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Maternal and Child Health Care: A Study among the Rongmeis of Manipur, India

Lorho Mary Maheo, Arundhati Maibam Devi

Abstract—Background: Maternal and child health (MCH) cares are the health services provided to mothers and children. It includes the health promotion, preventive, curative and rehabilitation health care for mothers and children. Materials and method: The present study sample comprises of 208 women within the age range 15-69 years from two remote villages of Tamenglong District in Manipur. They were randomly chosen for assessing their health as well as the child's health adopting an interview schedule method. Results: The findings of the study revealed that majority (80%) of the women have their first conception in their first year of married life. A decadal change has been observed with regard to the last pregnancy i.e., antenatal check-up, place of delivery as well as the service provider. However, irrespective of age of the women, home delivery is still preferred though very few are locally trained. Pre- and post-delivery resting period vary depending on the busy schedule of the agricultural works as the population under study is basically agriculturist. Postnatal care remains to be traditional as they are strongly associated with cultural beliefs and practices that continue to prevail in the studied community. Breast feeding practices such as colostrums given, initiation of breastfeeding, weaning was all taken into account. Immunization of children has not reached the expected target owing to a variety of reasons. Maternal health care also includes use of birth control measures. The health status of women would invariably improve if family planning is meaningfully adopted. Only 10.1% of the women adopted the modern birth control implying its deep-rooted value attached to the children. Based on the self-assessment report on their health treatment a good number of the respondents resorted to self-medication even to the extent of buying allopathic medicine without a doctor's prescription. One important finding from the study is the importance attributed to the traditional health care system which is easily affordable and accessible to the villagers. Conclusion: The overall condition of maternal and child care is way behind till now as no adequate/proper health services are available.

Keywords—Antenatal, breastfeeding, child health, maternal, Tamenglong District.

I. Introduction

HEALTH is understood in contrast to disease. It is always a culturally defined concept. Landy [1] defined health as the condition of the organism having the capacity to adapt to its environmental situation without much pain and discomfort in order to achieve some physical and psychic gratifications with a reasonable chance of survival.

The World Health Organisation (1948) has stated that health is not just the absence of disease or disability but rather a condition of complete physical, mental and social well-being.

Lorho Mary Maheo and Arundhati Maibam Devi are with P.G Dept. of Anthropology, D.M College of Science, Imphal (e-mail: marylorho@gmail.com, arundhati.maibam@yahoo.com).

According to Leiban [3], health is the result of interactions between an individual's heredity contribution with his or her natural and cultural environment. Biological and cultural adaptation together with evolution of the society and the population also determine health.

Basu [4] pointed out that health is the function of both medical care and overall development of society in relation to -culture, economy, education, and politics. He further mentions that each of these aspects has a deep influence on health which in turn influences all these aspects. Problems of health and illness are inextricably related to physical, behavioural and environment factors. Each of these factors contributed to the kinds of problems encountered in medical management [2], [5].

Maheo's[6] study on the Mao Naga tribe has found out that there was high incidence of gastro-intestinal problem which they attribute to high intake of salt and fresh/red meat. Both mother and child need extra health care attention. Mothers should be properly protected against disease and have proper nutrition or balanced diet which is necessary for maintenance of good health both for the mother and the fetus. However, most of the tribal communities have their way of living and different socio-cultural settings. Devi [7] asserts that despite the high literacy rate, the people still prefer the traditional health care practices. Several studies from the region have revealed that herbal medicine remains very popular and tribal populations continue to resort to traditional healing practices owing to easy accessibility, affordability, easy method of delivery etc. [6]-[8]. Reliance on faith healers or spiritual faith healing during sickness or difficulty is also a very commonly found practice in the tribal set up [9].

The delivery of primary health care is the foundation of rural health care system and forms an integral part of the national care system. However, in many cases the tribal women are unaware of the advantages. Maheo [7] has observed that Mao women do not visit any maternal health care centres if they do not experience any major health problem. Women beyond the reproductive age rarely seek health facility for any check-up or treatment [10]. Studies conducted in Haryana also revealed that women have a strong belief that the poor do not receive proper attention at Primary Health Centre (PHC) and therefore pregnant women visited PHC only when complications arose [11].

