical next step lies in understanding the mediating factors that influence the beneficiaries' actions and resource allocation decisions within the household. By mediating factors, we refer to the underlying mechanisms or social influences that shape their choices and priorities.

Also, AWWs and other FLWs need to transcend their traditional role as information providers. They must actively engage with the women, addressing not just what to eat but also how and why food consumption choices are made. This might involve sensitively intervening when women are relegated to eating last or after male members finish their meals—a practice indicative of deeper power imbalances within the household. Extended family members, in addition to mothers, should be engaged, and efforts made to bolster mothers' self-efficacy in child nutrition counselling (Athavale et al., 2020).

Furthermore, recognising that husbands often serve as primary grocery shoppers, AWWs should also extend their outreach to include husbands. Qualitative studies conducted in South India (Suryawanshi et al., 2012) and Delhi (Narang et al., 2013) have indicated increased involvement of husbands during the antenatal phase. However, their engagement tends to decline significantly during childbirth and immunisation stages (Suryawanshi et al., 2012). This decline in husbands' involvement during childbirth and immunisation stages has been linked to three key factors: work commitments, patriarchal societal norms, and financial constraints. The demands of work, compounded by insufficient holidays and paternity leave, as well as difficulties in coordinating

duties with colleagues and managing time effectively, limit husbands' ability to participate. Within patriarchal societies, birth preparedness is predominantly viewed as the responsibility of the mother's family, fostering a lack of cooperation between in-laws and perpetuating misogynistic beliefs that confine women to domestic roles and child-rearing duties. Financial limitations, stemming from factors like lack of preparedness, unplanned pregnancies, and early marriages, exacerbate the situation, hindering husbands' active engagement in these critical stages (Suryawanshi et al., 2012).

To promote a more inclusive approach, AWWs should actively involve husbands in discussions concerning nutrition and household food practices. By doing so, they can contribute to creating a supportive environment that encourages gender-equitable decision-making related to food allocation and consumption.

4. Feelings of Empowerment

Our study also delved into the understanding of respondent's comprehension of empowerment. The majority of participants (75%) *chose not to respond* when asked to describe an empowered woman in their community - what would she be like and what would she be able to do? Among those who did respond, the following answers were provided:
Respondent 1 - "*someone who makes their own decision by themselves*".
Respondent 2 - "*a person who is not dependent on anyone*".
Respondent 3 & 4 - "*someone who takes her own decision*"
Respondent 5- "*someone who is independent and can take her own decisions*".
Respondent 6 - "*self-employed, have taken care of themselves and their own family members in every situation, and have the strength to do everything".*
Respondent 7 - "*take decisions by own-self & keep own viewpoint strongly on right things."*

Based on the responses provided by the seven respondents, a common understanding of women empowerment emerges as the ability to make decisions independently without relying on others. Overall, the respondents' definitions suggest that they associate empowerment with self-sufficiency, independence, and the capacity to take charge of one's own life and circumstances. While these women beneficiaries demonstrate an understanding of empowerment, the challenge lies in their ability to practise it. On inquiring how they would want to spend the Mamata money if they had complete freedom over it, only six respondents answered and the recurring theme was preserving the money for the welfare of their children.

The low response rate to the empowerment-related questions suggests a negative perception of self worth and abilities among the surveyed individuals. When we consider J-PAL's definition of

agency, particularly the "Power Within"[3] indicator, it becomes apparent how barriers like patriarchal norms and intergenerational power dynamics may impact individuals' perceptions of their own worth and abilities.

The lack of/ hesitation in providing responses to questions related to empowerment could also reflect the mental load of juggling multiple responsibilities, coupled with 30 minutes to answer all the survey questions in the presence of other household members, with the last question potentially touching on asserting their identity or independence. Also, the emphasis on preserving the Mamata money for daughters shows the attitude of focusing on children's future versus the woman's own health. Factors such as patriarchal norms, social and cultural norms and intergenerational power dynamics may contribute to individuals' perceptions of themselves and their capabilities, potentially leading to a lower sense of agency. This lack of agency has detrimental effects on the health and nutrition of women and children in the household.

[3] According to J-PAL, "Power Within" includes having internal belief in one's worth and ability, which is measured through aspirations, self-efficacy, and attitudes about gender norms.

Conclusion & Policy Recommendations

The findings of this research shed light on the complex interplay of factors influencing women's agency, household dynamics, and the impact of the Mamata scheme on nutrition-related choices and women's empowerment.

Firstly, a significant portion of our study cohort had no employment history before marriage or pregnancy, highlighting the need to thoroughly assess the Mamata scheme's aim of addressing income loss during pregnancy and lactation. The findings suggest that the scheme's effectiveness in supplementing women's wages may be limited by entrenched patriarchal norms. Despite receiving financial assistance, many women still do not make independent decisions over household finances and there's an enduring influence of traditional gender roles and family structures reflected here.

