

Re-examining Janani Suraksha Yojana:

The Relevance of Intersectionality to Improve Maternal Health Policymaking in India

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This paper examines the relevance of the intersectionality framework for designing maternal health interventions in India, using the case of Janani Suraksha Yojana (JSY), a government scheme that aims to reduce maternal deaths by financially incentivising women to deliver in hospitals. Research indicates that JSY has failed to reach the poorest Indian women and has had limited impact on maternal mortality. For this paper, I used a secondary research approach, wherein I applied an intersectionality framework to analyse existing evidence on JSY. To my knowledge, this is the first paper that adopts an intersectionality lens to analyse and critique the JSY program and advocate for its relevance in understanding maternal mortality in India. This paper outlines three major flaws underpinning JSY: treating women as a homogenous category, lack of understanding of lived experiences, and inability to address social determinants of maternal mortality. The paper further argues that maternal mortality is caused by an intersection of different identity axes such as gender, caste, class, location, and indigeneity. Thus, instead of using a universal approach towards reducing maternal deaths, policy interventions in India should be rooted in an intersectional framework that recognises the lived experiences and realities of the most marginalised women in India.

**GENDER, INTERSECTIONALITY, MATERNAL HEALTH, PUBLIC HEALTH,
HEALTH INEQUALITIES, WELL-BEING, INDIA**

ABSTRACT

KEY WORDS

INTRODUCTION

This paper discusses why intersectionality is a relevant framework for Janani Suraksha Yojana (JSY), a maternal health policy in India, and addresses the gap around exploring the relevance of intersectionality in designing and implementing maternal health interventions in India. Addressing this gap is important as multiple studies (S. Banerjee et al., 2024; Gupta et al., 2010; Montgomery et al., 2014) have noted a disproportionately higher burden of maternal deaths among marginalised groups and communities, who experience multiple and interlocking levels of oppression and discrimination.

JSY is a maternal health scheme in India that aims to reduce maternal deaths by paying cash incentives to women for delivering in accredited hospitals. The scheme is part of the National Rural Health Mission launched in 2005 in India. JSY focuses on poor pregnant women with a special focus on states having low institutional delivery rates. Furthermore, the scheme's launch coincided with the global interest in the reduction of childhood and maternal mortality as part of the Millennium Development Goal¹ review process (Das, 2017, p. 92). To analyse JSY, this paper uses the framework of intersectionality, which was conceptualised in 1989 by Kimberlé Crenshaw, an American race scholar. The framework refers to how a person's social experience is constituted by the interaction of their identities with power structures in society (Crenshaw, 1997). Over the years, intersectionality has increasingly been mainstreamed in global health research (Kapilashrami & Hankivsky, 2018). The concept of intersectionality holds significance because maternal mortality is a complex phenomenon which is caused by the interaction of multiple factors. India has committed to achieving the United Nations mandated Sustainable Development Goal (SDG) of reducing MMR to less than 70 by 2030 (Meh et al., 2022). Given this context, as JSY is the largest maternal health intervention in India, it becomes imperative to critically analyse it through the lens of intersectionality. Using intersectionality as the underlying framework, this paper will look

at how different factors such as institutional, social, cultural, and economic intersect with each other to cause maternal mortality.

While JSY has increased institutional deliveries significantly, multiple studies (Dongre, 2014; Mishra et al., 2021; Powell-Jackson et al., 2015) have found that the scheme has failed to reach the most marginalised women in India, and there is no association between the rise in institutional deliveries due to JSY and the reduction in India's maternal mortality ratio. While these studies outline the unequal distribution of maternal deaths among marginalised groups and communities, they do not delve into how the interaction of a woman's lived experiences, caste, tribe, religion, location, class, etc. marginalises them. Additionally, these studies do not consider the fragmented political economy in India and the prevalence of clientelism, which has a significant influence on the delivery of welfare services (Dasgupta, 2016). Apart from examining the existing literature, I evaluate the assumption of JSY's universality within India, which is a significant problem. There has been no critical examination of JSY's program guidelines and its one-size-fits-all approach towards curbing maternal deaths.

Given that access to maternal health has been construed as a human right by international conventions and mechanisms, to which India is a signatory, this paper also integrates a human rights lens, while discussing the relevance of intersectionality for JSY. In 1999, the WHO, UNICEF and the United Nations Population Fund (UNFPA) declared: "human rights include access to services that will ensure a safe pregnancy and childbirth." (WHO, 1999). This holds significance in the context of maternal health as this would mean that when governments – as part of their economic and social rights obligations under specific international treaties – fail to provide health care that only women need such as maternity care, this failure is a form of discrimination against women that they are obligated to prevent and remedy (Cook, 2013). Building upon Cook's words, I argue that access to JSY, even though it has numerous flaws

and problems, should be a human right, as it is a government funded maternal scheme.

INTERSECTIONALITY: ORIGINS AND CONTEXTUALISATION WITHIN INDIA'S POLITICAL ECONOMY

Since its introduction in 1989, the term 'intersectionality' has emerged as a key theoretical framework and become a buzzword in feminist scholarship.

