# CHAPTER - 18

# STATUS OF MCH INDICATORS OF FOUR NORTH EASTERN STATES OF INDIA: A COMPARATIVE ANALYSIS OF TRIBAL AND GENERAL POPULATION USING NFHS 4 & 5 DATA

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## INTRODUCTION

The Constitution of India acknowledges the distinctive status of tribal communities, referred to as Scheduled Tribes, and enforces protective measures to safeguard their rights and heritage. Despite their significant numerical presence, estimated at 104 million as per the 2011 Census, tribal communities continue to exist on the margins, facing geographical, socio-economic, and political marginalization, leading to their relatively limited recognition in the national consciousness. In contrast, Northeastern states, constituting approximately 25.8% of the tribal population across 145 tribal communities, stand out with a higher tribal proportion compared to the national average of 8.6%. Specifically, Arunachal Pradesh, Meghalaya, Mizoram, and Nagaland exhibit a tribal majority, accounting for a

substantial percentage of their total populations—69%, 86.1%, 94.4%, and 86.5%, respectively. These states are deemed as more accurate representations of the tribal community in Northeast India [1][2].

There was an initial assumption that the health issues and needs of tribal communities mirrored those of the general population, and thus, the standard national rural healthcare model could be applied to them, albeit with adjustments in population-to-provider ratios. Unfortunately, this approach overlooked the distinct challenges posed by the different terrains, environments, social structures, cultural norms, and, consequently, unique healthcare requirements of tribal people. Consequently, healthcare in tribal areas has remained an unresolved issue [3].

The tribal community falls below the national average across various health indicators, with particular vulnerability observed among women and children. The Total Fertility Rate stands at 2.5%, and only 15% complete their Antenatal Care (ANC) visits. Merely 56% of children receive full immunization coverage, contributing to an Infant Mortality Rate (IMR) of 44.4 per 1000 live births and an Under-Five Mortality Rate of 57.2. These figures contrast starkly with the national averages of 30 deaths per 1000 live births and an Under-Five mortality rate of 35, emphasizing the significant health disparities faced by tribal communities [4].

## RESEARCH QUESTION

What were the differences between the service uptakes for MCH services of Tribal population of the selected northeastern states in comparison with the General population?

## RESEARCH OBJECTIVES

1. To examine the utilization of services between the general population and tribal communities in the states of Arunachal Pradesh, Meghalaya, Mizoram, and Nagaland.
2. To analyse the correlation between these utilization patterns and the socio-demographic features of the identified areas.
3. To conduct a desk review of both public and private intervention programs focused on Child Mortality, Maternal Health, Literacy, and Nutritional Status in the states of Arunachal Pradesh, Meghalaya, Mizoram, and Nagaland.

## RESEARCH METHODOLOGY

The study was designed as a descriptive approach based on a desk review, utilizing secondary data from NFHS 4 and NFHS 5 reports and factsheets. The research also incorporated a review of relevant publications and reports to establish corroborative evidence and relationships. The study was set in Arunachal Pradesh, Meghalaya, Mizoram, and Nagaland, focusing on a population derived from NFHS data with a sample size of 74,26,324 subjects, as per Census 2011.

The duration of the study spanned three months, from March 1st to May 31st, 2023. All participants were included in the sampling technique. Data collection relied on NFHS 4/5, where officials surveyed each household. The analysis was conducted using MS Excel. Ethical considerations involved the use of de-identified public domain data to mitigate the risk of disclosing personal information. The research aimed to shed light on the reasons behind the socio-demographic characteristics of the

identified areas lagging behind the state average and to assess the impact of intervention programs and tribal practices on these indicators, providing valuable insights for future interventions.

## RESULTS AND DISCUSSION

In all four indicators, the Northeastern states lag behind the national average but show a notable increase from NFHS 4 to NFHS 5. Mizoram consistently performs the best among the four states, though there is a concern about the decline in the number of surveyed women from NFHS 4 to NFHS 5. The full ANC coverage remains particularly poor, especially for tribal women. According to RSoC data, while 81.8% of Scheduled Tribe (ST) women received at least one ANC, only 15% received full ANC, the lowest among all social groups. Access to healthcare also decreased, with a dip in women receiving ANCs in the first trimester and those receiving at least four ANCs.

This decline is attributed to factors such as the unfriendly attitude of health workers, language barriers, a lack of trust in the healthcare system, and the mismatch between maternal health services and tribal beliefs and practices.

Mizoram's success in maternal health indicators is linked to the implementation of Rashtriya Kishor Swasthya Karyakram (RKSK) and the increase in health facilities under the National Health Mission (NHM). However, Nagaland faces challenges in expanding health infrastructure due to its hilly terrain, leading to wide inter-state variations in maternal and child health indicators. Overall, India's positive performance in maternal health outcomes is attributed to pro-poor policies, cash incentive schemes, and community-level involvement, especially through community health workers.

## CONCLUSION

In conclusion, while India has made remarkable strides in reducing maternal mortality and enhancing maternal health outcomes through the implementation of policies and cash incentive schemes under the National Rural Health Mission since 2005, the maternal health situation in the specific states of Arunachal Pradesh, Meghalaya, Mizoram, and Nagaland underscores the need for intensified efforts in maternal and child health-related activities. Achieving maternal and child health goals necessitates comprehensive progress across all sectors of healthcare provision. This includes enhancing public health facilities, fostering increased engagement of Community Health Workers (CHWs) to bolster community-level involvement, improving service accessibility in isolated terrains, and minimizing political disruptions.

The effective and targeted implementation of existing schemes emerges as a critical requirement. In the case of Nagaland, characterized by the poorest indicators, addressing health governance demands an enhanced socio-political vision. Two key priorities for Nagaland include ensuring an adequate presence of health personnel in designated health centers across districts to enhance the quality of medical care and diagnostic services. Additionally, prioritizing women's empowerment is pivotal for a demand-driven perspective, considering the state's low levels of female literacy, high total fertility rate, and substantial unmet need for family planning services. Overall, a concerted and strategic approach, coupled with sustained commitment, is imperative to bridge the existing gaps and elevate maternal and child health outcomes in these states.

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