Furthermore, the research underscores the importance of considering intergenerational power dynamics in understanding women's agency and decision-making within households. While women may receive cash transfers through the Mamata scheme, their autonomy in financial decision-making is often constrained by the authority of older family members, particularly mothers-in-law. This highlights the need for interventions that address not only women's economic empowerment but also the broader sociocultural factors shaping household dynamics. Moreover, the study reveals the impact of gender norms on food-related decision-making within households, with mothers-in-law often exerting significant control over food procurement and preparation. Despite efforts to promote nutritional awareness through programmes like Anganwadi centres, women's ability to implement dietary recommendations is hindered by various barriers, including cultural expectations and social influences within households.

In terms of empowerment, while some respondents demonstrate an understanding of empowerment as self-sufficiency and independence, the majority did not respond to questions related to empowerment, suggesting either a lack of comprehension or a reflection of the mental load of juggling multiple responsibilities, coupled with 30 minutes to answer all the survey questions in the presence of other household members, with the last question potentially touching on asserting their identity or independence.

In conclusion, the findings underscore the need for comprehensive interventions that address the multifaceted barriers to women's empowerment and nutrition outcomes. While the *Mamata* scheme is designed to achieve several objectives - including providing wage compensation for pregnant and nursing mothers to ensure adequate rest, increasing the utilisation of maternal and child health services, and improving mother and child care practices such as breastfeeding and complementary feeding - it's essential to recognise that its effectiveness is influenced by broader

societal factors. Gender norms and social structures significantly shape the interactions between the scheme and its beneficiaries. To truly empower women and positively impact maternal and child health outcomes, we must adopt a more holistic approach that extends beyond individual responsibility. This entails investing in a broader support network around women, leveraging the roles of Anganwadi Workers (AWWs) and state institutions to influence behaviours and purchasing decisions related to food and meal habits. It's crucial to actively involve not only the mother-in-law but also the husband in these efforts. However, achieving women's autonomy in spending money for themselves, especially in resource-constrained environments, remains a considerable challenge that underscores the substantial journey ahead.

Based on the findings and discussions presented in the research paper, several policy recommendations can be proposed:

1. **Addressing Intergenerational Power Dynamics:** Implement programmes and policies that recognise and address intergenerational power dynamics within households. This could involve sensitisation programmes for family members, including husbands and mothers-in-law, to promote gender-equitable decision-making and support women's autonomy in financial and household matters.

2. **Optimising Nutritional Interventions - A Couple-Centric Approach:** Strengthen Anganwadi centres to provide comprehensive nutritional education and support to women during pregnancy and lactation. To maximise their effectiveness, these programs can be enhanced by actively engaging both pregnant women and their husbands during pregnancy and lactation. By actively including husbands in nutritional education programs, Anganwadi centres can cultivate a more supportive and collaborative household environment. This empowers women to implement nutritional recommendations with greater confidence, ultimately leading to improved health outcomes for both mothers and infants. This should include information on dietary requirements, meal planning, and strategies for overcoming barriers to implementing nutritional recommendations within households.

3. **Promoting Women's Agency and Empowerment:** Launch awareness campaigns and community-based initiatives to promote women's agency and empowerment. This could involve workshops, seminars, and community discussions aimed at challenging traditional gender norms, fostering self-efficacy, and promoting women's rights within the household and community. This should also include ensuring women are financially literate, able to access their bank accounts, and have the required access to spend the money that they are receiving.

4. **Inclusive Approach in Programme Design:** Include in-depth consultations and pilots with the intended beneficiaries - in this case pregnant women and lactating mothers - to ensure that the government schemes and programmes being created for them are holistic and take into account the multi-faceted challenges faced by these women in the day-to-day, and thus their actual needs. For existing schemes, there should be a reviewing committee established, that does these ground reviews once a year, to ensure there is updation in the scheme, based on ground relalities.

5. **Monitoring and Evaluation:** Establish robust and continuous monitoring and evaluation mechanisms to assess the effectiveness of interventions in promoting women's empowerment and improving health and nutrition outcomes. This should take a gender inclusive perspective and include regular assessments of programme impact, feedback mechanisms for beneficiaries, and most importantly, adjustments in the provision, based on feedback received. There should be a third-party evaluation in regular intervals, with publicly published and accessible reports. Community participation in the monitoring can lead to a more sustainable program. A 3-5 plan of action can be created for the same.

