Tribal Mothers Help-Seeking Behaviour in Childbirth and Decision-Making: A Qualitative Perception

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Abstract

The health status of tribal populations in India is significantly influenced by socio-economic challenges such as poverty, illiteracy, and inadequate access to healthcare services. Maternal health is a major concern due to the heightened risks of adverse outcomes among tribal women. Factors like caste, education, and perceptions of infant mortality impact maternal healthcare utilization. In Nagaland, low rates of prenatal and postnatal care highlight healthcare access gaps. This qualitative study in Rüzazho village explores tribal mothers' health-seeking Behaviours during childbirth. Data from 89 participants aged 23 to 70 were collected through interviews and focus group discussions. Traditional beliefs about health strongly influence their seeking Behaviour. Addressing barriers to access and raising awareness of maternal health services is crucial for improving healthcare outcomes in tribal communities.

Introduction

Tribal health status in India is extremely poor, largely due to widespread poverty, illiteracy, malnutrition, lack of safe drinking water, inadequate sanitation, ineffective national health and nutritional services, and poor maternal and child health services (Singh, 2008; Jacob, 2014). Maternal health, in particular, refers to the well-being of women during pregnancy, childbirth, and the postnatal period. It aims to ensure positive experiences for both mothers and babies, and the primary goal is to prevent morbidity and mortality while promoting overall health and well-being for mothers and children (Jose et al., 2014; WHO, 2024; Bhattacharya & McCall, 2023). This issue is a critical concern globally and has been a priority in India, with maternal health programs evolving to address new challenges and improve quality to meet maternal mortality ratio (MMR) targets (Zahoor et al., 2020).

Globally, maternal mortality remains alarmingly high, with approximately 287,000 women dying during and after pregnancy and childbirth in 2020, predominantly in developing countries. India accounts for the highest number of these deaths, with a maternal mortality ratio (MMR) of 254 per 100,000 live births, most of which are

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preventable (RGI, 2009; Kumar et al., 2016; WHO, 2024). However, significant health disparities persist between tribal and non-tribal populations worldwide and in India (Zahoor et al., 2020). The Third National Family Health Survey (2005-06) revealed that the infant mortality rate (IMR) among the tribal population was 62.0%, higher than the national average of 57.0% (Kumar et al., 2016). Additionally, the under-five mortality rate for scheduled tribes was 50 deaths per 1,000 live births, compared to 33 deaths per 1,000 for non-scheduled castes or other backward classes.

Findings from several studies in India show that primitive tribal women tend to be at a greater risk of adverse maternal and child health outcomes than non-tribal women (Sandhya et al., 2007). Evidence from community and facility studies shows maternal healthcare seeking is comparatively less among tribal women than among non-tribal in India. The proportion of deliveries among tribal women without any antenatal care (ANC) prenatal services is 37.8%, which is higher compared to 22.8% among non-tribal women. A large proportion of the deliveries still occur at home (IIPS, 2007). The reason for the disparity in maternal health care utilization is not only a medical event but rather a social phenomenon that adversely affects most socially disadvantaged groups like Scheduled Castes and Scheduled Tribes (Paula et al., 2011). Several studies have documented the factors influencing maternal health care. In India, caste, socioeconomic condition, education level, occupation, standard of living, age at marriage, and perception towards infant and child mortality affect the utilization of maternal healthcare services (Dharmalingam & Morgan, 1996; Sandhu & Brown, 1996; Marpady & Singhe, 2020).

In Nagaland, maternal and infant health indicators are particularly poor. Only 70% of women receive prenatal care from a skilled provider, and the birth registration rate is 73% below national averages (NFHS-5, 2021). Data from the National Health Mission of Nagaland showed that first-trimester ANC registration was 27.3%, women receiving four ANC check-ups was 22.9%, institutional deliveries were 82.4%, and postnatal care (PNC) within two days was 39.8%, all significantly below national averages. In the Phek district, where the study village is located, only 9.5% of mothers received prenatal care, and institutional deliveries were 32.2% (NHS, 2021). Despite various measures taken by the government to reduce and improve maternal health, obstetrics care services utilization is lagging and shows big gaps in the outcome (Gopalakrishnan, 2019). Given the importance of maternal health care utilization, this qualitative study was conducted to explore and understand the help-seeking Behaviours and decision-making processes of tribal mothers in Rüzazho during childbirth. It aims to identify the critical gaps in prenatal care, institutional deliveries, and postnatal care utilization, as highlighted by the alarming statistics. It also provides insights into the healthcare choices made by the community, offering a comprehensive view of the interaction between conventional and indigenous healing practices.