It is a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, socio-economic status, and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression (i.e., racism, sexism, heterosexism, classism) at the macro social structural level (Bowleg, 2012, p. 1268).

In simpler words, it gave theoretical legitimacy to the already established idea of multiple discrimination faced by an individual. (McCall, 2005) terms intersectionality as one of the most critical theoretical contributions made by feminist literature. Over the years, the framework has evolved to include location, education, immigration status, indigeneity, caste, and other identities as axes of marginalisation as per local contexts.

Despite its relevance in feminist and social science scholarship, there have been multiple critiques of intersectionality, especially regarding its use as an analytic tool. (Nash, 2008) critically analyses intersectionality and outlines four key issues that need to be addressed. One, the lack of a defined intersectional methodology. McCall (2005, as cited in Nash, 2008, p. 4) finds that, despite the theoretical attention paid to intersectionality, there has been limited discussion around how to study or apply intersectionality methodologically. Two, the reliance on black women as prototypical intersectional subjects.

This reliance leads to black women being treated as a unitary and monolithic entity, i.e. Differences

between black women, including class and sexuality, are obscured in the service of presenting 'black women' as a category that opposes both 'whites' and 'black' men" (Nash, 2008, p. 8).

Three, the vague definition of intersectionality, which obscures the question of whether all identities are intersectional or whether only multiply marginalised subjects have an intersectional identity. Zack (2005, as cited in Nash, 2008, p. 10) argues that all women are intersectional subjects, precisely because of the possibility that their womanhood (already a socially disadvantaged position) will intersect with other social positions to further disadvantage them. This unresolved dispute makes it unclear whether intersectionality is a theory of marginalised subjectivity or a generalised theory of identity. Four, the coherence between intersectionality and lived experiences of multiple identities. ((Chang & Culp, 2002) as cited in Nash, 2008, p. 6).

Despite these critiques, (Bowleg, 2012) argues that intersectionality provides a unified framework for public health researchers who already engage in the impact of different social and cultural identities on health inequalities and outcomes. As my paper focuses on maternal health in India, it is essential to look at debates on intersectionality in India. The concept of intersectionality holds immense relevance as throughout India's history, several groups and communities have been discriminated against based on their identities. Due to India's diversity these identities are determined by caste, socioeconomic class, religion, sexual orientation, and geographic location, and play an important role in determining the social position of an individual (Anne et al., 2013). Within this diversity, certain identities are privileged over others, due to existing social hierarchies and inequalities.

One such hierarchy is the caste system among Hindus (the largest religious group in India), which determines one's social position according to their one or more traditional occupations and is the world's oldest surviving social hierarchy. Outside of this Hindu caste

system are the Dalits or untouchables, categorised as scheduled castes (SCs) according to the Indian constitution. As of 2011-12, 29% of SCs lived below the poverty line (Panagriya & More, 2013). Throughout India's history, Dalits and lower castes have been denied political and civil rights and opportunities for economic mobility. Multiple studies (Human Rights Watch, 2007; International Dalit Solidarity Network, 2016) have documented how lower castes have faced discrimination and oppression. The Indian constitution provides affirmative action for socially excluded and marginalised communities in the form of reservations in educational institutions, jobs, loan waivers, and financial support. In 1989, quotas were extended to include a grouping called the OBCs (Other Backward Classes) which fall between the traditional upper castes and the lowest castes. Apart from populations belonging to lower castes, there are several indigenous communities and groups who are termed as *Adivasis* or tribals¹ who are constitutionally classified as Scheduled Tribes (STs), who make up 104 million (8.6%) of India's population. Though poverty levels have declined over the years, 43% of the Scheduled Tribes population still lives below the poverty line (Panagariya and More, 2013, p. 7). Over several decades, social scientists have written extensively about the discrimination faced by these communities and groups. They didn't explicitly use the term intersectionality or intersectional discrimination, but as in the US, in India, multidimensional discrimination had been discussed much before Crenshaw. In the 1940s and 1950s, Mahatma Gandhi and Bhimrao Ambedkar, two prominent freedom fighters of India, had spoken, written, and fought against caste's inequality, injustice, and oppression in Indian society. However, it was Ram Manohar Lohia, a well-known socialist leader of the 1950s, who was the first scholar in post-colonial India to write extensively about multidimensional discrimination. (Kumar, 2010, p. 64) writes "Lohia contributed significantly towards the formulation of an intersectional approach for understanding the inequalities, exclusions, and exploitations in the power system of India".

Nivedita Menon, a prominent Indian feminist and

scholar, has critiqued the western model of intersectionality as she finds the assumption of its universal validity problematic. Menon (2015, p. 37) writes "in the Indian context, categories of women, caste, class and race are unstable and heterogeneous, and intersectionality as a universal framework doesn't capture this complexity". Citing Lohia's intersectional work (Menon, 2015, p. 37), she suggests, "there is a tendency when studying the 'non-West', is to test the applicability of theories developed through 'western' experience. The assumption is that the concepts emerging from Western (Euro- American) social philosophy necessarily contain within them the possibility of universalization— the reverse is never assumed".

