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Reproductive Health-Seeking Behaviour Among Oraon Women in Purulia and Paschim Medinipur Districts, West Bengal: A Qualitative study

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Abstract

The present paper presents a qualitative observational analysis of reproductive health-seeking behaviour (RHSB) among 250 Oraon tribal women across the districts of Purulia and Paschim Medinipur districts of West Bengal. Employing a mixed-method ethnographic design combining structured surveys, in-depth interviews, and direct observation, the study documents patterns of antenatal care, childbirth practices, postnatal rituals, contraceptive use, and healthcare decision-making. Findings reveal a syncretical health-seeking model wherein Oraon women demonstrate pragmatic openness to modern biomedical interventions during pregnancy yet adhere strongly to traditional practices for childbirth and confinement. Home delivery assisted by the traditional midwife (Kusrain) remains the dominant norm (72%), driven by cultural continuity, economic constraints, mistrust of institutional care, and perceived lack of family support. Patriarchal structures significantly influence reproductive autonomy, with marked son preference shaping fertility decisions (80% of women with two or more daughters expressed desire for additional children). Educational attainment is strongly associated with health literacy and contraceptive adoption. Structural barriers—including geographic distance, transport costs, and perceived poor quality of care—continue to impede optimal RCH service utilization. The study concludes that addressing reproductive health inequities among the Oraon requires culturally congruent interventions that respect ethno-medical traditions while improving accessibility, quality, and gender-sensitivity of maternal health services.

Keywords: *Oraon, Reproductive health-seeking behaviour, Traditional birth attendant (Kusrain), Son preference*

1: Introduction

The reproductive health outcomes of tribal communities in India remain a persistent public health concern despite decades of targeted government programs. Among the 8.6% of India's population belonging to Scheduled Tribes, maternal and child health indicators lag significantly behind national averages, reflecting deep-seated inequities in access, quality, and cultural appropriateness of services. West Bengal, with its diverse tribal composition, exemplifies this paradox: while state-level maternal health metrics have shown improvement, intra-district variations persist, with tribal women remaining disproportionately vulnerable.

The Oraon (Kurukh), a Dravidian-speaking tribe originally from the Chotanagpur plateau, constitute the second largest tribal group in West Bengal after the Santhal, with substantial populations concentrated in Purulia, Paschim Medinipur, Bankura, and Jalpaiguri districts. Ethnolinguistically distinct and culturally cohesive, the Oraon maintain elaborate lifecycle rituals, including birth, marriage, and death ceremonies that reinforce community identity. However, rapid socio-economic changes, migration, and expanding health infrastructure have placed traditional reproductive practices in tension with modern biomedical models.

While quantitative surveys have documented contraceptive prevalence rates, antenatal coverage, and institutional delivery proportions among West Bengal tribals, qualitative insights into the lived experiences, belief systems, and decision-making processes of Oraon women remain limited. This paper addresses this gap by presenting a qualitative observational analysis of RHSB among 250 Oraon women in Purulia and Paschim Medinipur—two districts with contrasting topographies and health infrastructure profiles. The study aims to: (1) characterize the patterns and determinants of health-seeking behaviour across the reproductive continuum; (2) elucidate the socio-cultural factors shaping decisions regarding antenatal care, childbirth location, and family planning; and (3) identify barriers and facilitators to optimal reproductive health service utilization.

2. Methodology

2.1 Study Setting

The study was conducted across selected villages in Purulia and Paschim Medinipur districts of West Bengal. Purulia, the westernmost district, is characterized by undulating lateritic terrain, forested tracts, and relatively low population density, with tribal communities concentrated in remote, hilly areas. Paschim Medinipur, adjoining Purulia to the east, features more developed transport networks and proximity to district headquarters, though tribal pockets remain underserved. These districts were

purposely selected to capture variation in geographic accessibility and health infrastructure.

2.2 Study Design

A qualitative observational design employing a mixed-method ethnographic approach was adopted, comprising:

- **Structured survey questionnaire** covering demographic characteristics, reproductive history, service utilization, and health-related knowledge.
- **Semi-structured in-depth interviews** exploring beliefs, decision-making processes, experiences with health services, and perceived barriers.
- **Direct observation** of childbirth practices, postnatal rituals, and traditional healing encounters where permissible.
- **Focus group discussions** (separate groups of women and men) to examine community norms regarding pregnancy, childbirth, and family planning.