Methodology

Area of study: The explorative qualitative study was carried out in Rüzazho village, home to the Chakhesang tribe, one of the sixteen major Naga tribes of Nagaland. This

village is situated in the eastern part of Nagaland, southwest of the district headquarters in Phek, approximately 79 kilometers from the state capital, Kohima, and 37 kilometers from Phek. Located at 25°74167 N 94°36541 E, Rüzazho village has a population of 2,848, with 1,435 males (50.4%) and 1,413 females (49.6%) living in 736 households and a literacy rate of 70% (Census Report, 2011).

Selection of site: The village was selected for two primary reasons. First, the village has a Government Primary Health Center (PHC) established in 2008, providing essential medical services as a comparison point for indigenous versus modern healthcare practices. The PHC has 11 staff members and offers outpatient and inpatient care, emergency services, immunization, prenatal and postnatal care, minor surgeries, family planning services, diagnostic tests, and ambulance referral services. Government-sponsored schemes such as Janani Suraksha Yojana, Janani Shishu Suraksha Karyakram, and Pradhan Mantri Surakshit Matritva Abhiyan are available to all pregnant women in the village. Second, the presence of traditional healers, especially Christian faith healers (FHs), provides a unique perspective on healthcare choices. These healers, addressing ailments believed to have supernatural causes, are sought after by both villagers and those from neighboring areas. This duality of healthcare options allowed an in-depth exploration of the interactions between conventional and indigenous healing practices.

Selection of participants and socioeconomic variables: Data was collected from 89 mothers aged 23 to 70 through snowball sampling. This technique began with key informants who identified initial participants and recommended others, expanding the sample (Bernard, 2006). Regarding age, 15 (16.85%) were aged 20-30, 20 (22.47%) were 31-40, 26 (29.21%) were 41-50, 16 (17.98%) were 51-60, and 12 (13.48%) were 61-70. In terms of education, 29 (32.6%) were illiterate, 18 (20.2%) had completed lower primary, 16 (18%) had upper primary, 16 (18%) had secondary, and 10 (11.2%) had higher secondary education. For monthly income, 33 (37.1%) earned 2000-3000, 19 (21.3%) earned 4000-5000, 12 (13.5%) earned 6000-7000, 12 (13.5%) earned 9000-10000, and 13 (14.6%) earned 13000 and above.

Duration of fieldwork: This research was conducted over three months, from January 3, 2023, to April 10, 2023, during which the researcher resided in the village to observe health-seeking Behaviours. The initial week focused on establishing a research foundation through discussions with PHC workers, the village chairman, and elders, providing crucial context and indigenous knowledge. Subsequent weeks involved intensive interviews with local informants to capture the detailed experiences and perspectives of tribal mothers on their maternal health-seeking Behaviours.

Methods of data collection: Informed verbal consent was obtained from participants, ensuring confidentiality and anonymity. Interviews and discussions were audiotaped with consent. Data was collected through in-depth face-to-face interviews using an open-ended structured interview schedule and case study method. On average, 2-3 mothers were interviewed daily, depending on their availability and willingness. The interview schedule covered personal information (age, age at marriage, marital status,

education, income, number of children), and topic-specific such as prenatal care, place of birth, postnatal care, and medical care decision-making. Additionally, two focus group discussions (FGDs) with 20-25 mothers each were conducted on help-seeking Behaviour during pregnancy to postnatal.

Data analysis: Data collected in the local language was translated into English. The researcher ensured comprehensive data visibility and created duplicate copies that were stored separately to prevent data loss. The participants' responses were imported into the qualitative software Atlas.ti (trial version). Data was then descriptively analysed, referencing field notes, verbatim quotes, and previous studies. This analysis incorporated healthcare utilization theories, establishing cause-and-effect relationships, making inferences, assigning significance, and evaluating instances that supported or contradicted existing studies.

Results

Prenatal Care

Prenatal care refers to the medical care and support provided to individuals during pregnancy. It focuses on monitoring the health and well-being of the pregnant and developing foetus, ensuring a healthy pregnancy, and reducing the risk of complications. It includes some practices such as regular check-ups, screenings and tests, vaccination, nutritional guidance, etc. Table 1 illustrates the breakdown of individuals who have received prenatal care and those who have not.