I argue that apart from intersectionality, there is a lack of theoretical frameworks which can incorporate the multidimensional discrimination constituted by the interaction of identities and power structures. Therefore, it is important to critically engage with intersectionality. Concerns around the Euro-centric origins of intersectionality and the relevant categories of identity being unstable in India and possible depoliticisation of intersectionality are valid but aren't enough to discard the framework. Just as there is no one simple feminist position on any issue, similarly there is/should be no one position or perspective on intersectionality. Though intersectionality originated from the multidimensional discrimination faced by black women in the US, over the years, it has evolved significantly. It has been used as a tool in multiple countries in different contexts which implies that assumed universality is not a core tenet of intersectionality.

Sinha (2012) cited in Menon (2015, p. 44) writes that to bring a global perspective to gender means not seeing the world through a universalising perspective, but taking theoretical cognizance of the local and empirical, thus producing a dense contextual analysis. Menon (2015, p. 44) cites Sinha to advance her argument that intersectionality as a universal framework may not be applicable in India. However, interpreting Sinha's (2012) argument above

in a different way, I argue that we can use the original intersectionality framework as a starting point and then depending upon where we choose to use it, we can contextualise it as per the context.

In post-colonial India, electoral politics have been strongly influenced by caste, class, location, and in few cases, indigeneity. The domination of a specific group – either economically or socially privileged or backward – in politics can alter the allocation of resources. Multiple scholars (Banerjee & Somanathan, 2007; Jaffrelot, 2003; Varshney, 2000) have written that among the historically disadvantaged social groups in India, those that mobilised themselves politically gained relative to others. For instance, in the 1980s, the SCs established a successful caste-based party (Bahujan Samaj Party [BSP]), which significantly increased their representation in national politics and allowed them to extract more public resources from the state than other groups.

When it comes to the Scheduled Tribes (STs), Lele et al. (1991) refer to them as India's largest politically slumbering minority. Research by Xaxa (2016) and Banerjee & Somanathan (2007) found that politically, STs are the weakest social group, which means that they are unlikely to have much access to the coveted public goods. Furthermore, they have fared worse than SCs in terms of access to resources. These authors found that while SCs have benefitted from affirmative action policies, STs have not.

The case of Muslims, a religious minority in India, is complicated. Banerjee & Somanathan(2007) write that while Muslims have officially been recognised as a socially marginalised community, they have not received the same benefits as the Scheduled Castes. In 2006, a government commissioned study 'Sachar Committee Report' (Ministry of Minorities Affairs, 2006) revealed that Muslims are socially and economically backward and provisions must be made to improve their condition. The study also found that Muslim women refrain from accessing public health institutions as they face discrimination. This report was widely criticized by the Hindu right-wing

for being biased and antithetical to the secular ethos of India. Currently, India is ruled by the Bharatiya Janata Party (BJP), a Hindu right-wing nationalist party, which has increased tensions between Hindus and Muslims and contributed to a polarising atmosphere. BJP also governs most of the states which have the highest maternal mortality rates, therefore, polarisation of politics has the potential to affect utilisation of maternal health services. However, Bowleg(2012) writes that intersectionality was not developed to predict behaviour. Nonetheless, the linkages between a polarised political atmosphere and access to maternal health services could be an area for further research.

While the linkages between domination of groups and allocation of resources is critical, the situation is more complex at the constituency level. Within a state, there is a high prevalence of clientelism i.e. constituencies which have legislators from the ruling party receive a larger share of public resources as they utilise their political influence to deliver additional public projects to their home constituencies to cultivate political support. However, communities that are best served by government are those that possess both top-down political connections to the ruling party, as well as high levels of grassroots local democratic mobilisation needed to place pressure on local politicians to deliver services (Dasgupta, 2016). Another unpredictable terrain is the behaviour of government officials. Irrespective of the government in power, the responsibility of last-mile distribution of public welfare services and goods are managed by government officials. The identity and bias of government officials results in corrupt practices and influence delivery of public services (Jeffrey, 2002).

As discussed in this section, in India, identities are deeply intertwined with local and national politics, therefore, any public welfare scheme must take the intersectionalities of political economy into account. While not all issues highlighted here hold relevance everywhere, they must be given due importance and consideration depending upon the context.

METHODOLOGY, LIMITATIONS AND POSITIONALITY

For this paper, I used a secondary research approach for analysis. A snowballing technique was employed to identify relevant sources. The process began with a set of key articles and seminal papers on maternal health in India, Janani Suraksha Yojana, and intersectionality. These articles were extracted from the reading lists of the MA Gender and Development program at the Institute of Development Studies, University of Sussex of which the author is an alumnus. Using this approach ensured that the initial selection of literature reflected rigour of academic articles as well as covered contemporary debates on intersectionality and JSY. The bibliography lists from these papers were examined to identify further relevant literature. The case study discussed in section five was chosen from a range of fact-finding reports on maternal deaths conducted by Socio-Legal Information Centre, an activist organisation in India.

