**STATUS OF WOMEN’S HEALTH IN RURAL INDIA: A STUDY OF JANANI SURAKSHA YOJANA**

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1. **INTRODUCTION**

The growth of human resources, living quality, and ultimately the social and economic advancement of the country all depend on good health. Population health has improved which has been considered a sign of social development. Furthermore, initiatives for sustainable development at the individual, community, and national levels prioritize health. The health of a nation's female population has a significant impact on both the women themselves and the children's health and education as well as the financial stability of households. In society, men predominate over women in all spheres, particularly in rural areas where they are unable to make the important choice that affects their family affairs. It is discovered that in the male-dominated culture, women are likewise treated with complete disrespect.In the developing or less developed countries, women are in very deplorable condition especially in the rural area so a special needs and attention is required for the women as they are the key factor in the household production function. Without taking proper care of womenfolk country cannot develop and grow economically. Women should take the important role in the inclusive growth path of the developing country like India but one of the main concerns is their health problem that is the major obstacle for productivity of the nation. To quote some of the data inferences it is referred that The Indian girl child is disadvantaged right from her birth. Every year in India 12 million girls are born but out of these only 9 million live up to the age of 15 years So, it is a matter of great concern that the number of girls per 1000 boys is constantly declining in India. The sex ratio for the whole country is 933 per 1000 male. For the 0-6 years of age group, the sex ratio is 927 per 1000 male child. (Registrar General and Census Commissioner, India, 2005). The adverse sex ratio, high maternal mortality rate, high prevalence of gynecological problems, and high death rate due to illegal abortions are some of the indicators which shows that women's health problems are not properly addressed by the government. As health is a serious concern for social and economic development of individuals, various steps have been taken by the Government of India to reform the condition of rural women. One of the important initiative was the National Rural Health Mission to bring transformation in the management of basic health care delivery system. The mission is based on focused on various segments that highlight the importance of nutrition, hygiene and access to safe drinking water. The basic motive of the plan is to increase public expenditure on health and provide equal opportunities for everyone for availing health services, bringing awareness among individual by initiating community development programmes for improving the women’s health. In order to achieve the objectives of the National Rural Health Mission (NRHM), JSY was launched in April 2005 to promote institutional deliveries among the Below Poverty Line (BPL) population through provision of referral, transport and escort services. (Mamtha, 2013). The NRHM aims to have a village based female Accredited Social Health Activist (ASHA) in 18 high focus states, which have been performing low with respect to institutional deliveries and, to act as the link between the people and the rural public health Some of the states of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa, and Jammu and Kashmir have implemented these programmes successfully

1. **LITERATURE REVIEW**

There are so many literatures on the different aspects of health studies. Some of these literatures are especially on the women's health. These literatures are on both Indian perspectives and as well as other countries perspective. These literatures are reviewed in a systematic order in the following:

Using the purposive sample method, Sharma and Dhawan (1986) ascertain the health issues faced by rural women in two villages in the Hisar area of Haryana. It has been noted that women have a variety of health issues, and that they typically use homemade remedies, or conventional methods. The government hospital is not equipped with the necessary medical facilities. The ineffectiveness of hospital care stemming from factors such as a shortage of physicians and medications suggest that the relevant authorities have paid little attention to the health issues faced by rural women. (Sharma, 1986).

The growth rate of India's elderly population is examined by Chanana and Talwar (1987) using data from the National Sample Survey. It has been noted that although the death rate is low, older people are more likely to experience transient illnesses and chronic disorders. They require medical attention for their issues. However, living situation and sexual orientation make getting medical care difficult. The study makes the case that putting welfare programs into place in various states can help older women's health. (Chanana, 1987)

According to Heise (1994), one of the factors contributing to women's health issues—which the government frequently ignores—is violence against them. Most of the time, women do not report this violence to the police. In rural areas, especially among illiterate families, beatings of wives are commonplace. This behavior has an impact on expectant mothers as well as their unborn children. Since violence against women weakens women's emotional and physical capacities, it also hinders their ability to fully engage in the economy, which has an impact on the nation's economic development. (Heise, 1994)

In addition to identifying solutions for enhancing women's health in Kamataka, Sidramshettar (2004) highlights the indicators of poor women's health status. It has been noted that the low health condition of women in Kamataka is caused by socioeconomic and cultural issues, illiteracy, early marriage, and rural residency. The study also shows that women's health is improved by family planning, immunization campaigns, enhanced health infrastructure, and awareness initiatives. (Sidramshettar, 2004)