The National Rural Health Mission (NRHM) was launched on the 12th April 2005 with a goal of improving the availability of access to quality health care for poor women and children residing in rural areas. In order to ensure that the services reach the target population the NRHM has introduced

an intensive accountability framework that includes Community based monitoring as one of its key strategy.

MCH care services provided to mothers and children include health promotion, preventive, curative and rehabilitation health care. The National Health Policy has envisaged various health care programmes through a network of integrated health and family welfare delivery system (Sub-centre, PHC, Community Health Centre, etc). Keeping this in mind, how far the present system has catered to the grass root level needs to be assessed.

As not much insightful work has been done with regard to MCH care in this area it is pertinent to carry out an in-depth study for a better tomorrow. The present study is embarked upon one of the major tribes of Manipur to highlight MCH care status and services in the hill areas of Manipur.

Aims and objectives: The present study aims to explore the belief and practices of MCH care prevalent in Tamenglong district in Manipur, India and to highlight the prevailing health care delivery system. It also endeavours to assess the overall health status of mothers and children (≤5 yrs).

About the people: Manipur has a total population of 2,855,794, out of which the males' population is 1438586 and females as 1,417208 according to 2011 census record, and the density is 128 persons per sq.km and the sex ratio is 985 females per every thousand males. As the state has 34 recognized scheduled tribes there is a mosaic of different ethnic groups with their rich unique and distinct socio-cultural heritage.

The Rongmei tribe is one such group who are distributed both in the hills and plain. The Rongmei populations settled in the hills are generally agriculturists. They cultivate varieties of vegetables and grow a number of fruit trees. They collect food, fuel, fodder, housing materials and also herbal medicines from the forests. *Jhum* and terrace cultivation are practiced with crude implements especially in remote areas. Though restriction on food habits is not given much importance by the population in general, yet, women are expected to abstain from certain foods during pregnancy, lactation and other health problem. They also have food taboo for clans, presumptuous of causing serious health problems. Traditional rice beer is taken as a very nourishing drink especially for lactating mothers. The non-Christian Rongmei who follow the traditional faith too consider rice beer as a nourishing food. It is prepared in large quantity and is served lavishly during festivals, social gatherings and ceremonies [12]. During agricultural slack seasons they engage themselves in other economic activities such like weaving, cutting and gathering logs, collecting leaves and fruits from the forest, etc.

II. Materials and Method

The present study sample comprises of 208 ever married women from two remote villages i.e. Longmai-IV (Peaceland) and Marangching-III of Tamenglong district in Manipur having a population of 730 and 629 respectively. The age ranges from 15-69 years. Interview schedule was mainly adopted for the data collection. Random sampling method was employed for assessing the mothers' health as well as that of the children (≤5 years). Secondary sources that can be relied upon to elucidate the task too were resorted to. In order to understand the health status of the population at large and in particular that of mother and child, a questionnaire was formulated to assess the health status particularly during the last pregnancy.

III. Results and Discussion

With the onset of menarche and further entering into marriage alliance a girl is ready to bring forth one's progeny. The age at menarche, age at marriage and also the age at first conception have a remarkable bearing in a woman's life and the society at large. Table I shows the age group wise distribution of the study population. The lower age limit of the sample is 15 and the upper limit is 69 years.

TABLE I
Age Group Wise Distribution of the Ever-Married Women

Age Group	Number of women	Percentage
15-19	2	0.9
20-24	12	5.8
25-29	18	8.7
30-34	31	14.9
35-39	38	18.3
40-44	31	14.9
45-49	20	9.6
50-54	22	10.6
55-59	16	7.7
60-64	9	4.3
65-69	9	4.3
Total	208	100.0

A. Reproductive Profile of Mother

In women's fertility, biological factor plays a very important role. Some biological factors which affect fertility are age at menarche, age at marriages, sterility, and socio-cultural factors like exposure to relationship, exposure to conception, exposure to gestation, etc. Other factors which also play a pivotal role are diseases, food habits, etc. In the present study the age at menarche of the Rongmei women ranges from 12-18 years with mean menarcheal age 15.01. A similar menarcheal trend has also been reported by Chakravartti [13] on the Kabui Naga.