Furthermore, I am cognisant that my positionality and subjectivity may have affected the findings of this paper. As I belong to an upper-caste Hindu family and an economically privileged background in India, my lens for reading and critically analysing JSY may inadvertently obscure some complexities. As a public health and social science researcher, I am aware of the class and caste dynamics in India, but these understandings are filtered through my own Hindu upper-caste and class privileges. While I have made all possible efforts to address and mitigate unintended biases arising from my positionality, I acknowledge that my analysis may be influenced by upper-caste and class normalisation, which could obscure some of the nuanced realities and lived experiences of discrimination faced by marginalised groups.

To address these challenges while writing this paper, I have:

- Engaged reflexively, documenting my assumptions and reflecting on how my background may influence interpretation of the findings in this paper

- Tried to prioritise and include papers from authors belonging to marginalised communities

MATERNAL HEALTH IN INDIA: CAUSES AND STATISTICS

I argue that maternal mortality is an intersectional phenomenon, where social, cultural, biological, and political factors interact to cause a woman's death. In official records, maternal deaths are attributed to medical complications, but structurally, a maternal death is an outcome of discrimination at multiple levels and in different forms, which range from social exclusion of women from marginalised communities to lack of emergency obstetric care services in public health institutions. Therefore, a maternal death carries a history of lived experiences and discrimination the woman was subjected to (Krieger, 1999). This is because discrimination creates and structures exposures to noxious physical, chemical, biological, and psychosocial insults, all of which can affect a woman's ability to save her life (Krieger, 1999). Each of these discriminations needs to be discussed individually, but they are mutually interlocking.

In India, a woman's disadvantage starts with the immense importance placed on motherhood, which often is the primary driver for taking family-oriented decisions. The subordinated position of women leaves them with limited or no bargaining power regarding how many children they want. The decision regarding the number of children to be borne by a woman is usually taken by the husband or the mother-in-law. Drawing on her experience, Unnithan(2015) writes that in Rajasthan, a state in North India which has a highly patriarchal society, women's bodies and reproductive capacities are regarded as publicly 'owned', with decision-making vested in families or other social (kin) groups. Childbearing is intrinsic to the construction of women's personhood (in a structural sense) (Unnithan, 2015). Furthermore, the preference for a male child can lead to a woman having multiple pregnancies, which can severely affect her health and nutrition levels.

Apart from social and cultural inequalities which 'force' women to bear children, they are further disadvantaged by India's dilapidated public health system. Das (2017) writes that in the context of maternal care, key health services are still not universally available in all districts. This is particularly important because evidence suggests maternal mortality can be reduced when deliveries are conducted by skilled birth attendants and women have access to emergency obstetric care (Sidney et al. 2016). This is due to the given the unpredictable nature of life-threatening complications that can occur at the time of childbirth. Thus, with public healthcare institutions not being able to provide quality care, women resort to private institutions and traditional medicine practitioners – who can provide care services for money – resulting in high out-of-pocket expenditure. An analysis of government data found that 46.6% of Indian mothers are pushed into poverty due to maternal care expenses, which include pre-natal, pregnancy, and post-natal care (Singh et al., 2016). The disaggregation of the data revealed that 71.5% of ST women and 49% of SC women were pushed into poverty due to maternal care expenses, reinforcing the fact that they are more disadvantaged than others. Therefore, maternal death is a treacherously complex phenomenon which includes interactions between various discriminations by different actors. A study by Banerjee, John and Singh (2024) noted a disproportionately higher burden of maternal deaths among SCs and tribal populations.

India's maternal mortality ratio² (MMR) has declined from 600 deaths per 100,000 live births in 1990 to 103 in 2020, but India missed its target MMR of 109 in the Millennium Development Goals in 2015 (PIB India, 2024). An analysis of MMR data (Joe et al., 2015) revealed that the pace of reduction in MMR over the past two decades (particularly, the rate of decline) does not commensurate well with the observed improvements in socioeconomic indicators across states. Furthermore, the decline in maternal mortality was far less in poor rural populations, and access to services in these areas continues to be poor (Montgomery et al., 2014). This finding may

be associated with the regional inequalities in MMR data which are obscured by the national MMR figure. Assam, a state in India's North-Eastern region, has an MMR of 195 as of 2020 while Kerala, a state in Southern India, has an MMR of 19, highlighting the wide disparity (Government of India, 2022).