2.3 Sample

A total of 250 Oraon women of reproductive age (15–45 years) who had experienced at least one pregnancy were recruited through purposive and snowball sampling. Stratification was applied to ensure representation across age groups, parity levels, and geographic locations (155 women from Purulia, 95 from Paschim Medinipur). Written informed consent was obtained in the local Kurukh language, with verbal consent additionally documented for illiterate participants.

2.4 Data Collection

Data collection was conducted over a 14-month period from September 2024 to October 2025. A team of four field investigators—including two fluent Kurukh speakers—administered the survey and conducted interviews in community settings (households, village common areas, and health facility premises). Each in-depth interview lasted 45–90 minutes; focus group discussions ranged from 90–120 minutes. Field notes were maintained alongside audio recordings (with participant consent). Observations focused on delivery environments, hygiene practices, the role of the *Kusrain*, and postpartum rituals.

2.5 Data Analysis

Qualitative data from interviews, focus groups, and observational field notes were transcribed verbatim (Kurukh translated into Bengali, then to English) and

analysed using thematic analysis in NVivo 14. Transcripts were coded inductively and deductively, with themes organized around the reproductive health continuum: antenatal, intranatal, postnatal, and family planning. Quantitative survey data were analysed using SPSS version 26 for descriptive statistics. Triangulation across multiple data sources (surveys, interviews, observations, field notes) and member checking with 20 participants (re-interviewed to verify interpretations) enhanced trustworthiness.

2.6 Ethical Considerations

All participants were clearly informed of their right to withdraw at any point; confidentiality was maintained through anonymized identifiers.

3. Results

The findings are organized around five thematic domains derived from the qualitative analysis, supplemented by quantitative descriptives.

3.1 Socio-Demographic Profile of Participants

Table 1: Demographic characteristics of study participants (N=250)

Characteristic	Category	Purulia (n=155)	Paschim Medinipur (n=95)	Total (%)
Age group (years)	15–24	42	28	70 (28.0)
	25–34	78	45	123 (49.2)
	35–49	35	22	57 (22.8)
Education	Illiterate	94	46	140 (56.0)
	Can sign only	36	24	60 (24.0)
	Primary school	18	15	33 (13.2)
	Middle school+	7	10	17 (6.8)
Occupation	Daily wage laborer	108	58	166 (66.4)
	Agriculture	32	24	56 (22.4)
	Salaried/service	2	3	5 (2.0)
	Housewife only	13	10	23 (9.2)
Marital status	Married	148	91	239 (95.6)
	Widowed/separated	7	4	11 (4.4)
Parity	1–2 children	51	38	89 (35.6)
	3–4 children	79	44	123 (49.2)
	5+ children	25	13	38 (15.2)

The sample predominantly comprised illiterate women (56%) engaged in manual labour or agriculture, with nearly two-thirds having three or more children. Purulia participants displayed lower literacy and higher parity compared to Paschim Medinipur.

3.2 Antenatal Care: Pragmatic Acceptance

Antenatal care (ANC) utilization revealed a pattern of pragmatic acceptance. Overall, 84% of women reported having received at least one antenatal checkup during their most recent pregnancy, with 63%

completing four or more visits. This aligns with NFHS-5 district-level data showing Purulia ANC coverage (four or more visits) around 53% versus Paschim Medinipur at approximately 68%. **Table 2** presents ANC components utilized:

Table 2: Utilization of antenatal care components among last pregnancy (N=250)

ANC component	Purulia (n=155)	Paschim Medinipur (n=95)	Total (%)
≥1 ANC visit	125 (80.6%)	85 (89.5%)	210 (84.0)
≥4 ANC visits	86 (55.5%)	72 (75.8%)	158 (63.2)
Tetanus toxoid injection (at least one)	140 (90.3%)	88 (92.6%)	228 (91.2)
Iron-folic acid tablets	118 (76.1%)	81 (85.3%)	199 (79.6)
Blood pressure checked	97 (62.6%)	76 (80.0%)	173 (69.2)
Abdominal examination	85 (54.8%)	71 (74.7%)	156 (62.4)

Source: Primary survey data

A 34-year-old Oraon woman in Purulia explained her problem from the ground level. According to her, “I went to the health sub-centre for TT injection—that I know is important for baby’s health. The nurse there also gave me iron tablets. But the doctor told me to come for checkup every month, which is not possible. The centre is far away—almost two hours walking—and I have other children to care for. So I went only three times total.” (Participant P-042, Purulia)

However, knowledge deficits were evident. Only 38% of respondents could correctly identify three or more danger signs during pregnancy (severe headache, bleeding, reduced foetal movement, fever). This

deficiency is consistent with earlier findings that the “Oraons’ knowledge of contraception, vaccinations, proper diet and supplements needed for successful pregnancy was severely deficient”.

