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MATERNAL HEALTH CARE PRACTICES OF LOTHA NAGA TRIBAL WOMEN IN INDIA

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Abstract

Tribal Women in India are more privileged in various ways as in comparison with the women of caste hierarchy. However, due to geographic isolation, they are deprived of access to basic amenities like livelihood opportunities, education, health, and sanitation. The twin factors of distance and cost of intensive maternal health care expenses hinders the tribal women in accessing to the health care services. For this reason, the traditional health care practitioners are profoundly preferred and they have been the largest maternal health care providers to the tribal women. The Maternal Mortality Rate (MMR) in India was 174 in 2015 (WHO, 2018) and the MMR in the State of Nagaland accounts of 160 (GOI-UNDP Report Nagaland, 2016). The Nagaland State also indicates as the lowest and poorest in maternal health care among the Northeastern States in India with an institutional delivery of only 33 percent. The institutional delivery in Wokha District of Nagaland accounts of 34 percent (NFHS-4, 2016). Thus, the study has been undertaken with an objective to portray the maternal health care status of the Lotha tribal women; to describe the maternal health care practices among Lotha tribal women; and to determine the health care infrastructure in the

study areas. The Sequential Explorative Research Design has been adopted, and the study ponders on the maternal health care practices of Lotha Tribal women residing in Yanpha and Old Ralan Villages of Wokha District in the State of Nagaland, India. The study therefore, intends to contribute in achieving Sustainable Development Goals (SDGs) at the national and global level.

Keywords

Maternal Health Care, Traditional Mid-Wives, Tribal Women

1. Introduction

Tribal people are inheritors and practitioners of cultures that are distinct from the dominant communities in which they live. All over the world, they are the most disadvantaged and vulnerable section of society. Each tribal community have unique cultural and traditional practices, however the foremost common challenges faced by them are in asserting the protection of their distinct cultural rights. The United Nations has estimated that there are about 370 million tribal communities in 90 countries across the world constituting about 5 percent of the worlds' population with 15 percent contributing to the poorest section (UN, 2018). In India there are 705 recognized ethnic communities composing of 8.6 percent of the total population. The tribal population in India has been classified into three zones, North-Eastern Zone, Central Zone and the Southern Zone. The North-Eastern Zone covering the Sub-Himalayan region and the hills and mountain ranges of the North-Eastern frontiers of India, has the highest tribal community (IWGIA, 2018). These tribal communities mostly belong to the Mongoloid race and speak Tibeto-Chinese language. Garo, Kachari, Khasi, and Naga are some of the tribes inhabiting the North-Eastern Zone. The tribal communities living in the Central Zone are scattered in all over the mountain-belt between the Narmada and Godavari rivers. The tribes inhabiting this area are Bhuiyan, Gonds, Ho, Juong, and Santals etc. The Southern Zone descends in the south of Krishna River. The tribal communities residing in this vicinity are considered as the most ancient occupants in India. Kurumba, Malayan, Urali, and Paniyan are some of the tribal communities of the Southern Zone (Rao, 2007).

1.1 Status of Maternal Health in India

Globally an average of 800 women dies every day, of which 20 percent of these women have been reported from India. It has also been estimated that about 44,000 of women in India die annually due to preventable pregnancy-related causes (Maternal Health-Unicef India, 2018). The Maternal Mortality Rate (MMR) in India have been declined to 174 in 2015

