



Who Deserves To Be Cared For?: A Critical Appraisal of Janani Suraksha Yojna Through The Lens Of Caste And Gender

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ABSTRACT

This paper looks closely at the Janani Suraksha Yojana (JSY), one of India's flagship maternal health schemes, through the layered realities of caste, gender, and class. While the scheme has led to a rise in institutional deliveries and helped in reducing maternal and neonatal death rates, these gains have not reached everyone equally. Dalit, Adivasi, and other marginalized women continue to face barriers that go beyond just policy. They face exclusion rooted in deep social hierarchies, everyday discrimination, and a healthcare system that often fails to see them with dignity. Using insights from literature, data trends, and policy reviews, this study brings out the structural gaps that limit JSY's reach and impact. It draws attention to issues like fund delays, poor quality of care, and the absence of culturally sensitive support systems. The paper ends by suggesting concrete ways forward: from intersectional policy thinking to more inclusive implementation, from ground-up community involvement to systemic change, so that no woman is left behind in her most vulnerable moments.

Keywords: Janani Suraksha Yojana (JSY), maternal health, caste discrimination, gender inequality, healthcare access, intersectionality, marginalized women, India, public health policy, reproductive rights

INTRODUCTION:

In a nation striving for universal health coverage, a stark reality persists: millions of marginalized women in India continue to face profound barriers to essential healthcare. Despite policy initiatives and a growing economy, the intersection of gender, caste, and class creates a complex web of exclusion, denying equitable access to vital services.

This paper aims to critically examine how the intricate interplay of gender, caste, and class profoundly influences healthcare and reproductive service access within India's marginalized communities. It seeks to illuminate the systemic disparities that persist despite national efforts, providing a comprehensive analysis of the challenges faced by vulnerable women. Furthermore, this study evaluates existing healthcare and reproductive health policies and programs through a gendered lens, assessing their effectiveness and identifying critical implementation gaps. By doing so, it underscores the urgent need for more equitable and responsive healthcare systems.

The significance of this topic cannot be overstated, as it addresses a critical human rights issue and a major public health challenge in India. By dissecting the complex interplay of social determinants on healthcare access, this research contributes significantly to the field of public policy and health equity. The findings offer crucial insights for policymakers, healthcare providers, and civil society organizations, enabling them to design and implement more targeted, culturally sensitive, and effective interventions. Ultimately, this paper aims to foster a deeper understanding of the barriers faced by marginalized women, advocating for systemic changes that ensure dignified, equitable, and comprehensive healthcare for all.



LITERATURE REVIEW

The World Health Organization (WHO) emphasizes the need of all women having access to mental and physical health care. However, women who are marginalized in particular are more deprived of these benefits. Numerous studies have also been done on the unmet healthcare requirements of women and ways to improve their access to healthcare. The provision of healthcare services that take into account the sociodemographic, cultural, and other variables related to marginalized women has, however, received little attention in the literature so far (Puja et al., 2024). Gender disparities in health are exacerbated by the replication of restrictive gender norms in health systems.

Khanday and Akram (2012) discusses how the system in India has failed at the implementation level to provide healthcare access to marginalized groups for a long time. The study focuses on the health status of marginalized groups and the exploitation women's face and the violations of their rights. The study analyzes the determinants on the basis of which Individuals who belong to marginalized groups face discrimination in healthcare, like how women face double discrimination, as in case of gender and marginalization due to other variables.

Ali and Chauhan (2020) demonstrate the enduring socioeconomic disparities in the consumption of maternal health services in rural India. Full prenatal care showed less improvement, despite a notable improvement in the disparity in competent birth attendance. They point to tribal status, mass media exposure, and secondary/higher education as major causes of the remaining discrepancies.

In their discussion of the gender-class relationship, Mahapatro, James, and Mishra (2021) illustrate the class gradient in unmet needs. According to an intersectional approach, Scheduled Caste/Tribe members of the lower class have significantly more unmet needs than those who are not SC/ST. 12 % of the total population is having unmet healthcare needs, where poorer women are more affected when caste and gender intersect.

Mishra et al. (2021) discuss the caste-based inequities in accessing India's Janani Suraksha Yojana (JSY), which is a safe motherhood intervention aimed at reducing maternal and neonatal mortality by promoting institutional deliveries. While 72% of the JSY access gap is explained by observable factors like primarily wealth quintile, type of delivery, and education, a significant 28% unexplained disparity shows the persistent caste discrimination. The authors underscore that persistent caste bias continues to impede fair access to maternal health benefits, especially among SC/ST women.

