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Awareness About Maternal and Child Health among the Tribal Women in Two Villages of North Bengal, West Bengal

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Abstract

Despite the implementation of various national programs in India, maternal and neonatal mortality and morbidity remain persistently high in tribal areas, primarily due to a lack of awareness about Maternal and Child Health (MCH) services among tribal women. This study was strategically designed to evaluate the knowledge levels of married tribal women in the reproductive age group regarding MCH services. The focus of this investigation is to understand the awareness about mother and child health services among tribal women in the reproductive age group in two villages, Shikarpur of Jalpaiguri and Hatighisa of Darjeeling district in West Bengal. A total of 100 (50 from each village) married women of reproductive age group were selected. All the participants were interviewed using a survey schedule. Among 100 respondents, 68% completed primary education. A significant proportion of child-birth/deliveries (81%) occur at home, prompting the need for safer institutional deliveries. Prenatal and postnatal care practices vary, with 68% receiving two Tetanus Toxoid doses. Healthcare consultations during sickness show diversity and 57 individuals did not seek any. Breastfeeding initiation within 24 hours was observed. Introducing complementary foods occurred mostly between 0-6 months. The study underscores the necessity for targeted interventions to improve vaccination coverage and healthcare-seeking behaviors, and emphasizes promoting exclusive breastfeeding for enhanced maternal and child well-being.

Keywords: Maternal Health, Child Health, ASHA, AWW, ANM

Introduction

Maternal health poses a significant challenge in developing nations and the enhancement of maternal health serves as a crucial component in achieving universal health. The Sustainable Development Goals (SDGs), introduced in 2016, set ambitious targets to reduce the global maternal mortality ratio (MMR) to less than 70 per 100,000 live births and eliminate preventable deaths of newborns and children under 5 by 2030. These goals also aim to achieve universal access to sexual and reproductive healthcare services, encompassing family planning, information and education, and the integration of reproductive health into national strategies and programs (1). In countries such as India, the issue of maternal and infant mortality is a pressing matter in public health (2, 3). Despite numerous national programs implemented since independence to enhance child and maternal health, inadequate access and underutilization of modern health services remain primary contributors to India's high maternal mortality

rate. Additional factors include high levels of female illiteracy, early marriages, widespread ignorance, high service costs, societal structures, detrimental health beliefs, personal characteristics, and prevalent malnutrition, particularly among rural and tribal populations. Consequently, beneficiaries' utilization of these services continues to be high in tribal areas despite the existence of various national programmes in India especially due to lack of awareness about Maternal and Child Health (MCH) services among tribal women (4). Hence, this study was designed to evaluate the knowledge and awareness levels in maternal health among married tribal women of reproductive age in two villages, Shikarpur of Jalpaiguri and Hatighisa of Darjeeling districts.

Objectives

a. To study the socio-economic condition of these tribal women in these two villages
b. To study about the Health Care Service Providers in the Study Area
c. To study the maternal health awareness among the tribal women

Research Methodology

The study focused on 100 married women of reproductive age between 29 to 49 years of age.
Data collection involved personal interviews using a semi-structured survey schedule during house-to-house visits. It was conducted to get the information about socio-economic background of the households, health care, related information about mother and children, and their awareness with respect to the health care facility in their villages. The data entry and analysis was done using excel software. Results were presented as percentage of number of study subjects with responses.

About the Study Areas

According to Census 2011 data, Shikarpur village is located in Rajganj Block of Jalpaiguri district, West Bengal, India. It is situated 3.7 km away from the sub-district headquarters Rajganj and 25.4 km away from the district headquarters Jalpaiguri. Shikarpur falls under the gram panchayat of Sikarpur, with a total geographical area of 3380.6 hectares and a population of 19,437 people residing in approximately 4,336 houses. The village has a significant child population, with 11.81 % aged 0-6 years, and an average sex ratio of 950, slightly lower than the West Bengal state average. The literacy rate in Shikarpur is 68.60 %, which is lower than the state average of 76.26 %, with male literacy at 75.15 % and female literacy at 61.75 %. Hatighisa is situated in Naxalbari Block within the Darjeeling District of West Bengal, India. It is positioned 4 kilometers from Naxalbari and approximately 535 kilometers away from the state capital, Kolkata. Hatighisa is surrounded by Matigara Block to the east, Kharibari Block to the south, Phansidewa Block to the east, and Siliguri Block to the east. Cities in proximity to Hatighisa include Siliguri, Darjeeling, Islampur, and Kalimpong.