(WHO, 2018). Despite the decline of MMR in India, the maternal death rate due to complications developed during child birth accounted of five women every hour. In most of the cases, the causes of maternal deaths are due to post-partum haemorrhage (Kaul, 2017). The major factor of maternal mortality in India is due to non-accessibility of health care services at an affordable expense. About 46.6 percent of women in India have been pushed to poverty due to maternal health care expenses inclusive of antenatal care, child birth, and post natal care expenses (Devanik Saha, 2017). In India, tribal women are the most disadvantaged in regard to availing intensive maternal health care due to multi-dimensional factors such as isolation, habitat, terrain, illiteracy, ignorance, unawareness, poverty, cultural practices and mis-beliefs (Srivasta, 2015). In times of child birth, tribal women mostly prefer home delivery being assisted by an untrained midwifery, elders or relatives and they often prefer crude method of abortion in order to avoid unplanned pregnancy (Panda, 2015). In cases of pregnancy complications, women are being referred to nearby health centres and on reaching some of the women loss the chance of surviving. Thus, all these factors contribute to higher rate of maternal and child mortality (Sharma & Bakshi, 2009). Therefore, the Central Government of India has adopted various interventions such as Maternity Benefit Programme, National Health Mission (NHM), Accredited Social Health Activist (ASHA), Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK), and ambulance services etc., to improve the maternal health care. However, the back drop behind the attempt in standardization of health care services is the variation in the implantation process across the country (Aparajita and Renuka, 2016).

1.2 Scenario of Maternal Health Care of Tribal Women in Nagaland

Among the Northeastern States of India, the State of Nagaland has been ranked as the poorest maternal and child health care (The Naga Republic& The Morung Express, 2018). The institutional delivery and full immunization coverage composed of 33 and 35 percent respectively (NFHS, 2016). In Nagaland the proportion of women who had received full Ante-Natal Care (ANC) course (i.e. at least 3 ANC with 100 Iron and Folic Acid (IFA), tablets, syrups and 1Tetanus) accounted of only 9.8 percent and 41.8 percent of women had received at least one ANC. The complications which most of the women experience during deliveries ranged from still births or prolonged labour (64.7 percent), obstructed labour (34.4 percent), excessive bleeding (17.4 percent), premature labour (17.1 percent), and convulsions or high blood pressure (11.9 percent). The delivery complication seems to be higher among those women who had undergone caesarean then that of those who had normal delivery. The

women in Nagaland stated to have low post- delivery complications composing of only 13.1 percent (DLHS-4, 2012-13).

1.3 Traditional Mid- Wives of the Naga Tribes

Nagaland State has a rich tradition of indigenous medicines and traditional healers still occupy high positions of respect. In every village, there are at least one acknowledged ethno-medicinal practitioner for treating various ailments and traditional healers like midwifery, bone – setter, chiropractor etc. Most of the villages also have prayer warriors who foresee the ailment through prayers and heal the people. Despite of increase in the establishment of health care centre in the rural areas and the expansion of health institutions with standardized equipments in the urban areas, the modern allopathic medicines have failed to reach the villages in Nagaland (State Human Development Report 2004). For this reason, even to this day the traditional mid-wives are the largest maternal health care providers in the rural areas of Nagaland. They are conveniently available to the tribal women and their practice of assisting in child birth is more of a charity. This practice of traditional mid-wives does not have a scientific study and approach. Their skills of assisting in child birth have been learned from the elderly traditional mid – wives, passed down from generation to generation orally. The belief of the traditional mid–wives is that, their ability of assisting in child birth without acquiring any formal education and training is a gift from God.

1.4 Need of the Study

The present study intends to explore the maternal health care system among the tribal women of Wokha District, Nagaland. This includes maternal health status, maternal health care practices, basic health care infrastructures and challenges of health care system among the Lotha tribal women. Comprehensive assessments on maternal health care system have not been conducted in the District of Wokha so far; therefore, the study introspects on both the positive and negative aspects of maternal health care system. It is quite significant in the present context as human development is essential for the overall development of human resource. It is a known fact that the health of a mother directly influences the health of the children, therefore an intensive health care of a mother in midst of pregnancy, delivery and post-delivery is very essential. The District Level Household Survey (DLHS-4), 2012-13, stated that in Wokha District, the intake of ANC accounted of 30 percent; where the percentage of women who availed full course of ANC reported of only 6 percent. Preference of home delivery showed to be more with 81.8 percent and institutional delivery comprised of only 18.2 percent. About 12.6 percent of the women faced complications during delivery

and 10.1 percent suffered from post-delivery but only 37.7 percent got treated from health institutions. The study aims to explore the maternal health care system and the challenges to availability, accessibility, affordability and acceptability of health care services. Henceforth, the study identifies the constraints and possibilities of the maternal health care of the Lotha tribal women in Wokha District.