Table 1: Prenatal Care

Prenatal care	No. of respondents (%)
Yes	78 (87.6)
No	11 (12.4)
Total	89 (100)

Source: Field data

Of the 89 mothers, 86 have received prenatal care on the advice of friends and nurses, primarily through Tetanus Toxoid (TT) injection. Additionally, a few mothers mentioned that their prenatal care included the administration of vitamins along with the TT. The advice from health workers or friends drove all those who received prenatal care. However, it is also noted a group of 11 mothers reported not receiving any prenatal treatment due to a lack of awareness about the benefits of the same.

Place of Childbirth

Table 2 shows the distribution of the place of birth of the children delivered by the 89 mothers. They are categorized into two groups: 66 mothers opted for 'home delivery,' with assistance from family members or their husbands, while 23 mothers had a combination of 'home and hospital delivery,' indicating that some children were born in a hospital while others were born at home.

Table 2: Place of Childbirth

Place of delivery	No. of respondents (%)
Home delivery	66 (73.7)
Hospital delivery & Home	23 (26.3)
Total	89 (100)

Source: Field data

Perceived Factors for Home Deliveries: The reported reasons for home delivery are categorized under two factors: unavailability of PHC along with the distance to the nearest hospital during childbirth and absence of health complications. The village lacked a PHC until it was established in 2008. However, by then, many children had already been born without the accessibility of proper medical facilities. In addition, the nearest health centre at that time was located in Chozuba village, 20 kilometres away. Consequently, this created considerable challenges for the expecting mothers as they faced difficulties traveling, particularly during labour. Another significant factor influencing their decision to deliver their children at home was the absence of health complications. Throughout their childbirth experiences, they were fortunate to have smooth and uncomplicated deliveries. Given this, they didn't perceive any urgent necessity to go to the hospital for medical intervention. The absence of complications gave them a sense of reassurance and confidence in their ability to manage the birthing process within their home's familiar and comfortable environment. They believed that medical assistance in a hospital setting was unnecessary when everything was progressing well, and they had the support and expertise of their family members. It reinforced their conviction that home births were a safe and viable option for them, considering their circumstances and the successful home births their mother had experienced. Below are a few selected responses, together with the age of the respondents concerned.

Unavailability of PHC and Distance to Hospital

"All my children were born at home, mostly with the assistance of my family. The absence of a nearby health centre meant I didn't go to the hospital; however, the ease of my earlier deliveries was another reason" (Duzolu Swuro, 61).

"Without a village hospital, it was not an option for me. Assisted by my husband and elder sister, all my homebirths were quick, sometimes occurring right after returning from the paddy fields" (Muzanelu Swuro, 50).

"With no primary healthcare centre in the village, hospital births were not an option. All my children were born at home with my husband and mother, following her example" (Savolu Sapuh, 42).

"All my children were delivered at home. Without a PHC in the village, hospital births were not an option. While my first delivery was difficult, and the baby did not survive, subsequent births were easier" (Rudu, 42).

"All my children were delivered at home with the help of my husband, mother, and grandmother. Without a PHC available, I relied on their experience, making hospital visits unnecessary" (Vepratsolu, 53).

"I had my children at home with my mother and grandmother. Being young and without the village PHC, the long travel to a hospital made home birth more convenient" (Noshilu, 45).

"My three eldest were born at home due to easy births with little labor pain. The last child was born in the hospital after the village PHC was established. However, home births were more convenient" (Shijoh, 40).

"Six of my children were born at home with a nurse and my husband's help; the last was born in a hospital. We chose home births due to the lack of a village PHC and transportation, but without any health complications, the home was always our first choice" (Zalo, 45).

No Health Complications

"All my children were delivered at home by my mother and a village nurse. I chose home births due to the lack of complications and the successful home births of my mother and grandmother" (Cekrozolu Swuro, 48).

"All my children were delivered at home, with my mother present and a nurse assisting. Without complications and with smooth labours, I saw no need to go to the hospital" (Vevoralu, 28).

"All my children were born at home with my grandmother present. I had uncomplicated deliveries and followed the family tradition of home births" (Vekhrunulu, 53).

"All my children were born at home with my mother and a nurse. Without complications, hospital visits weren't needed. With divine grace, we managed quick home births despite working in the fields all day" (Hupru, 42).