Sharma and Narang (2011) investigate the standard of primary healthcare in Uttar Pradesh's rural communities. People are seen going to several health centers to confirm the caliber of care they are receiving. The study finds that perceptions of males are dramatically influenced more so than those of women by enhanced health care delivery. Expectations of higher-quality healthcare from health centers rise with increased income and education. They discover that if medical facilities are offered in rural health centers, individuals with lower levels of education or illiteracy are prepared to go long distances for treatment. According to the study's findings, despite the Indian government's best efforts, the significance of rural health centers is diminishing because of the poor quality of the services they provide. (Sharma, 2011)

 Mutharayappa (2010) has revealed that the delivery institutional have increased that added the need for the awareness regarding family planning methods and government health services. These are encouraging sign for the sustainability of institutional deliveries to reduce pre natal mortality rates. Nandan (2008) was of the opinion that the JSY scheme has been important to spread awareness among the women. ASHAs one of the important initiatives has played an important role in the implementation process of the scheme. Ambrish (2010) highlight that in India, the short-term impacts of the scheme were visible. It has positively benefited the mortality ratio by integrating new innovation in the system. Hence he was confident about the impact of the scheme on rural women. For this he has put forward the instances from the various states of India. Wadgave (2011) have studied on the aspect of “Missed opportunities of the scheme among beneficiaries in slum areas. He focused his study on the reasons for missing up such opportunities and he said that only 32.78% women were benefitted from the scheme while 62.22% have missed the opportunity due to several reasons like lack of information, non-accessibility to official documents, non-filing and completion of government forms. Dilip (2012) in his study on “stumpy coverage of Janani Suraksha Yojana” highlighted that in the case of West Bengal there were inadequacy of funds that leads to low coverage of the scheme. Steps have been taken by the government to reform the condition of fund system so that facilities are delivered at the time of emergency. Implementation has been one of the important issues in the state on which the schemes are dependent. Kumari (2009) highlighted that there multiple benefits of the scheme in terms of population control. She further stated the need for water, bed, electricity in health centers for regulating the health system. She also believed that Rs. 1400 will be given to the rural mothers after the delivery of the child and full protection will be provided to women as well as child

The above studies highlighted that there are critical problems faced by the women in the health sector and the important concerns as relating to ineffectiveness, illiteracy, lack of health facilities at rural areas, male dominance to name some of them. This study is different from the earlier study as it not only highlights the problems faced by the women at the rural sector but also the scheme is taken into account to support and deeply understand the subject with possible policy solutions

1. **OBJECTIVES OF THE STUDY**
* To assess the women health in rural India
* To compare the condition of rural women before and after the implementation of the Janani Suraksha Yojana.
* To analyze the impact of the Janani Suraksha Yojana.
* To discuss the role of ASHA’s in the implementation of the Janani Suraksha Yojana
1. **RESEARCH METHODOLOGY**

The qualitative methodology was developed to explore and record the experience of the women beneficiaries. The research also has a paradigm of looking into aspects from Feminist perspective. In this research a feminist approach was adopted to understand the subjective experiences, perceptions of the women participants of the village .

1. **WOMEN’S HEALTH IN RURAL INDIA**

India is the second most populous country in the world, with 1,21,01,93,422 people ,Of these, 58,64,69,174 people are female and 62,37,24, 248 are male ((Census of India: 2011). India is among the few nations where the proportion of men to women is much greater. Over time, this imbalance has grown, and the country's rural parts have some of the worst rates of maternal death worldwide. India is the country responsible for 19% of all live births and 27% of all maternal deaths worldwide. India puts a lot of strain on its natural resources because it has 16 percent of the world's people but just 2.4 percent of its territory. Currently, land resources provide a living for more than 70% of India's population, including 84% of economically engaged women. One of the few nations where men greatly outnumber women is India, where the disparity has been worse over time. India has some of the highest rates of maternal death worldwide in rural areas.

From a global perspective, India accounts for 19 percent of all lives births and 27 percent of all maternal deaths. India has 16 percent of the world’s population, but only has 2.4 percent of its land, resulting in great pressures on its natural resources. Over 70 percent of India’s population currently derives their livelihood from land resources, which includes 84 per cent of the economically active women. India is one of the few countries where males significantly outnumber females, and this imbalance has increased over time. India’s maternal mortality rates in rural areas are among the worlds highest. From a global perspective, Indian accounts for 19 percent of all lives births and 27 percent of all maternal deaths (Gupta, 2006).