Mishra (2006) analyzes how the inequalities in Indian society and the limitations (financial and social) of certain groups have impacted the gender disparity in the access to healthcare.



According to the National Family Health Survey-2, around 35.8 % of women in India suffer from chronic energy deficiency, with a body mass index (BMI) of less than 18.5 kg/m². Before NFHS-2 the average maternal mortality rate at the national level was 540 deaths per 100,000 live births for a two year period.

A lack of sufficient data shows the gap of an intersectional approach in healthcare services and research is evident here. After analyzing the existing discourses, this paper tries to examine how the intersection of gender, caste, and class influences access to healthcare and reproductive services in India in case of marginalized communities. With an objective to analyze the existing healthcare and reproductive health policies and programs through a gendered lens this paper tries to evaluate the gender budgeting and resource allocation for women's health. At last this paper tries to propose evidence based recommendations for more inclusive and effective policy interventions by critically appraising the outcomes of these policies and implementation gaps as well.

THEME 1: STRUCTURAL EXCLUSION – INTERSECTION OF CASTE AND GENDER IN ACCESS TO HEALTHCARE

Health care must be used to enhance the dignity and respect for human rights by providing everyone access to basic services. However, in India, this vision remains a dream for many marginalized communities—specifically, Dalit women, who encounter profound systemic challenges influenced by both gender and caste dynamics.

Dalit women, who make up about 16.6% of the total female population of India (Census of India, 2011), are doubly marginalized. Their lives are not only shaped by patriarchal systems but also by the caste system, which has historically placed them on the fringes of social systems. Even as legal systems and state programs claim to guarantee equality, caste and gender discrimination continues to deprive them of even basic healthcare facilities.

Studies demonstrate that discriminatory practice starts at the most basic levels. Acharya (2010) and Sabharwal et al. (2014) demonstrate that frontline health workers avoid entering Dalit localities, avoid or postpone or deny services, and maintain physical distance when interacting with Dalit women. For example, medicines are dropped from a height instead of being handed over directly, anganwadi workers maintain physical distance from babies, and mothers are asked to weigh their own infants. Such seemingly minor acts send a powerful message: that the lives of Dalits are not equal in importance.

Sabharwal et al. (2014) in a seven-state survey in India had also reported that Dalit women were much less likely to avail themselves of proper antenatal and postnatal care. They were not even aware of government programs like Janani Suraksha Yojana (JSY), and even if they were, they did not receive the benefits assured in general. Thorat and Lee (2010) also noted



that Dalit women were 33% less likely than upper-caste women to avail themselves of JSY because of institutional neglect and discrimination on the basis of caste.

National data reinforces such inequality. NFHS-5 (2019–21) shows that 68.1% of Scheduled Caste women had antenatal care provided to them by a skilled personnel only, while 82.3% women from the general category had the same (International Institute for Population Sciences [IIPS] & ICF, 2021). Institutional delivery and immunization of children are also notably lower for Dalit and tribal women.

Discrimination is not only in the health domain, but also in state nutrition programs such as the Midday Meal Scheme, where Dalit children are discriminated against by being seated apart, served last, or excluded from receiving extra helpings (Thorat & Lee, 2010). These activities perpetuate humiliation and social exclusion from an early age.

Paul Farmer (2004) calls this structural violence—not harm which occurs as a result of personal design, but of entrenched inequality. For Dalit women, health care becomes yet another site where exclusion, indignity, and neglect become the norm.

To get closer to actual equity, we need to grapple with how caste and gender still influence access to healthcare in India—not only in policy, but also in practice on a day-to-day basis.

THEME 2: TO ASSESS THE IMPLEMENTATION AND OUTCOMES OF JANANI SURAKSHA YOJANA (JSY) THROUGH TREND BASED ANALYSIS

Theme 2 focuses on how public health policies are implemented and what outcomes they generate, with a specific emphasis on the Janani Suraksha Yojana (JSY). JSY is a key public health policy under the National Health Mission. It was launched to encourage childbirth in healthcare institutions as a means to lower risks for mothers and newborns. This section analyses national level data from 2014-15 to 2022-23 to understand its reach and impact. By studying the number of women who have availed benefits from JSY and observing trends in maternal mortality rate and neonatal mortality, we aim to evaluate how well the scheme has worked over the years.