TABLE II
Age at Menarche, at Marriage, and at 1st Conception

Variables	Mean
Age at Menarche	15.01
Age at Marriage,	20.81
Age at 1st Conception	21.04

Age at marriage is one of the factors that influence fertility. In every society marriage is the only way of legal reproduction of children. In India marriage takes place at very young age, in contrast to other countries such as West Indies where marriage takes place at late stage. In India the stipulated marriageable age of male is 21 and for female is 18 years. In the present study it has been observed that some women got married below the stipulated age. Further, it is found that maximum

number of marriages takes place through elopement which ultimately has an impact on early marriages. In the present survey about 80% of the Rongmei married women were found to have conceived in the first year of their married life. The mean age of mother at first conception is 21.04.

B. Health Status of Mother and Child (≤5 years)

The Alma Ata Declaration 'Health for all by the year 2000 AD' is indeed a solemn commitment and India is a signatory to that declaration. However, till date, it is yet to achieve the desired status in many of the backward communities owing to multiple reasons.

In general, there is an increase tendency of health problems during pregnancy. Many of the pregnant mothers have experienced different degree of health complaints in the early stages with nausea or vomiting sensation and toward the third trimester anaemia, acidity, backache etc.

In order to achieve improved health of mothers particularly the reproductive outcomes in various societies, availability of medical facility as well as accessibility of MCH services plays a vital role. Considering the health status of the present study about 19.7% of mothers had faced some major illness such as low BP, severe headache (migraine), injury, etc which required medical attention while 80.3% of the mothers did not encounter any major illness during the last pregnancy. Despite experiencing health problems about 8 of the women did not visit the PHC owing to various reasons. About 18.6 % (39) of the women who had gone for the routine ante-natal check-up also encountered problem such as non-availability of medicine and also shortage of staff. The situation is further aggravated by the frequent strikes/bandhs which affect the normal functioning and communication of not only the medical staff but the people too. Some of the older mothers preferred to resort to traditional medicine (42.8%) which is seen in Table III.

TABLE III
PRENATAL CARE OF WOMEN DURING THE LAST PREGNANCY

Age group	No. of women	Any major illness during pregnancy		Type of medical facility availed				Antenatal check-up completed		TT doses received		Iron & folic acid tablets taken	
		Yes	No	Modern	Traditional	Both	None	Yes	No	Yes	No	Yes	No
15-24	14	2	12	12	-	4	-	14	0	14	0	14	0
25-34	49	1	48	18	23	8	-	35	14	35	16	38	11
35-44	69	9	60	17	27	25	-	31	38	30	39	17	52
45-54	42	10	32	9	22	7	4	12	30	11	31	8	34
55-64	25	11	14	1	19	-	5	5	20	3	22	2	23
65 +	9	8	1	-	-	6	3	-	9	-	9	-	9
Total	208	41	167	57	89	50	12	97	111	92	116	79	29
%		19.7	80.3	27.4	42.8	24.0	5.8	46.6	53.4	42.2	54.8	38.0	62.0

TABLE IV
HEALTH CARE DELIVERY PRACTICES AMONG WOMEN

Age group	No. of women	Place of delivery		Conducted by		Before delivery				After delivery			
		Hospital	Home	Trained	Untrained	No rest	<than a week	2 wks	>2 weeks	upto2wks	one month	two months	three months
15-24	14	1	13	10	4	-	2	12	-	-	9	5	-
25-34	49	9	31	22	27	-	23	20	6	15	19	15	-
35-44	69	13	56	14	55	42	14	-	13	41	19	9	-
45-54	42	-	42	3	39	34	4	-	4	24	1	16	1
55-64	25	-	25	-	25	23	-	-	2	7	11	2	6
65 +	9	-	9	-	9	9	-	-	-	7	-	-	-
Total	208	23	185	49	159	108	43	32	25	100	54	47	7
%		11.1	88.9	23.6	76.4	51.9	20.7	15.4	12.0	48.1	25.9	22.6	3.4

Maternal antenatal check-up during pregnancy is a pre-requisite both for the mother as well as the child. From Table III it is observed that almost half of the mothers underwent complete antenatal check-up for the last pregnancy. With regard to the TT doses received and Iron & folic acid tablet taken most of the older mothers have ignored taking the complete dose leaving it to chance. In Chhattisgarh, mothers of 42 % of child did not receive any ante-natal check-up during the last child [14].