Lack of access to basic necessities including food, water, fuel, fodder, and medical facilities is one of the most prevalent issues facing women. It was also becoming more and more difficult for women to continue providing for their families as they had in the past due to the degradation of the natural environment and the loss of many of their traditional jobs.

 (Chambers,1983). Compared to their male counterparts, women living in rural areas have less access to fundamental resources, such as social, health, educational, and agricultural service systems. In addition, prejudices cause discrimination, humiliation, anxiety, and low self-esteem in rural women by treating them with contempt and causing them to feel violated. The sex ratios between man and women in India most clearly illustrate the systemic bias against women, as some women choose to abort their pregnancies if they know or suspect they are carrying a girl child.

The health of rural women is jeopardized by a complex network of interconnected elements functioning at various levels. A rural woman's death can be attributed to bleeding during childbirth, but this does not address the numerous other indirect circumstances that also contributed to her demise. Rural Indian women's health is severely impacted by poverty in these areas. Many pregnant women in rural areas do not receive proper care because they are unable to pay for facility-based treatment, transportation expenses to get to a facility, or the missed income of those who accompany the woman. Delays in obtaining necessary medical care until a condition reaches its most critical stage can be brought on by poverty (Faujdar , 2005). Rural women's compelled participation in activities that raise their risk of HIV and other AIDS-related illnesses is another effect of poverty and Another factor contributing to rural women's worse health condition is literacy and education.

Indian women's status in society is inextricably related to their health. Studies on women's status have revealed that Indian women's contributions to families are frequently disregarded and instead seen as financial liabilities. Given that sons are expected to take care of their parents as they age, there is a significant preference for sons in India. This desire for sons combined with the high cost of dowries for females might lead to the abuse of daughters. Indian women also have low rates of formal labor force involvement and education. Usually having little independence, they live under the supervision of their sons, spouses, and dads in order of precedence.

Indian women's health is negatively impacted by each of these variables. Women who are ill might have an impact on their families as well. Low birth weight babies are more likely to be born to women who are not well and have a lower likelihood of being able to give their kids enough food and attention. Lastly, a woman's health has an impact on the financial stability of the home since she will be less effective in the workforce if she is not able to contribute towards household work.

Although there are other major health challenges that Indian women must deal with, this profile only addresses five of the most important ones: HIV/AIDS, nutritional status, violence against women, unequal treatment of girls and boys, and reproductive health. The 25 states and 7 union territories that make up India have widely different cultures, religions, and degrees of development; thus it is not surprising that there are significant regional variations in women's health. Every effort will be made to publish data for the key states in order to provide a more comprehensive image.

Indian culture, like the majority of cultures worldwide, is firmly rooted in patriarchal traditions and beliefs. Throughout the nation, patriarchy is evident in both the public and private domains of women's lives, defining their "life chances" and elevating them to a lower social class in all socioeconomic domains. It seeps into organizations and institutions and employs a variety of cunning strategies to erode women's rights to lives of dignity. Because of these gendered existences, women's lived experiences are similar. Nonetheless, women's diverse and frequently unique needs are acted out on a varied terrain of age, caste, class, and region in India, a large and socio0culturally diverse nation, leading to a complexity of experiences. Women's lived experiences mirror traditional social stratification grounds like caste and class, as well as differences between rural and urban areas and regions. As women move through the life cycle, new requirements surface. It is so difficult to discuss women's health and access to healthcare in such a complicated setting. One of the worst things that may happen to rural women both physically and mentally is abuse at the hands of their husbands and other family members. The extent to which these behaviors are tolerated in many rural communities, along with the women's helplessness in stopping them—including the absence of a support system—combine to keep rural women in abusive relationships and restrict men's ability to modify their positive behavior. Conditions that are stressful seem to exacerbate the mistreatment of rural women.( Burnad, 2006). In addition, Younger married women are less likely to complete their education and learn about their rights and sexual and reproductive health, as well as how to get services linked to these issues. They are left to manage their own fertility and sexual and reproductive health and well-being, having received little information and having little access to reproductive health care. (Soloman, (1998),

In addition to the aforementioned theoretical justifications for women's subordination in Indian society and throughout the world, myths, legends, religion, and culture all have a significant influence on the roles that women play in society and the perceptions that are held of them. These factors go beyond the simple requirements of biology and social context. Consequently, it is evident that the root reasons that maintain women in subordination as "second sex" are identity-free. Furthermore, the demographic indicators that show the prevalence of disparity between men and women can be seen in the death rate, infant mortality rate, life expectancy, and reproductive illnesses.