Data analysis and interpretation

A. Socio-Economic Information of the Respondents

Data have been collected from sample of 100 rural tribal women (age between 19 to 49 years) residing in Shikarpur village of Jalpaiguri (50 respondents) and Hatighisha village of Darjeeling District (50 respondents). Bulk of the respondents i.e. 46 % were between 29-39 years of age.

Table 1-Religion of the respondents

Religion	Shikarpur	Hatighisha	Total
Hindu	33	45	78
Christian	17	5	22
Total	50	50	100

Source: Field Survey

Table 1 discloses that among 100 female respondents, the predominant identification by religion is Hindu (78%), with Christian respondents comprising 22%. Specifically, in Shikarpur, 33 individuals (66%) identify as Hindu, while 17 (34%) identify as Christian. In Hatighisha, the majority of respondents, totaling 45 individuals (90%), identify as Hindu, while 5 individuals (10%) identify as Christian.

Table 2-Economic category of the respondent

Category	Shikarpur	Hatighisha	Total
Above Poverty Line (APL)	33	16	49
Below Poverty Line (BPL)	17	34	51
Total	50	50	100

Source: Field Survey

In Shikarpur village, 33 respondents reside above the poverty line, whereas 17 individuals live below it. In contrast, only 16 respondents (32%) in Hatighisa village are situated above the poverty threshold. The majority of respondents in this study fall under the Below Poverty Line (BPL) category.

Table 3- Literacy Level of the Respondent

Literacy Level	Shikarpur	Hatighisha	Total
Illiterate	16	9	25
Primary	32	36	68
Secondary	2	3	5
Higher secondary	0	2	2
Total	50	50	100

Source: Field Survey

In Shikarpur, 16 respondents (32%) lack formal education, 32 individuals (64%) have completed only primary education, and a mere 2 respondents (4%) have attained secondary education. On the other hand, in Hatighisa, 19% of respondents are illiterate, 36% have completed elementary education, 3% have finished secondary education, and 2% have achieved higher secondary education. The majority of respondents, constituting 68%, have completed primary school.

Table 4-Types of family of the respondents

Types of Family	Shikarpur	Hatighisha	Total
Joint	25	21	46
Nuclear	25	29	54

Total	50	50	100

Source: Field Survey

Table 4 illustrates that in Shikarpur, 25% of respondents reside in joint families, while another 25% live in nuclear families. Conversely, in Hatighisa, a higher proportion living in nuclear families is observed with 29 individuals (58%), and 21 individuals (42%) in joint families. The predominant family structure among respondents is nuclear families.

Table 5- Type of house of the respondents

Type of house	Shikarpur	Hatighisha	Total
Kuccha	39	17	56
Pucca	0	2	2
Semi-pucca	11	31	42
Total	50	50	100

Source: Field Survey

In Shikarpur, the majority of respondents, totaling 39 individuals (78%), reside in homes classified as kuccha (not made of bricks and cement), while 11 respondents (22%) inhabit semi-pucca (half mud and bamboo structure) houses. Moving to Hatighisa, 17 respondents (34%) reside in kuccha houses, a mere 2 individuals (4%) live in pucca (made of bricks and cement) houses, and the bulk, comprising 31 respondents (62%), resides in semi-pucca houses.

Table 6- Provision of Electricity in the houses of the Respondent

Electricity facility	Shikarpur	Hatighisha	Total
Yes	27	42	69
No	23	8	31
Total	50	50	100

Source: Field Survey

In Shikarpur, 27 (54%) houses of the respondents have electricity connection. But in Hatighisha, electricity connection is available in most of the houses of the respondents.

Table 7- Size of family of the Respondent

Size of Family	Shikarpur	Hatighisha	Total
3-4 members	25	24	49
5-6 members	19	17	36
7-8 members	6	9	15
Total	50	50	100

Source: Field Survey

Table 7 illustrates the family sizes of respondents from Shikarpur and Hatighisha. In Shikarpur, 25 respondents have families consisting of 3 to 4 members, 19 respondents have families with 5 to 6 members, and 6 respondents have families comprising 7 to 8 members. In Hatighisha, 24 respondents have families with 3 to 4 members, 17 respondents have families with 5 to 6 members, and 9 respondents have families with 7 to 8 members. Overall, the majority of respondents (49%) share a family size of 3 to 4 members.