3.3 Childbirth Practices: The Persistent Preference for Home Deliveries

The most salient finding was the overwhelming preference for home deliveries. Despite high ANC utilization, 180 women (72%) delivered their last child at home. Among these, 162 (90%) were assisted exclusively by the traditional midwife, *Kusrain*.

Table 3: Place of last delivery and assistance (N=250)

Delivery characteristic	Purulia (n=155)	Paschim Medinipur (n=95)	Total (%)
Place of delivery			
Home	122 (78.7%)	58 (61.1%)	180 (72.0)
Government hospital/CHC	26 (16.8%)	30 (31.6%)	56 (22.4)
Private facility	7 (4.5%)	7 (7.4%)	14 (5.6)
Birth attendant at home deliveries			
<i>Kusrain</i> (TBA)	112 (91.8%)	50 (86.2%)	162 (90.0)
Family elder only	6 (4.9%)	4 (6.9%)	10 (5.6)
ANM/nurse	4 (3.3%)	4 (6.9%)	8 (4.4)

The home delivery environment, as observed across 23 deliveries (where the research team was permitted present), typically involved a secluded room with closed doors and windows—a practice noted in the literature as customary during labour. The *Kusrain*, an elder woman from the same or a neighbouring Oraon household, managed the delivery using traditional techniques, including abdominal manipulation, herbal preparations, and postpartum massage. Male family members were strictly prohibited from entering the delivery room, corroborating earlier ethnographic documentation: “Only women are allowed to be present inside the delivery room... the midwife takes major role in the delivery of child”. A 42-year-old *Kusrain* articulated the cultural logic: “In our tradition, a woman gives birth where she lives, surrounded by women who know her. The *dai ma* has brought hundreds of babies into this village. Hospitals are for when something goes wrong—bleeding, stuck baby. For a normal delivery, home is better. The mother is not scared. She has her mother-in-law, her sisters. And after birth, rituals must be performed properly.” (FGD-2, Purulia)

Reasons cited for home delivery preference were multifaceted: traditional custom (cited by 85% of home-delivering women), fear of C-section (73%), economic constraints (68%), lack of family support for institutional delivery (62%), and distance to facility (58%). A 29-year-old woman with three children in Paschim Medinipur explained: *My neighbor went to the hospital for her delivery. She stayed there for three days with no one to cook for her, no proper place to sleep. They did an operation without asking her family. I delivered at home with Kusrain ma, spent no money, and was eating my own home-cooked food within hours.*” (Participant M-087, Paschim Medinipur). This finding aligns with prior observations that the Oraons are very tradition bound with regard to the custom of child delivery at home.

3.4 Postnatal Rituals and Traditional Confinement

Postnatal practices among the Oraon are deeply ritualized. Observational data documented **postnatal rituals** in 94% of households visited. The *Chathi* ceremony—celebrated six to eight days after birth—marks the formal welcome of the newborn into the family and community. During the confinement period (traditionally 30 days), the new mother observes dietary restrictions, consumes herbal tonics prepared by the *Kusrain* or elder women, and receives daily abdominal massage. A 28-year-old mother of a newborn in Purulia described: “For one month after delivery, I eat only warm foods—rice porridge, ginger, turmeric, black pepper, goat meat soup. No cold water, no raw vegetables. The *dai ma* gave me a herbal paste to apply on my stomach to help the uterus return to its place. These are the things

my mother did, my grandmother did. Why would I change?” (Participant P-112, Purulia)

Notably, while 68% of women reported having heard of the need for early postnatal checkups for mother and baby, only 31% actually received a postnatal visit from an ANM or health worker within 48 hours of delivery.