1.5 Objectives

The objectives of the study are:

- To portray the maternal health care status of the Lotha tribal women
- To describe the maternal health care practices among Lotha tribal women
- To determine the health care infrastructure in the study areas

2. Methodology of Research

2.1 Research Design

The Sequential Explorative Research Design has been adopted for the study, characterized by qualitative and quantitative data. The qualitative phase is used to build an instrument of sampling technique in order to draw sample of the under study; and to identify an appropriate instrument of research tool to use in the follow – up of quantitative or to specify the variables that need to go into a follow – up of the quantitative study. The intent of the study is to develop better measurements with specific samples of populations and to see if the data from few individuals (in qualitative phase) can be generalized to a large sample of a population (in quantitative phase). The three – phase approach of qualitative data are to collect and analyze data, secondly as to develop an instrument of tools using the analysis and thirdly to subsequently administer to a sample of population (Creswell & Plano Clark, 2007).

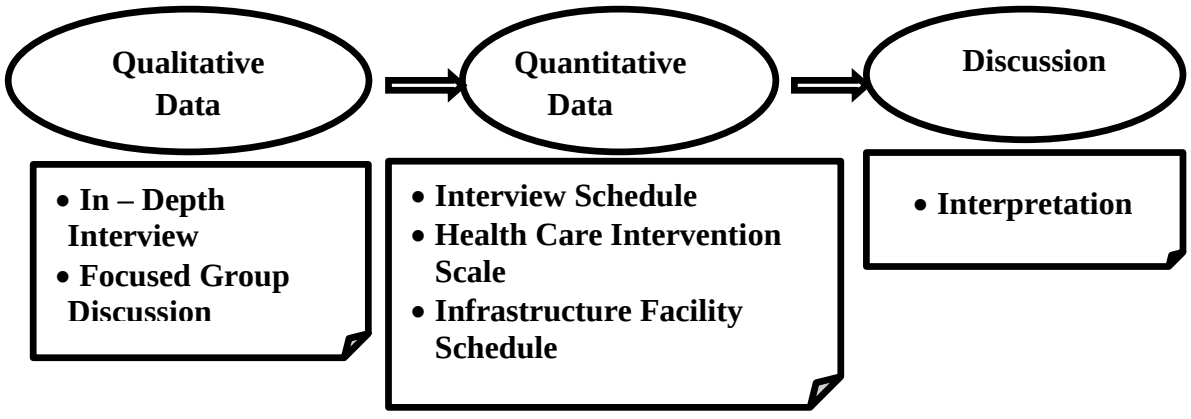

Figure 1: *Sequential Explorative Research Design*

According to Creswell (2013), in a Sequential Explorative Research Design the samples of both the qualitative and quantitative data are to draw from different individuals but from the same population. The two – phase approach of the research design makes it easier to implement, discover and report the phenomenon. Thus, as portrayed in figure 1 the researcher first collected the qualitative data through observation and focused group discussion. In second phase the quantitative data was collected through interview schedule and infrastructure facility schedule.