However, these statistics may not be completely reliable. A study (Barnett et al., 2008) used key informant surveillance systems to estimate the MMR in Adivasi populated areas in Odisha and Jharkhand. In a sample population of 228,186 people, their analysis found a maternal mortality ratio of 722 per 100,000 live births, much higher than the state's average of 367 (UNDP India, 2004) at that time. This study highlights the difficulties in measuring maternal mortality that are frequent constraints to having accurate measurements and monitoring the impact of interventions (Barnett et al., 2008). Furthermore, the official method of calculating MMRs does not address the underlying risks that women face. The MMRs cited above express the risk of dying during a single pregnancy. But most women have more than one pregnancy, especially in societies where a woman's value as a person largely depends on the number of children she has, as Unnithan (2015) highlighted from her work in Rajasthan.

An analysis of family survey data in India (Milazzo, 2018) found that strong preferences for male children are partly driving female mortality in adulthood, especially for women whose first born child is a girl. To ensure the desired sex composition of children, they can have repeated and closely spaced pregnancies until the ideal number of sons has been reached, a behaviour medically known to increase the risk of maternal mortality and morbidity (Milazzo, 2018, p. 14). Thus, many women run the risk of maternal death many times. Therefore, MMR data obscures the multiple risks of death a woman can face. Highlighting lifetime risk is critical because the only objective of maternal health interventions should not be to reduce MMR but also focus on ensuring safe pregnancies and deliveries.

JANANI SURAKSHA YOJANA: KEY FEATURES

The Janani Suraksha Yojana (JSY) is a maternal healthcare scheme under NRHM in 2005, which incentivises institutional deliveries by paying cash handouts to women for delivering in accredited hospitals. JSY focuses on poor pregnant women with a special focus on states having low institutional delivery rates – Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha and Jammu and Kashmir. These states have been termed as ‘low performing states’, the remaining states with high institutional delivery rates are termed as ‘high performing states’. The guidelines and cash entitlements differ based on these two categorisations. In low performing states, 1) all pregnant women, irrespective of age, poverty status, and number of births, are eligible if they deliver in a government medical facility; 2) only women from BPL households and women from Scheduled Tribes (ST) /Scheduled Castes (SC) households (whether above or below the BPL) are eligible if they deliver in an accredited private medical facility.

In high performing states, 1) only those pregnant women who are aged 19 years and above and belong to the BPL households are eligible for cash assistance; 2) women belonging to SC/ST households, irrespective of their poverty status, are eligible, provided they are above the age of 19, and 3) cash assistance is limited to only two live births, even for women belonging to SC/STs.

In low performing states, JSY provides performance-based incentives to women health workers, ASHAs or Accredited Social Health Activists, to promote institutional deliveries. ASHAs are women community health workers employed by the government to manage and deal with public health programmes on the ground. To receive their JSY incentives, ASHAs have several responsibilities. They identify pregnant women as beneficiaries for the scheme as well as report or facilitate their registration for ante-natal care (ANC); to assist them in

obtaining the necessary certificates, wherever necessary; to provide and/or help women receive at least three ANC check-ups including tetanus (TT) injections and iron and folic acid (IFA) tablets; among other related tasks.

Though JSY does recognise the fact that SC/ST women are marginalised and vulnerable to maternal mortality, it doesn’t address the intersectionality and complexities of these identities further, which is why these women still face challenges accessing JSY services.

Category	Rural Area		Urban Area	
	Mother’s package	ASHA’s package*	Mother’s package	ASHA’s package*
LPS	INR 1400	INR 600	INR1000	INR 400
HPS	INR 700	INR 600	INR 600	INR 400

Table 1 Incentive structure for JSY (National Health Mission, 2005)

Existing evidence suggests that JSY met its primary objective of promoting institutional deliveries, but it has failed on other fronts: One, reaching the poorest and most vulnerable women in the country, and two, reducing maternal deaths and MMR proportionately.

Between 2005 and 2021, the percentage of institutional deliveries has increased from 38.7% to 88.6% (Tripathi et al., 2023) but multiple studies over the years (Dongre, 2014; Lim et al., 2010; Mishra et al., 2021) have found that JSY has failed to reach the poorest and most vulnerable women. Despite the implementation of JSY, women from SC/ST households have not experienced higher increase in institutional deliveries and access to the scheme relative to the non-SC/ST households in both the groups despite being more disadvantaged (Dongre, 2014; Mishra et al., 2021). The difference in availing JSY services between SC/ST (37.6%) and Non-SC/ST (61.8%) women is 24.2 points (Mishra et al., 2021).

These findings underscore the importance of understanding the intersectionalities underlying maternal

health. Though JSY intends to target the poorest and most vulnerable women, it fails to address the structural discrimination that affects its outreach. From a public health perspective, one can argue that we need improved public health facilities and accountability, but to address the complexities of social and cultural inequalities, an intersectional framework is needed.