Table 8- Monthly Income of the family of the Respondents

Monthly income (in Rupees)	Shikarpur	Hatighisha	Total
Less or equal to 3000	33	8	41
3001-6000	15	19	34
6001-9000	2	17	19
9001-12000	0	6	6
Total	50	50	100

Source: Field Survey

Table 8 shows the distribution of respondents according to monthly family income. According to the data, in Shikarpur, 33 (66%) respondents had family income of less than or equal to Rupees 3000, 15 (30%) respondents had family income between Rupees 3001-6000 and 2 respondents had monthly family income ranged between Rupees 6001 to 9000. In Hatighisha, 38 % of the respondents had a family income between Rs. 3001-6000 and the family income of 17 (34%) respondents varied between 6001-9000. In Hatighisa, 6 of these families had an income between 9000 and 12000.

B. Awareness of Maternal Health-Care among the Respondents

Maternal health is of paramount importance in India, as it directly impacts the well-being of both mothers and their children. Despite progress in recent years, challenges persist, and efforts are ongoing to improve the health outcomes for mothers and children. Data collected on various aspects of maternal health are as follows.

a. Health Care Service Providers in the Study Area

Community Health Centres (CHCs), established and maintained by state governments, function as referral hubs for Primary Health Centres, offering a spectrum of services and actively fostering behavioral change. They encompass a diverse array of initiatives, including maternal and child health programs, family welfare, nutrition services, immunization campaigns, and the management of both communicable and non-communicable diseases (5).

Table 9- Health Care Service Providers to the Respondents

Health Care Service Providers	Shikarpur	Hatighisha	Total
Auxiliary Nurse Midwife (ANMs)	6	8	14
Accredited Social Health Activists (ASHAs)	25	39	64
Anganwadi Workers (AWWs)	19	3	22
TOTAL	50	50	100

Source: Field Survey

Table 9 shows the distribution of healthcare service providers to the respondents in the villages of Shikarpur and Hatighisa. It highlights the various roles played by the auxiliary nurse midwives (ANM), accredited social health activists (ASHAs) and Anganwadi workers (AWWs). The ASHA programme is essential for offering outreach services for Reproductive, Maternal, Neonatal, and Child Health and Nutrition (RMNCHN). ASHA workers and two additional female CHW cadres-auxiliary nurse midwives (ANMs) and Anganwadi workers (AWWs)-perform complementary duties in the field (6). In Shikarpur, only six respondents received healthcare services from ANM. In Hatighisa, only eight respondents received healthcare from ANM. ANMs provide antenatal care to pregnant women, assist in deliveries, conduct postnatal check-ups, and offer guidance on childcare and immunizations. ANMs are

often the primary point of contact for healthcare in many rural areas, where access to doctors or hospitals is limited. They serve as a bridge between the community and formal healthcare systems, contributing significantly to improving the health and well-being of rural populations. The majority of respondents (25 in Shikarpur & 39 people in Hatighisa) received healthcare services from ASHAs. In a study it is found that "…one of the most important works of ASHA workers was to provide antenatal and postnatal care services to women residing in her field service area. These services enable women to receive important services, such as tetanus vaccinations and screening and treatment for infections, as well as potentially life-saving information on warning signs during pregnancy" (7). Nineteen respondents in Shikarpur and only three women in Hatighisa received health services from AWWs.

b. Access to Media by the respondent

Media outlets provide a means to disseminate information quickly to a wide audience. Specifically television, radio, newspapers educate the public about health issues, diseases, prevention, and treatment options. They raise awareness about public health concerns, from infectious diseases to chronic conditions.