2.2 Study Area

Organogram of Study Area

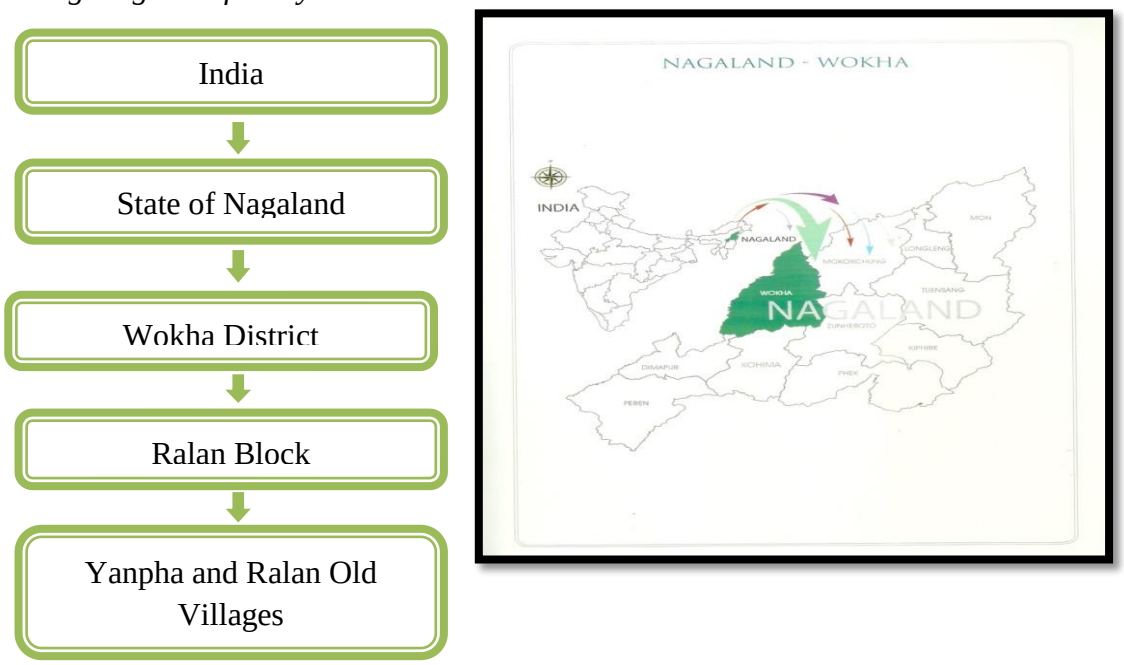

Figure 2: *Map of Nagaland*

Source: District Human Development Report Wokha, 2013

2.3 Universe and Sample of the Study

The universe of the study comprised of Lotha tribal women residing in Yanpha and Ralan Old Villages. These Lotha tribal women who belonged to the age group of 15 – 45 years and were available at the time of the research has been considered as the unit of the study. Simple Random Sampling Technique was adopted in order to draw a representative sample. The total number of eligible respondents from the two villages was 99 out of which only 72 (i.e 72.7%) samples were drawn due to non-availability of respondents at the time of data collection. The data have also been collected from the Village Chairman, Village

Council Members, Village Development Boards (VDBs), Accredited Social Health Activist (ASHA), Auxiliary Nurse Midwifery (ANM), and Anganwadi workers.

2.4 Tools for Collection of Data

The study comprises of both primary and secondary data. The qualitative data has been collected by adopting the tools of In-depth Interview and Focused Group Discussion (FGD). Whereas, the tools adopted for collecting quantitative data were Interview Schedule, Health Care Intervention Scale and Infrastructure Facility Schedule.

- **In – depth interview:** An in – depth interview was carried out with a group of elderly women within the age group of 70 years and above in order to study the maternal health care practices among the Lotha tribal women in the study areas
- **Focused Group Discussion (FGD):** FGD was conducted for facilitating the discussion on the maternal health care services provided by the health providers in the villages, maternal health care efforts initiated by government and civil societies. The discussion was carried out with the Village Chairman, Village Council Members, VDBs, ASHAs, Auxiliary Nurse Midwifery (ANM), and Anganwadi workers.
- **Interview Schedule:** The Interview Schedule was used for collecting socio-economic details and maternal health status of the lotha tribal women within the age group of 15 – 45 years.
- **Health Care Intervention Scale:** A Health Care Intervention Scale was adopted to obtain the different aspects of challenges faced by the lotha tribal women in regard to accessibility, availability, affordability and acceptability of health care services.
- **Infrastructure Facility Schedule:** The Infrastructure Facility Schedule was also used for assessing the availability of basic essential infrastructures in the villages. The details have been drawn from the Village Chairman, and Village Council Members.