"All my children were born home with my mother, except the last one. Smooth deliveries without complications meant I chose home birth" (Venelu Swuro, 48).

"I delivered my first two children at home with the help of a nurse and my mother, as it was easy and convenient. The third was born at the hospital due to complications" (Kudu, 29).

"All my children were delivered at home by my mother and a nurse. Although hospitals were available when my youngest two were born, I chose to stay home due to easy births" (Muzisalo, 45).

"All my children were born at home with the help of my husband. Although hospital deliveries are safer, I had easy births at home and didn't need to go to the hospital" (Zacivolu, 44).

"All my children were born at home, with my mother and husband present. I chose not to go to the hospital because I had smooth, complication-free home births" (Nuvetalu, 32).

"All my children were delivered at home with my husband. The births were easy and without difficulty, so I didn't feel the need to go to the hospital. It is not that I think hospital deliveries are unsafe" (Tolu, 35).

Perceived Factors for Hospital Delivery: Hospital deliveries were infrequent, as the figure above indicates. Most women chose to give birth at home unless there were signs of complications during the delivery process and advice from the nurse or doctors to deliver at the hospital. The decision to utilize hospital services was primarily driven by the need for specialized medical care and intervention to ensure a safe and successful delivery for the mother and the baby. The following presents a few selected responses from the mothers on the given subject.

Health Complications

"Complications in my last childbirth caused bleeding and cramps. Rushed to the PHC by my husband, I received treatment and was delivered comfortably at the well-equipped hospital" (Kuvesalu, 36).

"My first child was delivered in the hospital due to complications, but my husband and I delivered the rest at home. Since I had easy births for almost all of them." (T Swuro, 58).

"Complications during my first pregnancy led to premature birth at Chozuba Hospital, recommended by the PHC nurse. Attentive care ensured the health of both my baby and me" (Vepotolu Swuro, 26).

"I chose hospital delivery for my first baby due to early labour onset. Following advice from ASHA and ANGANWADI workers, I promptly admitted myself. Considering hospital delivery in changing times is important, though home birth is also safe in the absence of health complications" (Kuhuvelu, 34).

"I experienced early labour pain and complications while giving birth at home, with the assistance of my mother and mother-in-law. As a result; I was rushed to the PHC to deliver the baby" (Khruvesalu, 23).

"Due to some complications" (Zolue, 43)

"Due to early bleeding" (Sonu (51).

"Seeing the potential signs of danger, a doctor advised me to deliver at a hospital" (Kozu, 41).

"I delivered my baby in the hospital; however, the baby didn't make it due to premature delivery" (Swuro, 23).

"At prenatal visits, a nurse advised hospital childbirth for my recent child, prioritizing safety. Following her counsel, I delivered at Chozuba Hospital" (Kuvezalu, 45).

Postnatal Care

Postnatal care involves medical care and support provided after childbirth, promoting the mother's well-being and facilitating recovery. It includes physical and emotional support, breastfeeding guidance, nutritional advice, and baby care. Table 3 shows that 12 individuals (13.2%) chose professional care, and the majority, with 77 respondents (86.8%), managed postnatal care independently or using indigenous remedies at home.

Table 3: Postnatal Care

Postnatal care	No. of respondents (%)
Professional	12 (13.2)
Self-care/home remedy	77 (86.8)
Total	89 (100)

Source: Field data

Perceived factors for postnatal care: Factors influencing postnatal care seeking varied based on the presence or absence of health issues and awareness levels. Those seeking professional care did so due to delivery complications or nurse recommendations. Conversely, many opted for self-care due to the absence of health complications, perceiving professional assistance as unnecessary. This perception stemmed from their long-standing customary practice, overall well-being, and lack of specific concerns, leading to a disregard for seeking medical help. However, the fact that most respondents did not seek external postnatal care does not imply that they neglected their postnatal health. Instead, they embraced the traditional practice of vaphü. Vaphü nourishes women with foods believed to aid physical recovery after childbirth, such as chicken soup and protein-rich meats like rabbits and piglets. This practice reflects cultural beliefs in the importance of nourishment for healing and restoration post-birth, preserving traditional knowledge across generations. By participating in vaphü, individuals honour their cultural heritage and actively participate in their well-being. While external care may sometimes be necessary, vaphü showcases an alternative rooted in local customs. The following presents a few selected responses from the mothers on the given subject.