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Annexure

ANNEXURE 1: Female Respondents Characteristics

Sr. No.	Village name	Caste	Socio-economic status	Joint/ Nuclear household	Age	Grades passed	Head of HH	Pregnant/ lactating
1	Govindpur	ST	No ration card	Joint	27	8th	No	Lactating, second child
2	Govindpur	ST	Don’t know	Nuclear	26	5th	No	Pregnant, first child (unaware of pregnancy month)
3	Govindpur	ST	PHH	Joint	22	10th	No	Pregnant, third child (9 months)
4	Govindpur	OBC	PHH	Nuclear	30	B.ED	Yes	Lactating. (6 months)
5	Govindpur	ST	PHH	Joint	21	10th	No	Pregnant
6	Govindpur	OBC	BPL	Joint	24	12th	No	Lactating, First child
7	Govindpur	OBC	BPL	Joint	23	12th	No	Lactating, twin daughters
8	Govindpur	SC	BPL	Joint	23	12th	No	Pregnant, first child (6 months)
9	Govindpur	OBC	BPL	Nuclear	33	10th	No	Lactating, First Child
10	Govindpur	OBC	BPL	Joint	25	9th	No	Lactating, second child

11	Govindpur	SC	BPL	Joint	20	2nd	No	Lactating, first child
12	Govindpur	SC	BPL	Joint	23	6th	No	Lactating, second child
13	Govindpur	SC	BPL	Joint	24	9th	No	Lactating, first child
14	Govindpur	SC	BPL	Joint	20	7th	No	Lactating, first child
15	Govindpur	OBC	BPL	Joint	22	10th	No	Lactating, first child
16	Govindpur	SEBC	BPL	Joint	22	9th	No	Lactating, second child
17	Govindpur	OBC	BPL	Joint	24	8th	No	Pregnant, second child (6 months)
18	Govindpur	OBC	BPL	Joint	22	8th	No	Lactating, second child
19	Gengutia	Gen	BPL	Joint	28	10th	No	Lactating, first child
20	Gengutia	Gen	PHH	Nuclear	23	12th	No	Lactating, first child
21	Gengutia	Gen	PHH	Joint	27	12th	No	Pregnant,
22	Gengutia	OBC	PHH	Nuclear	26	10th	Yes	Lactating, third child
23	Gengutia	Gen	No ration card	Joint	24	Post Graduate	No response	Lactating, first child
24	Gengutia	OBC	PHH	Joint	22	Graduate	No	Lactating, first child

25	Gengutia	Gen	PHH	Joint	24	10th	No	Lactating, first child
26	Gengutia	Gen	PHH	Joint	24	Graduate	No	Lactating, first child
27	Gengutia	Gen	PHH	Joint	22	Graduate	No	Lactating, first child
28	Gengutia	Gen	PHH	Nuclear	26	Graduate	No	Lactating, first child

ANNEXURE 2: Usage of Mamata Money and Beneficiary's Decision-Making

	In General beneficiary's decision making in the household	Usage of Mamata money and beneficiaries decision making			Respondent Status
S.no	Need permission from somebody to spend on specific things that beneficiary might need or want for herself or the family	Need permission on whether and how to spend the Mamata scheme money	Is the Mamata scheme money spent for different purposes of the HH, or is it spent for one particular purpose?	How *beneficiary* spend the money	Pregnant/ lactating
1	Yes, husband	Yes, husband	Not spent	Saved the money for future use of both children.	Lactating, second child
2	No response	No response	No response	No response	Pregnant, first child (month unknown)
3	Yes, husband	Yes, husband & MIL	For Household purpose	medicines & also deposited in the bank for Sukanya Yojana	Pregnant, third child (9 months)
4	No	No	Not spent	Yet to check bank account	Lactating, second child (6 months)
5	Yes, Husband,& MIL	Yes, Husband,& MIL	For herself during pregnancy or after delivery; not for the Household purposes	food items - vegetables, fruits, horlicks, milk & medicines	Pregnant, (month unknown)
6	Yes, Husband	No	On herself during delivery	Milk, horlicks & medicines	Lactating, First child

7	Yes, Husband,& MIL	Yes, husband	Not spent	Saved in Sukanya samriddhi Yojana for twin daughters	Lactating, twin daughters
8	Yes, Husband	-	Not received instalment yet	-	Pregnant, first child (6 months)
9	No response	No	Spent on herself during and after delivery	fruits, milk, medicines	Lactating, First Child
10	No	Yes, husband	Not spent	Saved for daughters when they grow up	Lactating, second child
11	Yes, husband & MIL	Yes, husband & MIL	For household purposes	Do not remember how money was used	Lactating, first child
12	No	No	Spent on herself during and after delivery	fruits, milk, horlicks	Lactating, second child
13	Yes, Husband	No	Not spent	Saved for daughter	Lactating, first child
14	Yes, MIL	No	Not spent	Saved for son	Lactating, first child
15	Yes, Husband	No	Spent on herself during and after delivery	fruits - pomegranate, oranges, milk & horlicks	Lactating, first child
16	No	No	Not spent	No response	Lactating, second child
17	Yes, MIL	Yes, MIL	For household purposes as well as during pregnancy	Food items	Pregnant, second child (6 months)