3. Data Analysis

3.1.1 Description of Socio-Economic Status

The socio-economic profile of the tribal women of Yanpha and Ralan Old villages, from the Ralan block of Wokha district has been enumerated in the given table. It ascertained the distribution of age, education, family income, savings, marital status, and age at marriage for the Lotha tribal women of the two villages.

Table 1: *Profile of the Respondents*

S. No	Profile	Category	Percentage (N= 72)
1.	Age(in years)	15 – 18	2.8
		19 – 34	45.8
		35 – 45	51.4
2.	Educational Level	Illiterate	23.61
		Primary	43.06
		Elementary	8.33
		High School	22.22
		Higher Secondary	1.39
		Graduation	1.39
3.	Marital Status	Married	93.06
		Divorced	6.94
4.	Age at Marriage	15 – 18	51.4
		19 – 22	36.1
		23 – 26	8.3
		27 – 30	1.4
		31 – 34	2.8
5.	Family Income per Month (Rs.)	Below 1000	23.61
		1001 – 5000	55.56
		5001 – 10000	12.50
		100001 – 15000	1.39
		150001 – 20000	1.39
		Above 20000	5.56
6.	Status of Savings	Savings	9.7
		No Savings	90.3

The above table 1 depicts that, the majority of the tribal women belong to the middle age group of 35-45 years comprising of 51.4 percent. About 23.61 percent of the tribal women were found to be illiterate. The percentage of married tribal women inclines to be of 93.06 percent and divorced showed to be of only 6.94 percent. Majority of the tribal women composing of 51.4 percent married between the ages of 15 – 18 years. The average monthly income of most of the Lotha tribal family ranges between Rs. 1001-5000 with 55.56 percent, and savings in the bank institutions portrays to be 9.7 percent.

3.1.2 Pregnancy Confirmation Test

An effective pregnancy confirmation test is a basic element of maternal health services. As it is an important tool for both planned and unplanned pregnancy; an early

detection of pregnancy will help the women to take the right decision at the earliest. If the pregnancy is planned then, it is prerequisite for availing ANC; if the pregnancy is unplanned the abortions within the first trimester i.e. 12 weeks of pregnancy tends to be safer and more cost-effective then in the second trimester of pregnancy (Chelsea and Jennifer, 2006).

Table 2: *Pregnancy Confirmation Test*

Pregnancy Test Done	Frequency	Percent
Yes	30	41.7
No	42	58.3
Total	**72**	**100.0**

The above table 2 describes that 41.7 percent of the Lotha tribal women underwent for urine test for pregnancy confirmation. Whereas, 58.3 percent of women did not undergo urine test, as they were not aware of the pregnancy test kit. These women who did not undergo urine test perceived their pregnancy by means of absence of monthly menstruation, nausea or vomiting, and bloating of stomach. In many a case, they sensed their pregnancy only after two or three months.

3.1.3 Intake of Ante-Natal Care

Ante-Natal Care is an intensive and preventive health care, provided to women in course of pregnancy offering regular checkups, vaccinations, nutrition tablets, and screening of fetus, etc., for the safety of both the mother and the child.

Table 3: *Intake of Ante-Natal Care*

	Components	Frequency (N=72)	Percent
Ante-Natal Care	During First Pregnancy	53	73.6
	During Last Pregnancy	56	77.8

The table 3 depicts that 73.6 percent of the Lotha tribal women received ANC during their first pregnancy. In comparison to the intake of ANC during first and last pregnancy, a minimal percentage of improvements have been indicated in availing ANC.

3.1.4 Place of Delivery

The birth of a child from the health institutions in an appropriate setting of adequate facilities is very esstential. Hospitals and health centres are hygenic and are equiped with the essential instruments and medicines which reduce the cases of complication in midst of

delivery, saving lives of both the mother and the child, and also prevents maternal death (Kesterton.et al., 2010).