In the present studied population about 42.2% of the mothers availed the complete TT doses while about 38% of them took the required tablets. A form of decadal change is observable with younger mothers resorting to ante-natal check-up.

A look into the place of delivery, persons who assist or conducts the delivery would further highlight the health status of the people under study. Irrespective of the age of women home delivery is still the most preferred. Almost 90% of the deliveries were conducted at home while only 10% were institutional. Further, looking into the type of service delivered at the time of birth only about 23.6% deliveries were assisted by trained personnel. Taking into account the last delivery all the women in the present study experienced normal delivery. Umbilical cord was cut by using either bamboo split or new

blade even if the delivery was conducted at home.

Proper rest is indispensable to mothers prior to delivery. The health of the would-be mother depends not only on the intake of food alone but proper exercise and rest as well. This not only helps at the time of delivery, but it makes the mother to recuperate faster. It is observed from Table IV that about 50 % of the women continued with their routine work prior to delivery. These groups of women belong to the higher age group who perceived delivery as a normal happening. As the population under study is basically agriculturist seasonal works vary which ultimately has an impact on the resting period of pre-and post-delivery depending on the busy schedule. Minimum number of women (3.4%) extends their resting period upto three months while almost half of the women folk took rest for about two weeks before resuming light works. Post-natal cares for mothers and for new born babies are given in the traditional way.

Looking into the post-delivery care in the form of resting period it was observed that the period could extend to months unlike the resting time taken prior to delivery. Among the Meeteis/Meitheis [15], [16], three months of complete rest after delivery is ensured as per their custom. Such a practice is not found among the tribal populations of Manipur. Some of the respondents also informed that unless they are in the busy period of agricultural works they avoid heavy work for some period of time. Decadal change has been observed with regard to place of delivery and also on the service provider as well. The type of health care during pregnancy, after delivery as well as care of the child including the time of introduction of supplementary diet as reported by Devi [16] on the mothers of Imphal West District is almost absent in the present studied community.

C. Immunization of Children (≤5 yrs)

Out of 129 children, 90.7 % were fully immunized, 3.1% were partially immunized, 5.4% were yet to be fully immunized while 0.8% was not immunized. Immunization of children less than 5 years has yet to reach the expected target.

TABLE V
DISTRIBUTION OF IMMUNIZATION PROGRAMME FOR CHILDREN (≤5 YEARS)

Age	No of Children		Immunization programme				Total
	Male	Female	Fully immunized	Partially immunized	Yet to complete	Not immunized	
Total	63	66	117	4	7	1	129
%	48.8	51.2	90.7	3.1	5.4	0.8	100.0

D. Health Care and Its Delivery System

Availability of medical facility or accessibility of MCH services is a must for achieving improved reproductive outcomes in various societies. In the present study most women, particularly from Marangching village, have very little access to the modern health care and its delivery system. This is clearly depicted from the Table VI where 46% of the mothers were not satisfied with the health care and its delivery system while 36% gave no response. Further enquiry revealed that medicines were bought without the doctor's prescription for pain relief from a small shop in the village. Some of the respondents reported selling of domestic animals to meet health care expenses, especially in chronic cases. Taking into account the first option for health care in case of illness nearly half of the respondents i.e. 47.1 % resorted to indigenous practices. An interesting feature in this regard is a good number of respondents go to faith healers to ameliorate their ailments. Some of the reasons for giving first preference to indigenous system include availability, affordability, easy communication, faith, etc.