JSY's second failure is to address maternal deaths and MMR adequately. Multiple analyses (Dongre, 2014; Powell-Jackson et al., 2015) have found that there is a lack of relationship between the rise in institutional deliveries and reduction in MMR, as the rise hasn't been mirrored by a proportionate decline in MMR. One persuasive explanation for this finding is that JSY incentivised women to go to health facilities whose purpose was not to manage life-threatening complications (Powell-Jackson et al., 2015). Yamin and Maine (1999) write that without a clear understanding of the causal chain leading to maternal mortality (and how to break it), programs intended to reduce maternal deaths are likely to be ineffective. I find that Yamin and Maine's arguments hold particularly true in JSY's case as it failed on multiple fronts. I will delineate four reasons which explain JSY's failure to reduce maternal deaths: One, lack of understanding of the local context. Two, the quality of care at public hospitals. Three, discrimination against marginalised women, and four, excessive focus on statistics.

Lack of understanding of the local context: JSY has failed to understand women's lived realities. It only promoted or 'forced' the dominant but faulty narrative of institutional deliveries being the panacea for tackling maternal deaths. A study conducted among tribal communities in Raygada district of Odisha showed that the health system is ignorant about the traditional pregnancy, delivery, and childcare practices of the tribal communities (Contractor & Das, 2015, cited in Das, 2017). The promotion of institutional deliveries as the only 'correct' way discriminates against traditional birth practices which may be safer.

Quality of care in public hospitals: While JSY

promotes institutional deliveries, the quality of care at government hospitals and centres is deplorable. The quality of antenatal care is vital to reducing the risk of stillbirths and pregnancy complications, and the absence of it explains why more women enrolling for hospital deliveries does not translate to fewer maternal deaths. A survey conducted by Water Aid India in 343 public healthcare institutions across six states, revealed a lack of basic hygiene, toilets, clean water, and waste disposal (Water Aid, 2016).

Discrimination against marginalised women: Das(2017) writes that marginalised communities are stigmatised for not adopting the policies to increase institutional deliveries. This is a discriminatory as women from marginalised communities have a deep mistrust of public health services and thus, they do not prefer institutional deliveries. A study conducted in rural Uttar Pradesh revealed that 74% of ASHAs in their survey belonged to general caste or other OBC families. They are often relatives of village leaders, and hence hesitate to visit scheduled caste/tribe women (Khan et al., 2010). In some cases, the perceived hostility towards, or non-acceptance of ASHAs by Muslim families also deprives Muslim families from receiving advice from the ASHA.

Excessive focus on statistics: It appears that JSY is more oriented towards chasing statistical achievements of reducing the nationwide MMR, than addressing the maternal needs of the most vulnerable and disadvantaged. This is associated with the fact that JSY incentivised women to go to health facilities whose purpose was not to manage life-threatening complications (Jackson et al., 2015). Khan et al. (2010, p. 14) found that if an ASHA worker feels that a segment of women may not opt for institutional delivery because they are not educated, the village is remote, or for other reasons such as the practice of *purdah* or religion, she does not want to "invest" her time in them for registration of ANC or persuading them to undergo at least three ANC check-ups. This finding reflects that the ASHA worker may be more concerned about their cash incentives than preventing maternal deaths.

KEY FLAWS OF JANANI SURAKSHA YOJANA

It should be emphasised that the reasons I have discussed above are based on an analysis of studies which evaluated JSY's implementation on the ground. However, hardly any study or report has critically examined the basic structure of JSY through an intersectional lens. I analysed JSY's program structure and guidelines and found three flaws.

Women as a homogenous category: JSY treats women as a homogenous and universal entity and assumes that every woman's maternal needs and desires are similar. It assumes that a caste Hindu woman, a Dalit woman, a Muslim woman, and an *Adivasi* woman – whose lived experiences and social statuses will be different – will have the similar knowledge, agency, and bargaining power when it comes to maternal choices. Furthermore, these categories are heterogeneous. It does address the marginalisation of SC/ST women, but it must be remembered that these categories aren't monolithic either. Neither all Dalit women nor all *Adivasi* women are the same. A study conducted among tribal communities in Raygada district of Odisha showed that "the health system is completely ignorant about the traditional pregnancy, delivery, and childcare practices of the tribal communities" (Contractor & Das, 2015, cited in Das, 2017, p. 95).

Lack of understanding of the local context and lived experiences of women: JSY promoted the dominant narrative of institutional deliveries being the panacea for tackling maternal deaths. This promotion discriminates against traditional birth methods and practices which may be safer. In rural areas, based on their lived experiences, different communities have different lenses through which they view the state. This is particularly important as JSY is a government scheme, and assuming every woman will be receptive to it is a flawed assumption. During their research on JSY in rural northern India, (Jeffery & Jeffery, 2010) found that government health care provision is characterised by widespread and long-term mistrust of

state services among Muslims. Therefore, encouraging institutional deliveries without addressing the perceptions of potential service users is a flawed approach to reducing maternal mortality.

No provisions or guidelines to address the social determinants of maternal health: JSY assumes that maternal mortality can be curbed by focusing solely on increasing institutional deliveries and that a woman's health is determined only by her biology. In Unnithan (2015, p. 52) words, "it (JSY here) does not consider the experiential, embodied, inter-subjective, and phenomenological aspects of health". This approach of JSY is rooted in clinical and biomedical connotations, which discards social determinants of maternal health. In a report documented through visits in Uttar Pradesh, Acosta (2016, p. 4) writes:

"JSY's approach to maternal health had an assumption that health is only measured as per the woman's biological self. This framing nurtures the idea that the body is the appropriate target for health interventions and assumes that culture or social life is a set of mutually exclusive concepts and practices".

