Conditional Cash Transfers in Tribal India — Evidence, Adaptation, and the Mamata Lesson

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Conditional Cash Transfers are programmes that provide money to low-income households on the condition that they meet specific behavioural criteria — typically health-seeking behaviours like attending antenatal care, delivering in a health facility, vaccinating children, or sending children to school. The theory is that cash addresses the economic constraint that prevents poor households from making health and education investments, while the condition ensures the cash is used in ways that produce development outcomes.

The global evidence on CCTs across 100+ countries is among the most researched in development economics. The findings are broadly positive:

Child health and nutrition: A 2023 Nature study examining the effects of cash transfers on mortality found that cash transfers are associated with reductions in the risk of death among young children in low- and middle-income countries. A medrxiv 2025 preprint evaluating India's PMMVY national maternity benefit programme found that potential exposure to PMMVY is associated with improvements in weight-for-age and height-for-age z-scores — effects operating through increased pregnancy registration, antenatal care, and immunisations. The programme is cost-effective: the study estimates a short-run benefit-cost ratio of 1.35.

Maternal health: Multiple evaluations of Janani Suraksha Yojana (JSY) — the conditional cash transfer for institutional delivery — found significant increases in institutional delivery rates, particularly among women below the poverty line in rural areas.

The equity problem: The same research base consistently identifies an equity gap that systematic reviews call the "coverage-equity tension." The poorest households — those with the weakest documentation, the most limited mobility, the least familiarity with formal systems — are least likely to access CCT benefits, even as those benefits are explicitly designed for them.

The Mamata Evidence: What the Research Shows for Odisha

The Mamata Scheme, Odisha's state-level conditional cash transfer for pregnant and lactating women, is one of the most studied CCT programmes in India. Multiple peer-reviewed studies have examined its outcomes, providing an unusually detailed picture of what it produces and who it misses.

What Mamata produces when it reaches its intended beneficiaries

A 2017 PLOS One study — the first to provide quantitative outcome evidence specifically from Mamata — found that receipt of Mamata payments is associated with:

- A 5 percentage point increase in the likelihood of receiving antenatal services
- A 10 percentage point increase in the likelihood of receiving iron-folic acid tablets
- A significant decline in household food insecurity

A 2021 Journal of Nutrition study examined the maternal and child health benefits of Mamata more broadly, finding improvements in nutrition-linked outcomes for beneficiary households.

The 2023 Health Economics study is the most recent and most methodologically rigorous evaluation. It found that Mamata reduces child wasting by 7 percentage points overall. But the same study found that this average effect conceals dramatic heterogeneity: the programme produced significant benefits for higher-wealth quintile households and essentially no measurable benefit for the bottom wealth quintile. Children in the poorest households were 13 percentage points more likely to suffer from wasting than those in higher wealth quintiles — but received no protection from the programme designed to help them.

Why the poorest households are excluded

The 2023 study's diagnosis of why the bottom quintile is excluded is specific and important for NGO programme design:

Documentation barriers: Mamata payments require Aadhaar-linked bank accounts in the woman's name, a registered pregnancy at the Anganwadi, and documentation of attendance at specified health services. Households in the bottom wealth quintile are more likely to lack one or more of these — because they are more likely to have women without their own bank accounts, because they live farther from Anganwadis, and because their mobility is more constrained by economic necessity.

Health service access: The conditions for Mamata payments require health service attendance that is physically and economically costly for households in the most remote and impoverished communities. A woman who cannot afford transport to the Anganwadi for registration, or to the PHC for the required antenatal visits, cannot meet the conditions regardless of whether she wants to.

Awareness: Multiple field studies report that women in the most marginalised communities — PVTGs, geographically remote settlements — were unaware of Mamata's existence. A programme you don't know about cannot help you.

Payment delays: Even enrolled women frequently experience payment delays that reduce the incentive value of the programme. A conditional cash transfer whose

payments arrive six months after the condition is met provides little behavioural incentive and produces significant financial hardship for households that had planned around the expected cash.

PVTG-specific provision that few PVTG women access

For Odisha's 13 Particularly Vulnerable Tribal Group communities, the Mamata scheme has a specific provision: the two-live-birth limit is relaxed, and PVTG women receive Mamata benefits for all births, not just the first two. This is a meaningful policy acknowledgment that PVTG communities have higher fertility rates and that restricting benefits to the first two births would exclude many PVTG families from meaningful coverage.

In practice, few PVTG women know about this provision. AWWs in remote PVTG habitations often do not know about it either. The documentation burden for PVTG women — who are more likely to lack Aadhaar, bank accounts, and the mobility to reach registration points — is particularly acute. The provision exists on paper and is largely inaccessible in practice.

The Full CCT Landscape in Odisha: Mamata and Beyond

NGOs facilitating CCT access need to understand the full landscape of cash transfer programmes available to tribal and marginalised families in Odisha:

PMMVY (Pradhan Mantri Matru Vandana Yojana): ₹5,000 in instalments for the first live birth, conditional on pregnancy registration, ANC, and child immunisation. PMMVY has enrolled 38.3 million beneficiaries nationally as of March 2024. For Odisha tribal women, the combined JSY + PMMVY entitlement approaches the NFSA mandate of financial support for maternity. NGO role: ensuring eligible first-birth mothers are registered in PMMVY, linking with JSY registration.