3.5 Contraceptive Knowledge and Use: Educational Disparities

Contraceptive awareness and adoption revealed stark educational gradients. Overall, only 42% of women reported ever using any modern contraceptive method (predominantly female sterilization and condoms). **Table 4** presents contraceptive prevalence by literacy status:

Table 4: Contraceptive use by literacy status (N=250)

Literacy category	n	Ever used any modern method (%)	Current user (%)
Illiterate	140	38 (27.1)	28 (20.0)
Can sign only	60	28 (46.7)	22 (36.7)
Primary school+	50	36 (72.0)	30 (60.0)
Total	250	102 (40.8)	80 (32.0)

Knowledge of specific contraceptive methods was limited: 64% had heard of female sterilization, 48% of condoms, 31% of oral pills, and only 12% of IUCDs. A 32-year-old with five children expressed fatalism: “We want no more children—we already cannot feed so many mouths. But my husband will not agree to use a condom. The health worker told me about pills, but taking a pill every day is not possible—I forget. The operation, I am scared. So we do nothing. It is in God’s hands.” (Participant P-083, Purulia)

3.6 Son Preference and Patriarchal Constraints on Reproductive Autonomy

Pronounced son preference emerged as a dominant theme, shaping fertility intentions and contraceptive non-use. Among the 80% of women with two or more living children, 63% expressed desire for additional children if no son had been born. A 36-year-old woman with three daughters articulated: “Unless we contribute by bearing a son towards the family and tribe, our presence in the family does not mean anything substantial. Who will carry the family name? Who will perform the death rituals for us? Only a son can do these things. A daughter marries and goes to her husband’s village.” (Participant M-044, Paschim Medinipur)

This finding echoes broader observations that Oraon society, despite tribal egalitarian ideals, remains “*patriarchal and patrilineal*” with “*strong preference for male children*” and women regarded as “*reproductive machines*” for whom “*maternity is seen as their domain*”. Decision-making power regarding fertility and healthcare utilization rested

predominantly with husbands or senior male household heads in 74% of respondents’ accounts.

3.7 Structural Barriers to Formal Healthcare

Analysis of open-ended responses and focus group transcripts identified **structural barriers** impeding optimal health service utilization:

Table 5: Perceived barriers to formal reproductive healthcare utilization (multiple responses, N=250)

Barrier category	Specific barrier	Citing women (%)
Geographic	Long distance to health facility (>5 km)	148 (59.2)
	Lack of transport / cost of transport	120 (48.0)
Economic	Direct costs (medicines, investigations)	104 (41.6)
	Indirect costs (lost wages, travel)	86 (34.4)
Cultural	Preference for <i>Kusrain</i> / home birth	175 (70.0)
	Fear of C-section / surgery	152 (60.8)
	Discomfort with male doctors	96 (38.4)
Systemic	Long waiting times at facilities	138 (55.2)
	Perceived poor quality of care	112 (44.8)
	Lack of female provider	78 (31.2)
Social	No family support for institutional delivery	98 (39.2)
	Lack of childcare for other children	66 (26.4)

A focus group participant in Purulia summarized the systemic frustration: “*When we go to the block hospital, we sit for half the day on a hard bench. The nurse is rude—she shouts at us for not understanding Hindi properly. The doctor sees us for two minutes and prescribes medicines we cannot afford from the pharmacy outside. Who would choose to go there if we have another option?*” (FGD-3, Purulia)

3.8 Inter-District Variations

Several notable differences emerged between Purulia and Paschim Medinipur. Women in Paschim Medinipur—with marginally better transport connectivity and proximity to district headquarters—reported higher rates of institutional delivery (39% vs. 21%), completed ANC visits (76% vs. 56%), and contraceptive use (48% vs. 35%). However, son preference intensity was comparable across both districts, and trust in *Kusrain* remained high in both settings, albeit with slightly greater openness to institutional birth in Medinipur.

4. Discussion

The findings of this qualitative observational study among 250 Oraon women in Purulia and Paschim Medinipur reveal a reproductive health-seeking landscape characterized by **syncretic pragmatism**—a fluid navigation between traditional and modern biomedical systems depending on the phase of reproduction. While antenatal care is largely accepted as beneficial, childbirth remains resolutely within the domestic domain, mediated by the authoritative knowledge of the *Kusrain*.

4.1 The Persistence of Home Births in an Era of Janani Suraksha Yojana

The finding that 72% of Oraon women delivered at home—despite 84% having accessed at least one ANC visit—presents a paradox. Government programs such as Janani Suraksha Yojana (JSY) provide cash incentives for institutional delivery, yet these incentives appear insufficient to override deeply embedded cultural preferences. The reasons are not merely economic (though cost remains a barrier) but fundamentally **cultural and psychological**. Home

birth is perceived as *safer* because it occurs within a familiar environment, attended by a trusted female community member, and followed immediately by culturally prescribed postnatal rituals. Institutional delivery, by contrast, is associated with anonymity, potential surgery, disrespectful care, and disruption of ritual continuity.