Table 10- Access to Media by the respondent

Access to media in family	Shikarpur	Hatighisha	Total
Television	14	28	42
Radio	0	1	1
Nothing	36	21	57
Total	50	50	100

Source: Field Survey

Table 10 shows that in Shikarpur 14 families and in Hatighisa 18 families have access the television. It shows a higher prevalence of television access compared to radio in both locations and a significant number of families (57 %) with no access to either television or radio, especially in the "Nothing" category.

c. Benefits from Janani Suraksha Yojana (JSY) by the respondents

JSY is a government program that promotes institutional deliveries by providing cash incentives to pregnant women who choose to deliver in a health facility. Tribal communities often reside in remote areas with limited access to healthcare facilities. JSY encourages institutional deliveries by providing cash incentives to pregnant women, which helps overcome barriers to accessing hospitals or clinics, thereby reducing maternal and infant mortality. JSY promotes health education and awareness campaigns, which are crucial in tribal areas where awareness about maternal health, nutrition, and safe delivery practices might be lacking. It encourages women to seek proper prenatal and postnatal care. For tribal women, especially those from low-income backgrounds, the monetary incentives provided under JSY and it act as an encouragement to opt for institutional deliveries. This financial assistance can cover expenses related to transportation, hospital fees, and other associated costs.

Table 11- Benefits from JSY derived by the respondents

Benefits from JSY	Shikarpur	Hatighisha	Total
Yes	26	33	59
No	24	17	41
Total	50	50	100

Source: Field Survey

Table 11 illustrates the distribution of respondents who received or did not receive benefits under JSY in both villages of two districts. Forty one percent of respondents did not receive the benefits. However, in Hatighisa, 66 % of the respondents received benefit from this yojana.

d. Whether the respondents registered their name in the Government health centre during pregnancy

Registering their names at health centers during pregnancy is a wise step for rural women. This process allows them to access various healthcare services and programs available for expecting mothers. It often involves enrolling in prenatal care, which includes regular check-ups, guidance on nutrition, and information on safe birthing practices. These registrations also facilitate timely vaccinations, assistance during complications, and sometimes even educational workshops for both mothers and families. Overall, it's a crucial step toward ensuring healthier pregnancies and better outcomes for both mothers and their babies.

Table 12- Name Registered in health centre during pregnancy by the respondents

Registered Name	Shikarpur	Hatighisha	Total
Yes	50	49	99
No	0	1	1
Total	50	50	100

Source: Field Survey

Table 12 presents that all 50 women in Shikarpur registered their names during pregnancy in the health centre. In Hatighisha, 49 out of 50 women registered their names during pregnancy, while only one woman did not. This registration process helps the healthcare providers keep track of your medical history, schedule appointments, and provide appropriate care throughout your pregnancy. Therefore, 99 % tribal women registered their names in the health centre situated in the local area. These 99 % respondents regularly checked under Antenatal Care (ANC) services included physical examinations, immunizations, and discussion about nutrition, advice on healthy practices, and the identification or management of any potential risks or complications that may arise during pregnancy. However, in a study it is said that “the tribal women who registered their pregnancy in the first trimester better utilized the services compared to women who registered later….could be due to the possibility that women who did an early registration had higher awareness, which indirectly lead to full utilization” (8).

e. Numbers of Antenatal Visits by the Respondents

The frequency of antenatal visits, or ANC visits, during pregnancy can vary based on different factors, including the guidelines set by health authorities, the specific needs of the mother, and any potential risks identified during the pregnancy. It can vary by region or country based on their healthcare systems and specific guidelines provided by local health authorities.

Table 13- Numbers of antenatal visit

Number of antenatal visit	Shikarpur	Hatighisha	Total
1 time	0	5	5
2 times	3	14	17
3 times	16	13	29
4 times	21	12	33

More than 4 times	10	5	15
None	0	1	1
Total	50	50	100

Source: Field Survey

Table 13 shows the distribution of the frequency of antenatal visits among the tribal women in Shikarpur and Hatighisha. The majority of women in both areas had at least three or four antenatal visits, which is beneficial for monitoring maternal and fetal health during pregnancy. However, there are a few cases where women had fewer visits or none at all, which may pose risks regarding the monitoring and management of potential pregnancy-related complications.

f. Place of deliveries among the Respondents

Institutional delivery among tribal women in India has been a focus area for improving maternal and child health. Tribal populations often face challenges in accessing healthcare services due to factors such as remote locations, cultural beliefs, language barriers, and a lack of awareness about the importance of institutional deliveries.