JSY (Janani Suraksha Yojana): Cash incentive for institutional delivery — ₹1,400 in rural areas for BPL women. A 2025 narrative review of JSY found that while the programme significantly increased institutional deliveries, it continues to face payment delays, documentation obstacles, and low awareness in the most marginalised communities. NGO role: documentation support, payment delay follow-up with block health office.

Mamata Scheme (Odisha): ₹5,000 in two instalments for the first two births (all births for PVTGs). Registration at AWC. NGO role: awareness, registration facilitation, bank account linkage, payment monitoring.

Biju Sishu Suraksha Yojana (BSSY): Odisha state scheme for newborn and child care in government hospitals — covering treatment costs for sick newborns and children who would otherwise face out-of-pocket costs that push households into poverty. NGO role: awareness, ensuring families know to claim this at the hospital rather than paying out-of-pocket.

What NGOs Can Do: Targeted CCT Facilitation

The evidence on where CCT programmes fail most severely points precisely to where NGO facilitation adds the most value. The steps are specific:

Step 1: Identify the excluded

Map every pregnant woman and woman with children under 2 in your operational communities. Cross-reference with AWW records. Who is not registered? Who does not have a bank account in their own name? Who has registered but not received payments that should have been made?

This is the same entitlements mapping methodology described in the Entitlements Mapping Practice Note, applied specifically to maternal and child CCT programmes.

Step 2: Remove the documentation barrier

For women without bank accounts: accompany them to the bank branch for Jan Dhan account opening. The bank cannot require documents other than Aadhaar for Jan Dhan. If Aadhaar is missing, the process starts at the Common Service Centre (CSC) for Aadhaar enrolment.

For women not registered with the AWC: accompany them and ensure registration happens before the first trimester is complete, because early registration determines eligibility for the full sequence of Mamata instalments.

For PVTG women: specifically communicate the all-births provision and ensure AWWs in PVTG habitations are aware of it.

Step 3: Condition support — not just registration

The health service attendance conditions of Mamata, JSY, and PMMVY are not just bureaucratic requirements — they represent genuine health-seeking behaviours that produce better maternal and child health outcomes. The NGO's role is not just to help women register and receive payments; it is to support the health service attendance that makes the conditions meaningful.

This connects directly to the ASHA support work described in the ASHA Programme Practice Note: ASHAs who are properly functioning help women attend ANC, facilitate institutional delivery, and monitor immunisation completion. Where ASHAs are functioning well, CCT access improves. Where they are not, CCT access suffers. The health system support and the CCT facilitation are the same work seen from different angles.

Step 4: Monitor payment timelines and escalate delays

Payment delays are the most frequently documented failure mode in CCT implementation across all schemes. An NGO that tracks whether payments due to registered women have been received — and that systematically escalates delays to the CDPO and block health office — produces accountability that individual women

cannot create for themselves.

Simple tracking: a register showing, for each enrolled woman, the date of each condition completion, the expected payment date, and the actual payment date. A pattern of delays across multiple women in the same Anganwadi circle is grounds for a written complaint to the CDPO. A pattern across multiple circles in the same block is grounds for escalation to the district.

Step 5: Close the PVTG gap specifically

PVTG communities represent the most severe exclusion from CCT benefits and the most acute maternal and child health need simultaneously. Focused, sustained outreach to PVTG habitations — which standard AWW and ASHA reach often misses — is the highest-return activity in CCT facilitation. An NGO that has community relationships in PVTG settlements, that can work in the community's language, and that can provide the patient, repeated engagement needed to bring PVTG women into the CCT system is doing work that the formal health system cannot replicate.

For CSR Managers: What to Fund

The evidence suggests that the highest-leverage CSR investment in the CCT space is not in creating new cash transfer programmes — government programmes exist and are adequately funded in principle — but in the facilitation infrastructure that closes the access gap for the bottom quintile.

Specifically, CSR funding for:

- Community navigator positions (trained community members who help women in their neighbourhood navigate CCT registration and follow-up) pays for itself in benefits accessed by women who would otherwise be excluded
- Documentation support camps (helping PVTG communities obtain Aadhaar, bank accounts, and caste certificates in batch) remove the structural barrier that prevents CCT access

- Monitoring systems that track CCT payment status for enrolled women and generate escalation reports when payments are delayed produce the accountability pressure that improves government performance

None of these require building anything new. They require filling the facilitation gap between what the government programme provides and what the most excluded communities can access on their own.

Related Knowledge Commons content: Child Welfare Sector Primer (Sector 01) · Practice Note: Entitlements Mapping — Helping Tribal Communities Access What They Are Owed · Practice Note: ASHA Programme — How NGOs Can Strengthen the Last Mile

Evidence Grade: A/B — The 2023 Health Economics Mamata study and the 2025 medrxiv PMMVY evaluation are the primary evidence sources; the 2017 PLOS One Mamata study and 2021 Journal of Nutrition study provide supporting evidence. Grade A is assigned for the PMMVY quasi-experimental evidence; Grade B for multi-study assessment of the broader CCT landscape. Last reviewed: April 2026.

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