Janani Suraksha Yojana is a policy that targets improving maternal health and neonatal health under the National Health Mission. It was launched by the Ministry of Health and Family Welfare in April 2005. By promoting childbirth in medical facilities, the scheme seeks to lower risks for mothers and newborns, particularly among the women from marginalised sections of the society. Through conditional cash support, the scheme motivates women to seek antenatal services, give birth in healthcare institutions and access proper postnatal care. These cash benefits help reduce the cost burden. Accredited Social Health Activities (ASHAs) play a crucial role in identifying eligible women, encouraging them to go for regular check-ups and ensure they receive timely care both before and after childbirth

**Methodology:**

For this study we have relied on secondary data collected from government sources, such as reports published by the Ministry of Health and Family Welfare. The key indicators we focused on include the number of women who received JSY benefits, changes in maternal mortality and neonatal mortality over the years. We've looked at data ranging from 2014-15 to 2022-23. By comparing the data year by year, we aim to understand the progress of the scheme and how efficiently it has met its goals over the years. Therefore, instead of relying on advanced statistical models, this study adopts a descriptive approach to observe year-wise trends.

Table 1: Number of JSY beneficiaries, Maternal Mortality and Neonatal Mortality in India from 2014-15 to 2022-23

Year	No of JSY beneficiaries (in lakhs)	Maternal Mortality	Neonatal Mortality
2014-15	104.39	137	27.09
2015-16	104.16	129	25.96
2016-17	104.59	121	24.86
2017-18	110.21	113	23.8
2018-19	100.41	107	22.7
2019-20	107.35	101	21.4
2020-21	99.92	101	20.18
2021-22	96.95	155	19.09
2022-23	101.29	90	18.15

Source: Ministry of Health and Family Welfare, Government of India, Sustainable Development Report 2025, Macro Trends.



Table 2: Descriptive Statistics of JSY Beneficiaries, Maternal Mortality, and Neonatal Mortality (2014–15 to 2022–23)

	No of JSY beneficiaries (in lakhs)	Maternal Mortality	Neonatal Mortality
Median	104.16	113	22.7
Sample Variance	16.48261944	420.1111111	9.677886111
Skewness	0.221982007	0.645867172	-0.006158598
Minimum	96.95	90	18.15
Maximum	110.21	155	27.09
Count	9	9	9

Source: Computed by the researcher using data from table 1.

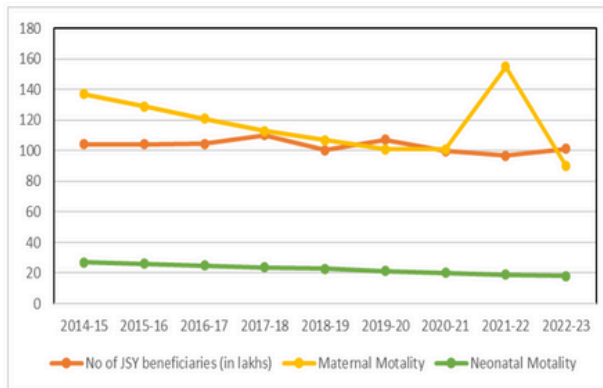
The following analysis presents the descriptive statistics of JSY beneficiaries, maternal mortality, and neonatal mortality rates in India from 2014–15 to 2022–23. Over this period, the number of JSY beneficiaries ranged from 96.95 lakh to 110.21 lakh, with a median of 104.16 lakh. The low variance (16.48) and slight positive skew (0.22) suggest that beneficiary uptake has remained relatively stable, with gradual increases over time.

In contrast, the maternal mortality rate varied more widely, ranging from 90 to 155 deaths per 100,000 live births, with a high variance (420.11) and a positively skewed distribution (0.64), indicating uneven declines. The neonatal mortality rate was more consistent, ranging between 18.15 and 27.09, with a lower variance (9.68) and a nearly symmetrical (slightly negative) skew (-0.006), suggesting relatively uniform outcomes over time.

Overall, while JSY has helped improve maternal and neonatal outcomes, the data suggests uneven impact on maternal health and a need for deeper outreach, especially in underserved regions and among marginalized populations.



Figure 1: Trends in JSY Beneficiaries, Maternal Mortality, and Neonatal Mortality in India (2014–15 to 2022–23)



Source: Computed by the researcher using data from table 1.

The trend analysis reveals a gradual increase in the number of JSY beneficiaries from 2014–15 to 2019–20, followed by a slight dip during 2020–21, likely due to COVID-19 disruptions, before stabilizing again. The maternal mortality rate shows an overall declining trend, but with significant fluctuation—most notably a sharp spike in 2021–22, which may reflect pandemic-related service gaps, before dropping again in 2022–23.

Meanwhile, neonatal mortality rates have declined consistently and steadily, indicating more stable progress in newborn health outcomes.