1. **JANANI SURAKSHA YOJANA: A REVIEW**

**Janani Suraksha Yojana (JSY)** is a safe motherhood interference undertaken by the National Rural Health Mission (NRHM) whose objective for reducing maternal mortality by promoting institutional delivery mechanism among the disadvantaged pregnant women. JSY integrates cash assistance with delivery and post-delivery care. “Under the JSY, eligible pregnant women are entitled for cash assistance irrespective of the age of mother and number of children for giving birth in a government or accredited private health facility.  The scheme focuses on poor pregnant woman with a special dispensation for states that have low institutional delivery rates, namely, the states of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha, and Jammu and Kashmir.  While these States have been named Low Performing States (LPS) under the scheme, the remaining States/UTs have been named High Performing States (HPS).  The scheme also provides performance based incentives to women health volunteers known as ASHA (Accredited Social Health Activist) for promoting institutional delivery among pregnant women” (Mamatha, 2013). Hence it can be said that the scheme have benefitted the pregnant women in rural areas.

Cash entitlement for different categories of mothers is as follows (JSY, 2006)

**Cash Assistance for Institutional Delivery (in Rs.)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Category** | **Rural Area** | **Total** | **Urban Area** | **Total** |
|  | **Mother’s package** | **ASHA’s package\*** | **Mother’s package** | **ASHA’s package\*\*** |
| **LPS** | 1400 | 600 | 2000 | 1000 | 400 | 1400 |
| **HPS** | 700 | 600 | 1300 | 600 | 400 | 1000 |

\*ASHA package of Rs. 600 in rural areas include Rs. 300 for ANC component and Rs. 300 for facilitating institutional delivery

\*\*ASHA package of Rs. 400 in urban areas include Rs. 200 for ANC component and Rs. 200 for facilitating institutional delivery

The condition of women in rural areas suffers from poverty and illiteracy. As Rural women are vital in India’s national economy. Further they have to face many kinds of exploitation and deprivations. They have to work longer and have no property rights. Majority of them do not have the right to choose their partners. As it is a patriarchal setup therefore the birth of women is not welcomed. The preference of male child exists in society. Moreover the system of dowry also makes family disabled and disadvantaged as they suffer on the account of repayment. “There is statistical bias in under estimating the role of rural women in development. Women work for longer hours than men and contribute substantially to family income, they are not perceived as productive workers”. (Pankajam and Lalitha, 2005). “India accounts for the maximum number of maternal deaths in the world at 17 per cent of the total, with nearly 50,000 of the 2.89 lakh women having died of complications in pregnancy or childbearing in 2013. According to the National Health Portal, the primary reasons for the high levels of maternal mortality are directly related to socio-economic conditions and cultural constraints limiting access to care” (Press trust of India, United Nations 2014). “Although maternal care is ostensibly free under the National Rural Health Mission (NRHM), it still entails transportation and incidental costs associated with hospital delivery that prevent women, particularly the poor among them, from accessing health services. The consequence is a large proportion of births taking place at home, where it is difficult to respond to unexpected emergencies such as the occurrence of placenta previa or foetal distress” (World Health Organization, 2014). Hence it can be analyzed that the poor women face lots of health inconsistencies so to empower and improve their condition steps have been taken place to enhance the quality of life.

It also to be mentioned that individuals with the great need for health care face the greatest difficulty in accessing health services and are the least likely to have their health needs met. “Poverty, lack of awareness among the concern populations and rise in the cost of health care lead to high out-of-pocket expenditure on maternal health services. In addition, gender inequality in the household and unwillingness among the family members to invest in women health also plays a role in depriving women of health care” (Statistical report 2009). The health services failed to reach the masses due to the dominance of richer section that dominate the poor people. Hence it can be analyze that the women residing in rural areas are neglected with the options of health facilities so with the scheme it can improve their conditions.