Table 14- Place of delivery

Place of delivery	Shikarpur	Hatighisha	Total
Home	40	41	81
Medical	10	9	19
Total	50	50	100

Source: Field Survey

It appears from the Table 14 that the majority of deliveries in both Shikarpur and Hatighisha are taking place at home, which may suggest that a significant portion of childbirth (81 %) happened outside of formal medical facilities. Only a smaller proportion of deliveries (19 %) were assisted by medical professionals in a medical setting. This information can be crucial for health authorities and policymakers to understand the delivery practices in these areas and develop strategies to ensure safer childbirth practices, especially by promoting institutional deliveries with skilled medical assistance.

g. Persons who conducted / monitored child birth/delivery of the Respondents

In rural India, delivery services vary significantly due to infrastructure, accessibility, and local needs. In rural areas of India where access to healthcare facilities might be limited, untrained birth attendants, often referred to as traditional birth attendants (TBAs), might still be involved in assisting with deliveries.

Table 15- Person conducted delivery of the Respondents

Person conducting delivery	Shikarpur	Hatighisha	Total
Doctor, Primary Health Centre	0	2	2
Auxiliary Nurse Midwife (ANMs)	3	0	3
Accredited Social Health Activists (ASHAs)	43	40	83
Untrained Birth Attendant	4	8	12
Total	50	50	100

Source: Field Survey

Table 15 reflects, that doctors from Primary Health Centres are not involved by the respondents' families or engaged in conducting deliveries in Shikarpur, and there have been only two instances of deliveries conducted by them in Hatighisha, totaling to two deliveries. There were three instances of deliveries conducted by ANMs in Shikarpur and none in Hatighisha. ANMs, in particular, are trained to conduct deliveries, especially in rural areas where immediate access to a hospital or doctor might not be possible. They ensure safe delivery practices, manage complications to the best of their abilities, and refer cases that require higher medical intervention to hospitals or higher-level healthcare facilities. In Shikarpur, 43 deliveries conducted by ASHAs, while in Hatighisha, 40 deliveries conducted by them. Combined, they have conducted a total of 83 deliveries. Four deliveries conducted by untrained birth attendants in Shikarpur, and eight in Hatighisha. These untrained birth attendants are typically women from the local community who have acquired skills and knowledge about childbirth through traditional practices and experiences rather than formal training. They often assist pregnant women during childbirth due to their accessibility, cultural acceptance, and familiarity within the community. The ASHAs conducted the highest number of deliveries, followed by ANMs, untrained birth attendants, and doctors from Primary Health Centres.

h. Awareness about maternal health of the Respondents

Tribal communities often reside in remote or rural areas, lacking access to adequate healthcare facilities, trained medical personnel, and essential services like prenatal care, skilled birth attendants, and emergency obstetric care. Limited education and awareness about maternal health, family planning, hygiene practices, and nutrition contribute to challenges in ensuring healthy pregnancies and childbirth. A study has identified that "Education of woman emerged as an important factor affecting utilization of maternity care services by tribal women. Level of education of the tribal women who did not utilize full services was significantly lower than those who utilized"(9).

Table 16- Awareness about maternal health of the Respondents

Tests done during pregnancy	Shikarpur	Hatighisha	Total
Yes	47	44	91
No	3	6	9
Tetanus Toxoid taken			
Single dose	6	3	9
Two doses	39	29	68
Booster dose	4	3	7
None	1	15	16
Iron folic acid tablets taken			
Less than 100 tablets	10	14	24
100 tablets	17	22	39
More than 100 tablets	21	10	31
Not taken	2	4	6
Health functionary consulting during sickness			
Auxiliary Nurse Midwife (ANMs)	4	8	12
Anganwadi Workers (AWWs)	9	9	18

Doctor, Primary Health Centre	2	2	4
Private doctor	4	5	9
No	31	26	57
Brest feeding Started			
Less than 24 hour	47	41	88
2nd day	2	5	7
After 3 days	1	1	2
No	0	3	3
Age of Child for giving Complementary food			
15 days	0	1	1
Less than 6 month	42	41	83
6-9 month	7	5	12
9-12 month	1	1	2
More than 12 month	0	2	2
Types of complementary food			
Milk	0	7	7
Semi solid	48	38	86
Solids	2	5	7