Therefore, using (Sinha, 2012) words discussed earlier and interpreting them in this context, I summarise that JSY sees all women in India through a universalising perspective, which doesn't take theoretical cognisance of the local and empirical realities and given the India's cultural and social diversity, this universalisation is a critical roadblock in its objective to tackle maternal deaths.

MATERNAL DEATH IN ODISHA: HOW INTERSECTIONALITY OPERATES LOCALLY

Till now, I have discussed the issues at the national level, however, it is important to understand the relevance of applying an intersectional framework in JSY through a case study. In this section, I will discuss the maternal death of an *Adivasi*³ woman in Odisha. Using her case, I will discuss how her death was an outcome of multiple discrimination by different

actors.

In February 2016, the Socio-Legal Information Centre (previously known as the Human Rights Law Network), a human rights organisation in India, went on a fact-finding mission to Balasore, a coastal district in Odisha, to investigate the maternal death of an *Adivasi* woman and prepared a detailed report on their findings (SLIC, 2018).

Gauri Sasamal, a 30-year-old *Adivasi* woman, had two sons and became pregnant for a third time, hoping for a daughter. She was suffering from anaemia, too. She was registered under the JSY scheme. In November 2015, Gauri went for delivery at the local community health centre (CHC). As the designated gynaecologist and obstetrician were not present, the attending medical officer was Dr Bhuyan, a surgeon specialist. Though he didn't specialise in delivery and care of pregnant women, he still handled deliveries. The report found that during the delivery Gauri was subjected to significant verbal abuse from Dr Bhuyan for being pregnant despite having two sons. After she delivered a boy, Gauri started bleeding and in the absence of a blood bank at the CHC, no intervention was attempted by the medical officer.

Gauri's family repeatedly called the state government's run ambulance helpline⁴, so she could be taken to another hospital for treatment, but it didn't come. Her body was severely weak from anaemia, which exacerbated the situation. Within a few hours, Gauri bled to death as she didn't receive any medical help (SLIC, 2018). Furthermore, the family did not receive entitlements due under the JSY scheme and had to pay out-of-pocket expenses to take her body back to their village. Additionally, Gauri did not receive any services entitled to her under the Janani Shishu Suraksha Karyakram (JSSK) program⁵. The study further found, that in the CHC, the patient wards were filthy, with recently sterilised women lying on a blood-stained carpet on an unclean floor.

Situating this case in the realm of arguments and discussions in the first sections of this paper, I argue that her death did not occur due to excessive bleeding, as

it was documented in official records. Gauri's death was also due to an interaction of several factors. The common thread among these factors is the discrimination meted out to her by different actors.

Discrimination by the state government: As the HRLN report found, the public health facilities were pathetic, and this can be attributed to the state government's inaction and lack of interest in improving the ramshackle condition of health centres in *Adivasi* dominated areas. Official guidelines mandate that a CHC should be equipped to handle 24-hour delivery services, including normal and assisted deliveries, but clearly the CHC in Basta, an *Adivasi* area, was in dilapidated condition⁶. Furthermore, the non-arrival of the ambulance service and the lack of a blood bank at the CHC can also be attributed to the inadequacy of the state government.

Discrimination by her local legislator: In section 1.3, I had mentioned that as compared to SCs, STs have not been able to organise themselves politically to demand better public services. (Dasgupta, 2016) research found that communities that focus on top-down and bottom-up approaches are best served by legislators. It appears that in Gauri's village, people couldn't push the politicians to ensure basic health services. My analysis revealed that in 2016 the local legislator of Basta belonged to the political party which governed Odisha for 20 years. Therefore, not ensuring adequate health facilities in the constituency is neglect and discrimination on his part and since that led to Gauri's death, it's a human rights violation.

Discrimination from local health authorities: Gauri was verbally abused by Dr Bhuyan, the medical officer in charge at the CHC on her delivery day. This is consistent with what (Das, 2017) wrote about abusive discrimination against marginalised women. She or her family could not protest the abuse because Gauri and her family needed his services at that point, and they were helpless. Additionally, she wasn't given any additional assistance to manage blood or transferred to another hospital where she could have been

treated. Therefore, Gauri's right to free medical services was violated by the local health authorities.

Gauri's death is an example of Krieger (1999) argument discussed above on p. 9 – her death carried the history of the discrimination she was being subjected to. The cause of her death wasn't bleeding, but it was a result of structural discrimination, which found its way into the public health institution through the functionaries (state government, medical officer, and staff at the CHC), negating the legal and policy obligations of providing safe services. Gauri also had anaemia (SLIC, 2018) which is directly associated with 20%, and indirectly associated with 50% of maternal deaths in India (Anand et al., 2014). Gauri's death highlights how other factors, which are beyond the scope of JSY, may have led to her death.