1. **Impact of JSY**

It is been observed that after the implementation of the scheme, there has been increase in institutional deliveries in hospital in various Indian states. The role of ASHA is significant in context to their support and assistance to rural women in regard to the institutional deliveries. A study found that more than half of the maternal deaths were among illiterate women but after the implementation of the JSY, there was significant decrease in maternal deaths. While these findings are encouraging, it also to be mentioned that there is a need for improved targeting of the poorest women. “An observational study was conducted by (Gupta, 2012) in a tertiary care hospital of Madhya Pradesh, before and after the implementation of JSY, with the sample comprising women who had undergone institutional deliveries. The results ostensibly showed that the incidence of institutional deliveries increased by 42.6% implementation of the program, including among the rural, illiterate and primary-literate persons belonging to the lower socioeconomic strata of society”. It can be said that the scheme have variously benefitted the different states of India. The table below depicts that there have been different kinds of impact on states in terms of the beneficiaries of the scheme. It highlights that there have been variation yearly and beneficiaries are dependent on the ratio of women availing the schemes.

**TABLE1. State-wise and year-wise details of number of beneficiaries under**

**Janani Suraksha Yojana (JSY) from 2012-13 to 2014-15**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S. No.** | **Name of States** | **2012-13** | **2013-14** | **2014-15** |
| 1 | Assam | 421359 | 451748 | 448143 |
| 2 | Bihar | 1829916 | 1695843 | 1531020 |
| 3 | Chhattisgarh | 277653 | 290276 | 321762 |
| 4 | Jharkhand | 282169 | 283562 | 249455 |
| 5 | Jammu and Kashmir | 127041 | 143129 | 116642 |
| 6 | Madhya Pradesh | 979822 | 1010824 | 942644 |
| 7 | Odisha | 547648 | 530089 | 498046 |
| 8 | Rajasthan | 1072623 | 1106262 | 1090012 |
| 9 | Uttar Pradesh | 2186401 | 2388204 | 2325010 |
| 10 | Uttrakhand | 89506 | 95344 | 100261 |
|  | **Sub Total** | **7814138** | **7995281** | **7622995** |
| 11 | Andhra Pradesh | 341041 | 383135 | 261558 |
| 12 | Goa | 1387 | 1100 | 828 |
| 13 | Gujarat | 308880 | 253005 | 277433 |
| 14 | Haryana | 61902 | 44076 | 45742 |
| 15 | Himachal Pradesh | 13626 | 15766 | 16182 |
| 16 | Karnataka | 407611 | 383251 | 411423 |
| 17 | Kerala | 116816 | 138527 | 114677 |
| 18 | Maharashtra | 364039 | 403405 | 345761 |
| 19 | Punjab | 79511 | 96873 | 103423 |
| 20 | Tamil Nadu | 358224 | 457770 | 470003 |
| 21 | Talangana |  |  | 135652 |
| 22 | West Bengal | 659996 | 363655 | 491356 |
|  | **Sub Total** | **2713033** | **2540563** | **2674038** |
| 23 | Andaman and Nicobar Islands | 298 | 366 | 398 |
| 24 | Chandigarh | 449 | 899 | 1713 |
| 25 | Dadra and Nagar Haveli | 786 | 1203 | 1241 |
| 26 | Daman and Diu | Not implemented | 245 | 107 |
| 27 | Delhi | 21722 | 12096 | 13723 |
| 28 | Lakshadweep | 494 | 992 | 1000 |
| 29 | Pondicherry | 3728 | 3754 | 3527 |
|  | **Sub Total** | **27477** | **19455** | **21709** |
| 30 | Arunachal Pradesh | 12200 | 11827 | 12906 |
| 31 | Manipur | 18145 | 17064 | 21667 |
| 32 | Meghalaya | 21082 | 20151 | 43334 |
|  |  |  |  |  |
|  |  |  |  |  |
| 33 | Mizoram | 12057 | 12871 | 5605 |
| 34 | Nagaland | 17609 | 13390 | 16430 |
| 35 | Sikkim | 2668 | 2383 | 2278 |
| 36 | Tripura | 18682 | 15502 | 17943 |
|  | **Sub Total** | **102443** | **93188** | **120163** |
|  | **otal** | **10657091** | **10648487** | **10438905** |

**Ref: JSY Guidelines,** <http://nrhm.gov.in/images/pdf/programmes/jsy/guidelines/jsy_guidelines_2006.pdf>

**Dongre (2012)** finds “that the JSY led to a marginal increase in the gap between LP and HP states in terms of institutional deliveries, within 18 months of its launch. However, from 2007 onwards, the gap began to decline, with LP states witnessing much larger increases in institutional deliveries. Pre-JSY trends show that convergence between LP and HP states (that may have taken place even without the program cannot be an explanation for these results”. Hence, he highlighted that there have been increase in institutional responsibilities for the impact assessment projects. There is a need to analyze impact assessment, it can be understood that maternal death have substantially reduced further women are having awareness about the health scheme and they are taking advantage of the benefits of the scheme. However, there are some States where the result of the scheme is not very encouraging in terms of failure to provide output due to the institutional deficiencies.