Table 4: *Place of Delivery*

Place of Delivery	**Frequency**	**Percent**
Institutional	18	25
Home	54	75
Total	**72**	**100.0**

The study shows that majority of the tribal women enclosing of 75 percent, preferred home delivery and the preference of Institutional constituted of only 25 percent. The sensation of comfort and safer of being assisted by someone they know from the community (traditional mid-wives and nurse), and the low cost of being delivered from home, are the core factors for less preference of institutional delivery. The distance of adequate health care institutions, non-affordability of the maternal health care expenses, and poor transport services are also factors encumbering in availing and accessing to health care institutions for an institutional delivery.

3.1.5 Post-Natal Care

The first 24 hours after the child birth, the health of both the mother and the child is predisposed to be crucial, requiring for an intensive care. Therefore, in course of this duration, the supervision of the mother and the child by a skilled provider is very vital, as the first Post-Natal Care to the mother is also provided during the first 24 hours after delivery.

Table 5: *Post Natal Care*

Post Natal Care	**Frequency**	**Percent**
Yes	19	26.4
No	53	73.6
Total	**72**	**100.0**

A significant distribution of Lotha tribal women, with 73.6 percent did not register for availing Post Natal Care and only 13.89 percent availed Post Natal Care. The base that, most of the women did not avail an intensive post-natal care is that they have not been a victim of any severe health complications after their previous child births; therefore they procrastinate in availing intensive maternal health care and they end up without availing any post natal care at all.

3.1.6 Types of Contraception

The use of contraception prevents pregnancy and also it reduces the need of abortion of unplanned pregnancy. There are different types of contraception such as birth control pills (oral contraception/ tablets), condoms of both male and female, spermicides, Intrauterine devices (IUDs), Tubal ligation (sterilization), and vasectomy.

Table 6: *Types of Contraception Used*

Types of Contraception	Frequency	Percent
Male Condom	16	22.2
Contraceptive Pills	7	9.7
Intrauterine Devices (IUDs)	2	2.8
Tubal Ligation	4	5.6
Not Applicable	43	59.7
Total	**72**	**100.0**

The above table 6 depicts the different type of contraception used by the Lotha tribal women in the Yanpha and Ralan Old villages. The data denotes that 59.7 percent of the women did not use contraception and practiced the abstinence of menstruation. Among the tribal women who used contraception, 22.2 percent used male condoms, and 9.7 percent opted for birth control tablets. Only 2.8 percent inserted Intrauterine Devices (IUDs) and 5.6 percent of the women preferred for Tubal Ligation. The tribal women mostly do not use contraception on grounds of trust and faith on their counter partner from having physical relationship with another woman. Even to this day, the abstinence of menstruation is widely practiced among the Lotha tribal women.

3.2 Maternal Health Care Practices of Lotha Traditional Mid-wives

Even to this day, the Lotha tribal women in the Yanpha and Ralan Old villages do not have access to intensive health care institutions due to geographical isolation and absence of road connectivity to the District hospital. The sub-centre established in 1987 in the vicinity of the villages equipped with basic diagnostic machines provides first aid treatments in cases of emergencies. For this reason, the preference of child birth in homes, assisted by the traditional mid-wives are profoundly high. Ever since the inception of the Yampha and Ralan Old villages, the mid-wives have been playing a vital role in assisting child birth. The traditional mid-wives in the study areas stated that, "we have the learned the art of assisting child birth from the elders; assisting under their guidance when they were alive, build our confidence and made us more skillful". One of the traditional mid-wife from Ralan Old

village noted that, "usually we use Knife and clean cotton clothes white in color in the process of child birth delivery; we boil the knife and cloth by adding salt for preventing gangrenous or infections".