While the data suggests that JSY has had a positive correlation with improved maternal and neonatal health over time, the irregularities in maternal mortality trends raise questions about program resilience, especially during crises. These trends underscore the need for stronger safety nets, improved last-mile service delivery, and continued policy attention to reach marginalized women, particularly during health emergencies.

THEME 3: TO CRITICALLY APPRAISE THE IMPLEMENTATION AND OUTCOMES OF THESE POLICIES, IDENTIFY REASONS, AND PROPOSE EVIDENCE-BASED RECOMMENDATIONS

While the Janani Suraksha Yojana (JSY) has notably increased institutional births and contributed to declining maternal and infant mortality rates (MMR from 254 to 97, IMR from 57 to 32) (Ministry of Health and Family Welfare, various years), its full potential is hindered by systemic inefficiencies.

A critical appraisal reveals JSY's limited effectiveness in ensuring comprehensive antenatal



(ANC) and postnatal care (PNC), which are crucial for holistic maternal health (Lim et al., 2010). Delays in fund disbursement, sometimes exceeding a year, undermine the scheme's financial incentives, particularly for vulnerable families (The Indian Express, 2024). This financial burden, coupled with healthcare system flaws, pushes families to the brink (Livemint, 2024).

Quality of care remains a significant challenge. Despite increased institutional deliveries, access to consistent ANC and PNC is inconsistent. Unused equipment due to lack of trained technicians, as seen at Cottage Hospital in Dahanu, forces women into expensive private care (Livemint, 2024). India's shortage of skilled healthcare workers, below WHO recommendations, directly impacts maternal care quality and institutional birth rates (World Health Organization, ongoing reports). Reliable emergency transport and referral systems, as in Assam and Haryana, prove critical for safe childbirth (Livemint, 2024).

Furthermore, JSY's inclusiveness is questioned in regions where poverty and lack of education persist. States like Bihar and Jharkhand show low institutional birth rates despite incentives (IIPS & ICF, 2021). Education is a strong determinant; more educated women are almost four times more likely to deliver in a facility (Singh & Singh, 2012). Culturally sensitive communication is also vital; initial resistance among tribal communities in Jhabua district highlights the need for tailored approaches (Sharma & Sharma, 2017).

Reasons for Shortcomings:

1. Systemic Inefficiencies: Delays in fund disbursement and weak monitoring negate financial incentives (The Indian Express, 2024; Kumar et al., 2018).
2. Inadequate Quality of Care: Limited focus on comprehensive ANC/PNC and insufficient infrastructure impact outcomes (Lim et al., 2010; Livemint, 2024).
3. Human Resource Deficiencies: Shortage of skilled healthcare professionals compromises service quality and access (World Health Organization, ongoing reports).
4. Socio-demographic Barriers: Poverty, lack of education, and cultural beliefs impede uptake, unaddressed by financial incentives alone (IIPS & ICF, 2021; Singh & Singh, 2012).
5. Limited Culturally Sensitive Approaches: Programs failing to adapt to local beliefs face lower acceptance (Sharma & Sharma, 2017).

Evidence-Based Recommendations:

1. Strengthen Digital Tracking & Fund Disbursement: Implement real-time digital platforms for transparent and timely cash benefit delivery to reduce out-of-pocket expenses (Kumar et al., 2018).
2. Prioritize Holistic Maternal Care: Expand JSY to incentivize and ensure quality ANC and PNC, encompassing a continuum of care beyond delivery (Lim et al., 2010).
3. Invest in Healthcare Workforce: Increase training and deployment of skilled professionals, addressing shortages in rural areas and ensuring equipment utilization (World Health Organization, ongoing reports).
4. Enhance Infrastructure and Emergency Services: Improve public health facilities and strengthen emergency transport and referral systems (Livemint, 2024).
5. Address Socio-Demographic Factors: Link JSY with other welfare schemes and promote education to overcome underlying barriers (IIPS & ICF, 2021; Singh & Singh, 2012).
6. Develop Culturally Sensitive Campaigns: Design culturally appropriate awareness



- campaigns, involving community leaders and leveraging models like Maharashtra's ASHA program (Sharma & Sharma, 2017; Ghosh et al., 2015).
7. Leverage Technology for Monitoring: Utilize digital platforms for quality monitoring and patient feedback to drive continuous improvement.
 8. Context-Specific Policy Adaptation: Adapt policies to regional needs, considering socio-economic and cultural contexts, learning from diverse state experiences (IIPS & ICF, 2021).

By implementing these recommendations, JSY can evolve into a more inclusive and effective policy, ensuring dignified, safe, and continuous care for every mother.