CRITICAL ANALYSIS OF THE SCHEME

1. **CRITICAL ANALYSIS**
* This scheme cannot fill the poor-rich gap in terms of the institutional delivery rate. Not only lack of awareness but there have been other internal institutional barriers.
* Despite receiving JSY benefits majority of the households were forced to still borrow the money to cover other expenditures.
* The non-monetary factors like quality of care as well as distance also impinge the process of the scheme.
* The study also highlighted that in many districts of Jharkhand and Orissa states have performed poorly in terms of incurring benefits of the scheme.
* The main objective of JSY was to help the poor rural women to receive the facility of the scheme. However, it was found that richer women were also the recipient of the government facility.
* There was unequal distribution of the benefits of JSY benefits as it favored pro-rich class. It cannot be a medium to reduce the gap between rich and poor sections of society.
1. **RESULTS**
* The paper highlighted that the scheme has been thriving in addressing the issues of the concern of health of rural women in terms of inequalities, disparities, and lack of adequate healthcare services.
* The customs and cultural ideas that dictate the way family members consume and serve food are based on the idea that women are inferior to men. Even now, inequality still exists in rural regions when it comes to how food is distributed within families between males and females.
* Her The poor health and nutritional status are therefore caused by her inferior social rank in the family, the caste system, and inadequate state government health infrastructure.
* The gap between the rice and the poor in terms of healthcare services has declined since the implementation of Janani Suraksha Yojana.
* Though the rate of health care access in the poor performing states have not achieved that much success but many minor transformation have impacted the health of the pregnant women.
* It is one of the initiatives towards women empowerment as the women are able to access the health facilities so they will be active enough to contribute towards the society.
* This scheme also highlighted that maternal death have reduced leading to the enhancement of the life expectancy.
* With the popularity of this scheme, the majority of the women is becoming aware and is thinking in terms of their well-being.
1. **SUGGESTIONS**
* Government should take steps to understand the loopholes in the functioning of the scheme so that steps are taken to improvise the implementation process.
* The study reveals that due to absence of specialist doctors and especially lady doctor for the gynecological treatment in rural health centers the rural women are suffering badly. So, it is suggested that more specialist doctors and specially lady doctors should be appointed more in the rural health centers.
* The majority of physicians are unwilling to serve patients in rural areas; thus, the government should take this seriously and implement policies requiring them to treat patients in these areas. A required health service policy ought to be in place for physicians. In any case, the government ought to reveal a competitive salary plan for physicians working in rural areas.
* Research should be conducted at the ground level so as to understand the barriers and problems faced by women residing in rural areas.
* The government organisations should organize workshops in rural areas so that majority of the women are aware of the positive impacts of the scheme to transform their health quality.
* Media, press should also play an active role in bringing the scheme at the limelight for the people living in rural societies.
* NGOs should play active role by educating and delivering the basic needs related to the health of pregnant women.
* JSY incentives should be significantly increase so that sufficient funds may be used to promote the benefits of the scheme.
1. **CONCLUSION**

Good health is essential for the development of human resources, the standard of life, and eventually the nation's social and economic progress. The improvement in population health has been interpreted as an indication of social development. In addition, health is given priority in national, local, and individual sustainable development programs. The state of a country's female population greatly affects not just the health and education of the children but also the financial stability of homes and the women themselves. From the discussion, it is clear that rural women's health is still in poor condition due to a variety of factors, including a varied work load, exposure to inefficient cooking, and lack of access to facilities for drinking water, sanitation, ventilation, cooking, and medical care. In addition, it is discovered that women's health is negatively impacted by the stress of giving birth to multiple children in inappropriate locations. The study highlighted the impact of JSY scheme on rural women. The scheme has been significantly successful in terms of addressing social and economic gap between rich and poor in access to health care services. In addition, the study also reveals that the women using institutional deliveries have witnessed a steep rise. However, there are existing inequalities which cannot be entirely filled. The impact can be seen at two levels one is cash incentives provided to the women delivering the babies as well as health workers. The long-term financial and social investment in women's literacy would definitely add to the benefits under JSY in India.

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