DISCUSSION AND CONCLUSION

Since its introduction in 1989, intersectionality has become a buzzword for addressing issues of multi-dimensional discrimination. Several issues concerning intersectionality still need to be addressed (Nash, 2008) as discussed in the introduction, in any case, its usefulness as a tool to study, and possibly address, issues of inequality and discrimination cannot be undermined. From an Indian perspective, Menon (2015) has critiqued intersectionality for being a western framework assuming universalisation, but I argue that assuming universality has never been a core tenet of intersectionality. This argument is based on the premise that one of the key tenets of intersectionality – focusing on discrimination faced by historically oppressed and marginalised communities – holds immense relevance in India. The dominance of identity-based politics in India at the national and local level influences access to public welfare services (Jeffrey, 2002).

The case for applying intersectionality to the JSY is underscored by the fact that maternal mortality is an intersectional phenomenon due to the interaction between several factors, which range from structural discrimination against women to lack

of emergency medical services. While JSY's objective to curb maternal deaths is well intentioned, its sole focus on institutional deliveries as a panacea to tackle maternal mortality is problematic. The scheme's structure is geared towards chasing statistics as substantiated through the example of ASHAs in UP (Khan et al., 2010) who were more concerned about their cash incentives than ensuring safe pregnancies. Furthermore, JSY fails to give recognition to the lived experiences and social realities of women, and assumes that Indian women are a homogeneous category without accounting for the heterogeneous categories of caste Hindu women, Dalit women, *Adivasi* women, and Muslim women. This is reflected in its failure to reduce maternal deaths. These maternal deaths are attributed to the multiple forms of discrimination faced by pregnant women, as demonstrated through the discussion of Gauri's death. In the context of maternal health, these discriminations can be termed as human rights violations (Bouchard & Meyer-Bisch, 2016). Globally, access to maternal health has been construed as a human right and therefore, to reduce maternal deaths, JSY needs to treat access to the scheme as a human right. India is a signatory to several international human rights mechanisms and conventions, which makes it legally obligated to prevent maternal deaths.

Though there has been extensive research on JSY, my analysis found that the scheme doesn't treat maternal death as an intersectional phenomenon and assumes causality, which is evident through its standalone focus on institutional deliveries. Thus, I argue that JSY is a biomedical intervention on women's bodies rather than an evidence-based program. Furthermore, none of the existing studies critically question the basic structure and rationale of JSY. Their evaluation of the scheme's implementation assumes JSY's universality. Though it cannot be conclusively stated, my analysis tends to point towards the fact that none of the studies fully understand the process and reasons behind maternal deaths in India, which is sync with Yamin & Maine(1999, p. 564), who write “without a clear understanding of the causal chain leading to maternal mortality (and how

to break it), programs intended to reduce maternal deaths are likely to be ineffective”.

To conclude, this paper has demonstrated the relevance and utility of the intersectional framework in guiding maternal health interventions in India. Based on the discussions in this paper, I emphasise that JSY must take the intersectionalities of women into account and not follow a universal approach to reduce maternal mortality. However, demonstrating the usefulness of intersectionality to address maternal mortality in India - like this paper has done - is

not an end goal. This paper hopes to stir further research and conversations on how intersectionality can be employed in maternal health policymaking and practice in different contexts of India. Future research could focus on how the Intersectional-based policy analysis (IBPA) framework (Hankivsky et al., 2014) can be used to design and implement maternal health interventions in India, that can address the needs of the poorest and most vulnerable women in the country.

NOTES

[1] MDG is Millenium Development Goals that were agreed as international development targets for the year 2015 during the Millenium Summit in 2000. As stated on p. 2 earlier, MDGs have now been replaced by Sustainable Development Goals (SDGs) that are to be achieved by 2030.

[2] Maternal Mortality Ratio is defined as the number of deaths per 100,000 live births

[3] Adivasi is a term used for indigenous communities in India.

[4] With the support of the Central Government, Odisha State Government launched a free ambulance service (108) to provide a “high-end ambulance transportation system from the doorstep of the patient to the appropriate care in a hospital.

[5] JSSK was introduced in 2011 to curtail “high out of pocket expenses” incurred during institutional delivery. JSSK “assures free services to all pregnant women and sick neonates accessing public health institutions. The scheme envisages free and cashless services to pregnant women including normal deliveries and caesarean section operations and treatment of sick newborn[s] (up to 30 days after birth) in all government health institutions across state/UT.”

[6] CHCs are required to allow for a minimum 48 hour stay after delivery, and 3-7 day stay post-delivery for complicated deliveries. Furthermore, medical staff should be proficient in identifying and managing complications arising from post-partum haemorrhaging, eclampsia, and sepsis. Essential and emergency obstetric care, including surgical interventions like caesarean sections and other medical interventions, provisions for JSY and JSSK should also be available at the facility.

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