ADDITIONAL INSIGHTS:

Beyond the structural and programmatic challenges already discussed, recent insights highlight several critical dimensions impacting healthcare access for marginalized women in India. Despite notable progress in maternal and child health indicators, significant disparities persist, particularly for women residing in rural areas, those from lower socioeconomic strata, and tribal communities. These inequalities are often exacerbated by geographical barriers, out-of-pocket expenses, and the absence of female healthcare providers, reinforcing the need for more localized and accessible service delivery models.

A broader understanding of women's health is also gaining traction, moving beyond purely reproductive health to encompass a wider spectrum of issues. This includes addressing prevalent challenges such as malnutrition, anemia, and the rising burden of non-communicable diseases like breast cancer and cardiovascular conditions, which disproportionately affect women. Mental health disorders, often compounded by poverty and social stigma, also represent a critical area requiring more focused attention and integrated care.

Technology emerges as a powerful enabler, with telemedicine platforms offering transformative solutions to bridge distance and accessibility gaps. These digital health initiatives can facilitate remote consultations and reduce the need for arduous travel, proving particularly beneficial for women in underserved regions. However, the existing digital gender gap, where women often have lower access to mobile phones and the internet, necessitates targeted interventions to ensure equitable digital literacy and access for this potential to be fully realized.

Furthermore, the importance of community-based interventions and women's empowerment is increasingly recognized. Engaging local leaders, fostering peer education, and building women's groups can effectively disseminate health information, promote positive health-seeking behaviors, and address underlying power imbalances that hinder access. Empowering women through education, financial independence, and enhanced decision-making autonomy is crucial, as these factors directly correlate with improved healthcare utilization and better health outcomes. These additional perspectives underscore the need for a holistic, multi-pronged approach that integrates technological advancements, community participation, and sustained efforts towards social empowerment to truly achieve equitable healthcare for all marginalized women in India.



CONCLUSION:

Our analysis of the Janani Suraksha Yojana (JSY) revealed its positive correlation with improved maternal and neonatal outcomes, yet also highlighted inconsistencies and vulnerabilities, especially during crises like the COVID-19 pandemic. Furthermore, the critical appraisal of existing policies exposed significant shortcomings, including delays in fund disbursement, inadequate quality of care, human resource deficiencies, and persistent socio-demographic barriers. The discussion emphasized that while policies exist, their effective implementation is often hampered by deep-rooted inequalities and a lack of culturally sensitive approaches, preventing the full realization of equitable healthcare for all.

The findings of this study carry profound implications for public health policy and practice in India. They underscore that achieving universal healthcare coverage is not merely about increasing service availability but fundamentally about dismantling the structural barriers rooted in social hierarchies and gender norms. The persistent disparities highlighted herein demonstrate that a 'one-size-fits-all' approach to health policy is insufficient; instead, interventions must be tailored to address the unique vulnerabilities arising from the intersection of caste, class, and gender. Recognizing the uneven impact of programs like JSY, particularly on the most marginalized, signifies the urgent need for robust monitoring mechanisms and adaptive strategies. Ultimately, ensuring equitable access to healthcare is not just a matter of public health but a fundamental human right, essential for fostering social justice and sustainable development across the nation.

Moving forward, future research should delve deeper into the long-term impacts of digital health initiatives on marginalized communities, specifically examining how the digital gender gap can be effectively bridged to maximize their benefits. Further qualitative studies are needed to capture the lived experiences of women facing multiple forms of discrimination within healthcare settings, providing nuanced insights into the everyday realities of structural violence. From a policy perspective, there is a compelling need to integrate intersectional analysis into the design and evaluation of all health programs, ensuring that resource allocation and implementation strategies explicitly address the specific needs of the most vulnerable. Strengthening community-led health initiatives, investing significantly in the training and deployment of culturally competent healthcare professionals, and ensuring timely and transparent financial aid disbursement are critical practical actions. Moreover, a concerted effort to promote women's education and economic empowerment will serve as a foundational pillar for improving health outcomes, fostering greater autonomy, and ensuring dignified healthcare for every woman in India.

In conclusion, while India has made commendable strides in public health, the journey towards truly equitable healthcare for all its women remains ongoing. The insights gleaned from this analysis reiterate that health is inextricably linked to social justice. Addressing the deeply entrenched issues of gender, caste, and class in healthcare requires not just policy reforms but a fundamental societal shift towards recognizing and valuing the inherent dignity and rights of every individual. By prioritizing inclusive policies, empowering marginalized communities, and fostering a healthcare system that is truly responsive to diverse needs, India can move closer to its vision of health for all, ensuring that no woman is left behind in the pursuit of well-being.



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