A traditional mid-wife in Yampha village affirmed that, "in situations when women faced with complications of the fetus position in midst of pregnancy, I use to massage and set the position of the fetus". A mid-wife from Ralan Old village stated, "during child birth most of the women experience prolong labour pain and retained of placenta. In situations when the placenta retained for several hours I used to insert my bare hand and pulls down the placenta". Another mid-wife from Ralan Old village responded, "child birth was rather easier during our days as compared to the present day. I even delivered one of my child by myself in the kitchen near by the fire place and only then I send out my husband to call for a mid-wife to cut the embryo cot connected to the placenta. Every child was accepted as a gift from God with joy and happiness despite our poverty and termination of pregnancy was unknown to us."

3.3 Health Care Infrastructures at Tontongo Village

The only health care services available in Yanpha and Ralan Old villages are pharmacies. The nearest health care institution accessible by the tribal women in Yanpha and Ralan Old villages is the Sub-Centre established at Tontongo village which is at an approximate distance of 2 to 3 kilometers from the study areas. The sub-Centre acts as the first contact point between the Lotha tribal women and health care services under the supervision of Auxiliary Nurse Midwife (ANM). There are five attendants inclusive of both male and female attendants, one pharmacist and a worker for cleaning and maintaining the surroundings of the Sub-Centre. The Indian Public Health Standards (IPHS) had laid down certain guidelines for physical infrastructures which should be provided in every Sub-Centre in the respective States. The physical infrastructures as per the specifications of IPHS are, in terms of location of the Sub-centre, building of the Sub-centre, labour room, clinic room, waiting room, water supply, electricity, storage, waste disposal, telephone, residential facility for the staff and toilet facilities etc. (IPHS Guidelines for Sub-Centres Revised, 2012).

Table 8: *Availability and Non-Availability of Basic Infrastructure in the Sub-Centre*

Status	Types of Infrastructure
Available	Building
	Electricity
	Clinic Room
	Labour Room
	Waiting Room
	Bed
	Storage/ Refrigerator
	Toilets
	Waste Disposal
Not-Available	Water Supply
	New Born Corner
	Backup Generator/ Inverter
	Residential Facility for the Staff
	Telephone

The building of the Sub-Centre in Tontongo village is owned by the Government which consists of four rooms - Clinic Room, Labour Room, Waiting Room, and Storage room. The Labour Room is equipped with one bed and the storage room with a refrigerator for storing the medicines. The Centre has been electrified but a backup mechanism of generator or inverter has not been installed. Toilets have been built but there is no connection of pipe line for supply of water therefore, water is fetched from the tube wells nearby the sub-centre. It has a proper disposing site for disposal of waste. There were no provision of providing residential facility for the Staffs and telephone connections are also not available in the Sub-Centre.

3.3.1 Ante Natal Care (ANC) Services at the Sub-Centre

In the Sub- Centre at Tontongo village, the services provided at the time of Ante Natal Care (ANC) are- weighing and measuring of the weight and height of the women, testing and checking the level of Hemoglobin and Blood Pressure (BP). Vitamin and vaccines are also prescribed and the heart palpitation of the fetus is also checked. The abdomen of the women is manually examined so as to know the position of the fetus. Subsequently resulting upon the health condition of the women and necessity the tribal women are guided further for institutional delivery in the hospitals. The ANM quoted," Inclusive of the registration most the women schedule for three ANC while some of the them even schedule for four to five times. Over the years the intake of ANC is increasing but still many of them prefer for home delivery. At the time of delivery when I am called for assistance I rush as quick as possible, however due to poor transportation at times it is difficult to manage."

3.3.2 Challenges of Health Care Services

Adopting the health care intervention scale, the challenges faced by Lotha tribal women for acquiring maternal health care services in form of Availability, Accessibility, Affordability and Acceptability of health care services, has been portrayed. A five point scale was used for the study, of which the total score was 15 points. The maximum scored points depicted to be 13 and the minimum scored points as 5. The descriptive statistical analysis of the study has been presented in table 9.