Source: Field Survey

Table 16 provides insights into various aspects of prenatal and postnatal care, including the various medical tests, vaccinations, nutrition, healthcare consultations, breastfeeding practices, and the introduction of complementary foods for infants in the regions of Shikarpur and Hatighisha. The total number of pregnant women who had tests done is 91. This data provides insight into the coverage and shots of Tetanus Toxoid vaccinations among pregnant women in these areas, highlighting the number of women who received various doses and those who did not receive any vaccinations against tetanus during their pregnancy. Sixty eight percent pregnant tribal women received two doses of tetanus toxoid and 16 pregnant tribal women did not receive Tetanus toxoid doses. This table illustrates the varying intake levels of iron folic acid tablets among pregnant tribal women in these regions, indicating the number of women who took different quantities of tablets, as well as those who did not take any during their pregnancy. Ninety four tribal women took different quantities of tablets during their pregnancy. This data provides insights into the preferences and patterns of seeking healthcare consultations during episodes of sickness, indicating the different healthcare providers consulted and the number of individuals who did not seek any consultations in Shikarpur and Hatighisha. A total of 57 individuals did not seek any consultation during sickness in these areas. In Shikarpur 47 mothers initiated breastfeeding within the first 24 hours after childbirth and in Hatighisha, 41 mothers initiated breastfeeding within the first 24 hours. It appears that in both locations, the majority of children began receiving complementary foods between 0-6 months, primarily in the form of semi-solids. There were only a few instances of solid foods introduced after 6 months. It's important to note that the World Health Organization (WHO) recommends exclusive breastfeeding for the first six months of life, with the introduction of nutritious complementary foods thereafter while continuing breastfeeding up to 2 years or beyond.

Summary and Conclusion

The Hindu population constitutes the majority of respondents in both Jalpaiguri and Darjeeling districts, comprising 91 % of the surveyed individuals who use wood as their primary fuel source. Notably, 100 % of households in Shikarpur Gram Panchayat, Rajganj block, Jalpaiguri district, lack toilet facilities. Additionally, a significant portion of respondents in both districts lack access to media, such as television or radio.While respondents in both districts have availed themselves of Janani Suraksha Yojana (JSY) benefits; it is noteworthy that despite registering at government sub-centers during pregnancy a considerable majority still opt for home births, may be because of the existing tribal customs. Approximately 25 % of the total respondents are unable to read and write with the majority (68 %) having received education up to the primary level. Family planning awareness is lacking among parents, and a notable 10 % of respondents in Hatighisha, Naxalbari block, Darjeeling district, remain uninformed about child immunization. The data reveals significant variations in the delivery practices and healthcare providers in Shikarpur and Hatighisha. In Shikarpur, Primary Health Centre doctors did not conduct any deliveries, while there were two instances of deliveries conducted by them in Hatighisha. ANMs, which are specifically trained for deliveries in rural areas, performed three deliveries in Shikarpur and none in Hatighisha. A notable trend in both Shikarpur and Hatighisha revealed that a significant majority of deliveries (81 %) occur at home. Understanding that a substantial portion of deliveries takes place outside formal medical facilities is crucial for developing strategies to enhance the safety of childbirth. Encouraging institutional deliveries with skilled medical assistance should be a priority as it can contribute to improved maternal and neonatal outcomes. ASHAs played a prominent role in both locations, conducting 43 deliveries in Shikarpur and 40 in Hatighisha. Interestingly, untrained birth attendants, often local women with traditional knowledge, assisted in four deliveries in Shikarpur and eight in Hatighisha. Their involvement may stem from accessibility, cultural acceptance, and familiarity within the community.The study sheds light on various facets of prenatal and postnatal care in the Shikarpur and Hatighisha regions, encompassing medical tests, vaccinations, nutrition, healthcare consultations, breastfeeding practices, and the introduction of complementary foods for infants. Of the total number of pregnant women, 91 underwent tests, providing insights into the Tetanus-toxoid vaccination coverage. Notably, 68 % of pregnant tribal women received two doses of Tetanus-toxoid, while 16 pregnant tribal women did not receive any Tetanus-toxoid doses during pregnancy. Furthermore, the study highlights breastfeeding practices, with 47 mothers in Shikarpur initiating breastfeeding within the first 24 hours after childbirth and 41 mothers in Hatighisha following suit.

The study reveals a reliance on government hospitals and Anganwadi centers for health checkups, with all respondents benefiting from the services provided by these centers. ASHA workers play a crucial role in disseminating information about Reproductive and Child Health (RCH) services to the majority of respondents.Illiteracy emerges as a significant factor contributing to the poor health conditions of both mothers and children. Hence, the study revealed a preference for non-institutional childbirth practices. ASHA workers contribute significantly to safe delivery practices, managing complications, and referring cases requiring higher medical intervention to appropriate healthcare facilities in both villages.

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