TABLE VI
DISTRIBUTION OF STATE OF WOMEN'S HEALTH

Total	Health care satisfactory			Self-Medication				First option for health care.				Contraceptive used			Complication due to use of contraceptive	
	Yes	No	No response	Regularly	Often	Sometimes	Rarely	Traditional	Modern	Faith Healer	No Response	Yes	No	*NFP	Yes	No
	37	96	75	66	51	65	26	98	50	30	30	21	118	69	6	15
%	17.8	46.1	36.1	31.7	24.5	31.3	12.5	47.1	24.0	14.4	14.4	10.1	56.7	33.2	28.6	71.4

*Natural Family Planning.

Reproductive health care also includes use of birth control or family planning measures. Awareness is being propagated at different periods by conducting health camps from time to time. However, adopting the measure would create an impact and not merely by awareness alone. The health status of women would invariably improve if family planning is meaningfully adopted either in the form of oral contraception or use of different devices or even adopting the natural family planning method as propagated by Dorairaj [17].

In this population only about 33% adopted the NFP while 10.1% adopted the contraceptive measures and from among them about 6 mothers (28.6%) encountered complication due to the contraceptive use.

For majority of the people inhabiting in the remote areas their only solution to keep themselves healthy is to stay close to mother earth that provides all the basic requirements. For different type of ailments, the same herbs can be used in different doses or using different parts of the plant such as leaf, shoot, bark, roots etc. Unlike allopathic medicines which they belief to have side effects the herbal medicine is considered to be free from side effects. Hence, many of the women would definitely resort to traditional practices as the first option for health care in case of illness. Another interesting feature in this regard is that a good number of respondents go to faith healers to ameliorate their ailments. Some of the reasons for not opting modern medicinal system as stated are high cost, non-availability, side effects, less awareness of the modern facility, poverty, etc.

About 66% of the women used the local herbs for treating ones' ailments which has been observed from Table VII.

TABLE VII
DISTRIBUTION OF LOCAL HERBS USE AS WELL AS USE TO WARD OFF THE EVIL EYE

	Herbal use in one's treatment			Herbs use by mothers to ward off evil eye		
	Yes	No	No answer	Yes	No	No answer
Total (208)	137	42	29	44	140	24
(%)	65.9	20.2	13.9	21.2	67.3	11.5

Prevalence of evil is rather a common belief among tribal communities since early days. To ward off such fear the tribal people use local plants such as ginger, turmeric, garlic, etc. For instance, the Mao tribe of Manipur has the practice of plucking one or two leaves of *Elsholta commmnis* and placing it on the ear to ward off any evil spirits that might come on their way. Besides these, there are other means of warding off evil spirits such as tying a black thread around the neck/wrist or ankle, applying charcoal or ash on the forehead, wearing the scale of giant ant eater around the neck, etc.

The traditional religious practices involve use of different kinds of herbs to perform rites during the first seed transplantation, harvest time, or at birth, death etc, With the coming of Christianity the traditional religious practices are no longer popular hence, only a few percentage of people adopt it (2.8%). Among the Christians (especially among the Catholics) the practice of wearing a medal, relics, scapula, rosary etc. for seeking protection from any evil spirit is common.

In short, the Rongmei have different ways of confronting different ailments. They possess ample knowledge of the therapeutic properties of various plants. However, with the advent of Bio-Medical system traditional practitioners are losing significance. The younger generation prefers to consult with doctors, or to take allopathic medicines for instant action. Nevertheless, the Rongmeis in general still believe and also continue to depend on the traditional medicine for curing various ailments.

As also pointed out by Singh and Maheo [18], the Mao tribe of Manipur still have a firm belief in the effectiveness of their traditional medicines. Similarly, inspite of the availability of modern medicines, the Rongmeis continue to resort to their age-old traditional practices till today, including supernatural invocations. Many of the older people generally prefer traditional medicine for problems which people are familiar with and need no medical advice. Further the present location and position of the people of Marangching in particular pose great difficulty in rushing to modern health care centres. Hence the traditional medicine at times becomes the only means or a very good alternative for immediate relief. However, continuous deforestation has led to disappearance of various medicinal herbs. Besides men's greed, his ignorance for preservation especially in the rural areas is another cause of concern.