18	Yes, husband & MIL	No	For household purposes as well as during pregnancy	Do not remember how money was used	Lactating, second child
19	Yes, Husband	No	Not spent	Saved for daughter	Lactating, first child
20	Yes, Husband & MIL	Yes, MIL	For herself during pregnancy; not for the Household purposes	medicines, foods, fruits & horlicks	Lactating, first child
21	No	Yes, husband	Not spent	Recently received	Pregnant, (month unknown)
22	Yes, Husband	No	For food items for herself	fruits, biscuits, bread, Horlicks, fish, meat, milk & vegetables	Lactating, third child
23	No	No	spent on food items.	dry fruits, fruits, milk, egg, fish, chicken, vegetables & Horlicks.	Lactating, first child
24	Yes, Husband & MIL	Yes, Husband & MIL	No response	No response	Lactating, first child
25	No	No	For her nutrition	milk, fruits, Horlicks & green vegetables	Lactating, first child
26	No	No	spent on food items.	Fruits, dry fruits, Horlicks, vegetables, milk, fish, meat, egg	Lactating, first child
27	No response	No	For her nutrition	milk, fruits, egg, meat & Horlicks	Lactating, first child
28	Yes, Husband	Yes, Husband	spent on food items.	milk, fruits, Horlicks, dryfruits, fish, meat, egg & medicines	Lactating, first child

ANNEXURE 3: Decision-Making in Food Purchases/Cooking in Mamata Beneficiary Household

Respondent	Joint/ Nuclear HH	On a day-to-day basis, who decides what to buy for food in your HH?	On a day-to-day basis, who decides what to cook in your HH?	Should boys and men of the HH eat more than all the female members of the HH?	Do you ever eat any meal of the day together as a family?	Pregnant/ lactating
1	Joint	Whoever goes to the market	No response.	Yes	Yes	Lactating, second child
2	Nuclear	Husband	Herself	Yes, because men do hard work as compared to females	Yes	Pregnant, first child
3	Joint	Husband & MIL	Husband & MIL	Yes, because men do hard work as compared to females	Yes	Pregnant, third child (9 months)
4	Nuclear	Husband & herself	Herself	Yes	Yes	Lactating. (6 months)
5	Joint	Husband & MIL	MIL	Yes	No	Pregnant
6	Joint	MIL	MIL	No response	No, after elders have eaten	Lactating, First child
7	Joint	MIL & herself	MIL & herself	No response	Sometimes	Lactating, twin daughters

8	Joint	MIL	Females of the HH	No response	No response	Pregnant, first child (6 months)
9	Nuclear	Husband & herself	Herself	According to need	Yes	Lactating, First Child
10	Joint	MIL	MIL & herself	According to need	No, After males have eaten	Lactating, second child
11	Joint	MIL	MIL	No response	No response	Lactating, first child
12	Joint	Husband	MIL, SIL & herself	Equal portions for all	No	Lactating, second child
13	Joint	MIL & herself	MIL & herself	No	Yes	Lactating, first child
14	Joint	MIL & herself	MIL & herself	No	Yes	Lactating, first child
15	Joint	MIL	MIL	According to need	No	Lactating, first child
16	Joint	MIL & FIL	MIL	According to need	No, eats last	Lactating, second child
17	Joint	MIL	MIL & herself	No response	No, only with MIL	Pregnant, second child (6 months)
18	Joint	MIL	MIL & herself	According to need	Sometimes	Lactating, second child
19	Joint	MIL & herself	MIL & herself	According to need	Sometimes	Lactating, first child
20	Joint	All	MIL & herself	Yes	Yes	Lactating, first child

21	Nuclea r	Husband & herself	Herself	According to need	Yes	Pregnant,
22	Nuclea r	Husband & herself	Husband & herself	According to need	Yes	Lactating, third child
23	Joint	All	All	According to need	Yes	Lactating, first child
24	Joint	All	Females of the HH	Yes	No, Only with female members	Lactating, first child
25	Joint	Elders of the HH	Elders of the HH	Yes	No	Lactating, first child
26	Joint	All	All	Yes	Yes	Lactating, first child
27	Joint	All	All	Yes	Yes	Lactating, first child
28	Nuclea r	Husband & herself	Husband & herself	Yes	Yes	Lactating, first child