This has important policy implications. Rather than attempting to replace traditional birth attendants, programs should consider **integrating trained *Kusrain* into the formal health system**—providing them with clean delivery kits, training in recognition of danger signs, and referral linkages. Such approaches have been successful in other tribal contexts (e.g., Chhattisgarh’s *Mitanin* program) and could be adapted for the Oraon.

4.2 Son Preference and Its Demographic Consequences

The pronounced son preference documented in this study—expressed by 63% of women with only daughters desiring more children—is not merely a cultural artifact but a driver of high fertility, closely spaced pregnancies, and associated maternal health risks. Despite the demographic transition occurring in much of West Bengal, tribal groups such as the Oraon continue to exhibit “*a pro-natal approach to their lives with a strong preference for male children*”. This is not simply a matter of “backwardness”: son preference is deeply embedded in patrilineal kinship structures, land inheritance patterns, and ancestral ritual obligations.

Interventions must move beyond supply-side family planning services to address the **demand-side drivers** of son preference. Community-led dialogues that engage men and elders, combined with economic empowerment programs for girls (conditional cash transfers linked to education), may gradually shift norms over a generational timescale.

4.3 Educational Attainment as a Transformative Lever

The strong association between literacy and positive health behaviors (contraceptive use, institutional delivery intent, danger sign recognition) confirms that **female education is perhaps the single most powerful intervention** for improving tribal reproductive health. Among literate Oraon women in this study, contraceptive prevalence was 72% compared to 27% among illiterates—a gap of 45 percentage points. Education enables women to access information, communicate with health providers, assert preferences within households, and plan their families intentionally.

Yet literacy rates among Oraon women remain abysmally low (only 20% in this sample had completed primary schooling). Accelerating universal

access to quality education for tribal girls—including addressing barriers such as distance to school, lack of sanitation facilities for menstruating girls, and culturally incongruent curricula—must be prioritized.

4.4 Limitations

This study has several limitations. First, the sample of 250 women, while purposively selected across two districts, may not fully represent the diversity of Oraon experiences across West Bengal. Second, recall bias is possible for events (e.g., complications during prior pregnancies) occurring several years ago. Third, the presence of researchers may have influenced some responses, particularly regarding socially sensitive topics such as son preference (though triangulation with FGDs and observations mitigates this). Fourth, the study did not include a comparative non-tribal control group, limiting claims about tribal-specific patterns. Finally, the qualitative design prioritizes depth over generalizability; quantitative associations (e.g., education–contraceptive use) should be interpreted as descriptive, not causal.

5. Conclusion

This qualitative observational study of 250 Oraon women in Purulia and Paschim Medinipur provides empirical grounding for understanding the complex reproductive health-seeking behaviour of this tribal community. The findings reveal:

1. A **syncretic health-seeking model** in which modern antenatal care is pragmatically accepted but traditional childbirth practices—mediated by the *Kusrain*—remain dominant.
2. **Deeply rooted cultural preferences** for home births, driven by tradition, fear of surgery, economic constraints, and trust in community-based care.
3. **Pronounced son preference** embedded in patrilineal kinship structures, sustaining high fertility and constraining women’s reproductive autonomy.
4. **Educational attainment** as a critical determinant of contraceptive adoption, health literacy, and service utilization.
5. **Structural barriers**—geographic, economic, and systemic—that perpetuate inequitable access to quality maternal health services.

Recommendations

Based on these findings, the following interventions are recommended:

- **Formalize and train Kusrain:** Develop accredited training programs for traditional birth attendants in clean delivery practices, danger sign recognition, and referral protocols, while respecting their cultural authority.
- **Improve quality and respect in public facilities:** Address disrespectful care, long waiting times, and lack of female providers through patient-centred quality improvement initiatives and community scorecards.
- **Engage men and elders:** Design community-based health education that addresses son preference, family planning, and maternal nutrition through participatory dialogue involving male household heads.
- **Invest in girls' education:** Expand access to quality schooling for Oraon girls through residential hostels, menstrual hygiene management facilities, and conditional cash transfers.
- **Strengthen outreach services:** Deploy mobile health units and village-level health workers to improve ANC/PNC coverage in remote tribal hamlets.

Ultimately, improving reproductive health outcomes among the Oraon requires moving beyond a one-size-fits-all biomedical model toward culturally congruent, community-engaged approaches that respect traditional knowledge while expanding access to safe, respectful, and high-quality care.

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