With regard to administration of colostrums 181 women (87.0%) had given colostrums while 27 women (13.0%) failed to do so. Table VIII shows that 87 women (41.8%) and 90 women (43.3%)fed their children within and after an hour of delivery respectively while that of 31 women (14.9%) breast fed only after a day. It is also observed that 88 women (42.3%) had started feeding solids to their children at the age of 3 to 4 months. The next second highest is found among age of 5 to 6 months numbering 62 (29.8%). The third highest is found among the age of 1 to 2 months numbering 34 (16.3%). And the fourth and fifth was age of 1 month and 6 months with the percentage of 8.2 and 3.4 respectively.

TABLE VIII
CHILD CARE PRACTICES

	Colostrums given		Breast feeding started			Duration of exclusive breast feeding					Introduction of supplementary food /duration of breast feeding			
	Yes	No	Within an hour	After an hour or two	After a day	>1 month	1-2 months	3-4 months	5-6 months	6 months	>6 months	>1 yr	1-2 yrs	2-3yrs
Total	181	27	87	90	31	7	34	88	62	7	2	20	110	76
(%)	87.0	13.0	41.8	43.3	14.9	8.2	16.3	42.3	29.8	3.4	1.0	9.6	52.9	36.5

Introduction of supplementary food /duration of breast feeding were found highest in 1-2yrs duration with percentage of 52.9. The next second highest is the duration of 2 to 3yrs with percentage of 36.5. And the third and fourth were 1year and 6months with the percentage of 9.6 and 1.0 respectively.

IV. CONCLUSION

The maternal health care delivered to the Rongmei women cannot be rated satisfactory as observed from the time of pregnancy through post-delivery care period. Immunization of the children is not done regularly as per the information. Some women residing at Marangching village are unable to avail the best medical care for both mother and child owing to its location. Though the women are aware of the modern treatment facilities, poor connectivity coupled with low financial status hamper medical treatment. Despite awareness of modern birth control measures only 10.1 % adopt it. Women who have crossed their reproductive age rarely seek medical assistance. Based on the self-assessment report on their health treatment a good number of respondents resorted to self-medication which can prove hazardous. Another important finding is the importance attributed to the traditional health care system. Affordability and accessibility attract the older population to traditional medicine while the younger generations have developed more faith in modern medicine. Hence an overall improvement in health status can be expected. As clan and church leaders occupy important positions in tribal societies, they can help in creating awareness on MCH care.

The accessibility and quality of health services have a great impact on the community's health status. Although facility births at any well-established health centres are increasing

through the appointment of ASHAs (Accredited Social Health Activists) in different sectors of the region yet it is still a far cry and the quality of care at birth remains a major challenge. Many women give birth at home and may not see a skilled health worker before or after delivery. The present population is in urgent need of receiving proper and adequate information regarding the importance of antenatal care, safe delivery, importance of immunization against preventable disease, the advantages of a small family and adequate child spacing. Women who are beyond the childbearing age rarely seek health facilities. Though modern medicine is slowly gaining popularity, traditional medicine is still relied upon. Indigenous treatments, as observed in this study, are not restricted to this tribal community alone. Other studies such as Jaggi [19], Das [20], Mathur [21], and Singh and Maheo [18] revealed that similar methods are being followed by many people all over India irrespective of their rural or urban and even religious backgrounds. As rightly pointed out by Kurian [22] that, plants are an integral part of nature and they are the life-sustaining force on earth. Scientists in many parts of the world have carried out extensive research and have also proven to humanity the effective use of herbal medicine. However, in the name of development, there has been continuous deforestation which is mainly responsible for disappearance of various medicinal herbs which is of high value. This needs to be earnestly looked into and also revitalize strategies for protecting it.

No doubt MCH services have been created strengthened and expanded over the years yet; their output in terms of their utilization has not reached its target especially in the rural region. In short, the overall condition of maternal and child care among the Rongmei is yet to become satisfactory. Easy accessibility and quality services will have a great impact on the community's health at large and that of mother and child in particular. Hence, MCH promotional activities need to be intensified and the benefits of these services be properly explained to mothers for the overall betterment of community health.

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