Table 9: *Descriptive Statistics*

Health care Services	Range	Minimum	Maximum	Sum	Mean	Std. Deviation
Accessibility	2.00	11.00	13.00	898.00	12.4722	.83872
Availability	2.00	7.00	9.00	591.00	8.2083	.88711
Affordability	8.00	5.00	13.00	709.00	9.8472	2.04636
Acceptability	7.00	5.00	12.00	634.00	8.8056	1.38033

Among the sub – scales the availability and acceptability of health care services with lower scores draws the attention. This shows that the acceptability of the health care services depends on the availability of the health care provided to the Lotha tribal women. Whereas the accessibility and affordability of health care services scored higher points, which denotes that those who can afford the medical care expenses had an access to the health care services.

Table 10: *Association among Scores of Health Care Services*

Scores of Health Care Services	Accessibility	Availability	Affordability	Acceptability
Accessibility	1			
Availability	-.058	1		
Affordability	.412**	-.037	1	
Acceptability	.080	-.024	.004	1

**. Correlation is significant at the 0.01 level (2-tailed).

The table 10 depicted the association among Scores of Health Care Services regarding accessibility, availability, affordability and acceptability provided to the Lotha tribal women. The analysis of association showed that there is a positive association between affordability and acceptability of health care services provided, at a significance level of 0.001.

4. Suggestions and Conclusion

4.1 Major Findings

- The monthly family income of the Lotha tribal women composing of 55.56 percent showed to be between the average ranges of Rs. 1000-5000.
- The preference of home delivery showed to be higher than institutional delivery with an average percentage of 75.
- Majority of the Lotha tribal women constituting about 73.6 percent have not availed any post natal check-ups after their child birth.
- About 59.7 percent of the Lotha tribal women widely practice abstinence of menstruation even to this day.
- The basic infrastructures at the Sub- Centre established in the vicinity of the study areas have not been manned as per the IPHS guidelines.

4.2 Suggestions

- The poor mode of transportation in the villages, distance of a Delivery point or hospital and the non-affordability of the expenses of the transport and medical care is the major hindrance being faced by the Lotha tribal women of Yanpha and Ralan Old villages in accessing to better health care services. Therefore, provision of public transportation on a regular base at an affordable amount can be ventured through private – public partnership by the District Transport in charge or by the civil societies.
- Majority of the tribal women in Yanpha and Ralan Old villages do not have access to intensive maternal health care as there are no other health institutions in the vicinity of the villages or in the region. As a result, only, those women who can afford the medical care and transport expenses have better access to health care services. Hence establishment of a Primary Health Care in the vicinity of the villages is the need of the hour.
- The Chief Medical Officer (CMO) at Wokha District should take the initiative for providing the required basic physical infrastructure and diagnostic equipment's at the Sub-Centre located in Tontongo village as it renders services to eleven villages.

4.3 Conclusion

Tribal women in India have been victims of poor Maternal health care over the decades due to geographical isolations, limited access to health care services, non-affordability of medical expenses and non-availability of adequate health care institutions in the vicinities of the tribal communities or villages. The study on the maternal health care

practices of the Lotha Tribal women in the Wokha District, Nagaland portrayed that, the major hindrance faced by the tribal women in the study areas were inadequate access to health care services due to distance of health institutions impacted by high cost of travel and medical expenses. As a result, they choose to give birth from home being assisted by traditional mid-wives as their contributions are more of charity and it reduces the expenses. They have also been deprived of seminars and awareness programmes on maternal health care. Significantly in the villages, the traditional mid-wives play a vital role in assisting child birth reducing the expenses of family. However, the intervention of health care providers is also the need of the hour in order to provide intensive maternal health care which is a pre-requisite but mostly ignored due to non-affordability; and also to reduce Maternal Mortality Rate.

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Annexure I

Glimpse of Yanpha and Ralan Old Village

Traditional mid-wife, Ralan Old Village

Sub – Centre at Tontongo Village

Private Pharmacy in Yanpha village

Private Pharmacy in Ralan Old village