Health Complications - Professionals

"After my first childbirth, I faced urgent surgery in Kohima for an abdominal issue.

Prioritizing biomedical intervention over traditional healers, I sought immediate medical care" (Ruduvolu, 42).

"Due to excessive bleeding" (Zalu, 49).

"Postpartum bleeding after my third child led to a week-long hospitalization in Chozuba, then transfer to Kohima" (Cekrozolu Swuro, 48).

"I was recommended by one of the nurses at PHC for postnatal care to prevent potential complications" (Zolu, 28).

"A few days after the birth of my child, I became so weak that I had to seek care from doctors" (Vulo, 59).

"I received postnatal care in the hospital for my first child since I gave birth there" (Vepo, 26).

"I received postnatal care from the hospital after the birth of my last child. Besides that, we primarily care for ourselves at home after giving birth" (Ano, 47).

"After one of my deliveries, I experienced a lack of appetite, so the nurse provided me with some vitamins. Other than that, I didn't require any additional postnatal treatments. I received care at home" (Zalu, 45).

"After the birth of my first child, I received postnatal treatment from the hospital. However, for my last two births, I didn't seek any postnatal treatment. I was doing well and received care at home, so going to the hospital was unnecessary" (Vehutalu, 34).

"I went for postnatal treatment after my child's premature delivery since my nurse suggested" (Khruvesalu Swuro, 23).

No Health Complications - Home Remedy

"I received no postnatal care from either doctors or traditional healers, as care was provided at home. Our elders even discouraged new-born vaccinations, leading to the avoidance of postnatal treatments for both baby and mother" (Thukuvolu, 46).

"After giving birth, I experienced fatigue and rashes but opted not to go to doctors or traditional healers, considering it not serious and preferring to avoid medication. Instead, my mother cared for me at home" (Vevoralu, 28).

"I didn't undergo postnatal treatment from doctors and traditional healers. Doing fine after birth, we received care at home with nutritious food (vaphü) and returned to our routine in a day or two" (Vekhru, 47).

"I didn't seek any postnatal treatment because there was no reason to do so. We prefer to care for ourselves at home and typically resume normal life within 2-3 days after giving birth" (Chisane, 46).

"I didn't undergo any postnatal treatments. My mother provided care for me at home, and since I had no reason to seek postnatal treatment, I didn't go" (Noshi, 45).

"I didn't seek any postnatal treatments either. Without any complications after giving birth, there was no need for me to go" (Talu, 32).

"I didn't seek any postnatal treatments. We prioritize rest at home, eating nutritious food like 'vaphö,' and returning to normal life. We don't visit doctors or traditional healers unless there are complications" (Vekhru, 43).

"We don't seek postnatal treatments. Resting and eating ' vaphö ' at home, we return to normal lives. Mothers typically don't get themselves checked up by doctors or traditional healers after giving birth, as it's not customary" (Muzanelu Swuro, 50).

"Skipping traditional postnatal treatment from doctors or traditional healers, I received home care, including nutritious ''vaphö' meals. This involved chickens, ducks, and others. Family support and nourishing food helped regain strength after birth" (Sholu, 56).

Decision Making

To further enhance their health-seeking Behaviour, a question was asked regarding who decides where to seek treatment during illness, aiming to identify key decision-makers (see Table 4). 48 out of 89 mothers reported that they decided by themselves when seeking medical care for any illness. Twenty-one mothers reported making the decision jointly with their husbands, while another 20 reported making the decision jointly with their other family members.

Table 4: Decision-Making

Decision-making	No. of respondents (%)
Alone	48 (53.9)
With husband	21 (23.6)
With other family members	20 (22.5)
Total	89 (100)

Source: Field data

Discussion

This study explored the factors associated with the health-seeking Behaviours of tribal mothers. It was influenced by several educational, geographical, socioeconomic, and cultural factors, including their conception of health and customary practices. Among

these, their traditional concept of health played a profound role in deciding whether or not to seek, whom to seek, and when to seek professional care or traditional healers. The concept called 'preventive medicine and maintenance' introduced by Foster and Anderson (1978) provides insight into understanding the difficulties of traditional people in changing their health Behaviour. According to them, traditional peoples' etiological ideas and therapeutic interview images share one important premise: illness or disease is evidenced by pain and suffering. Therefore, they struggle to accept the idea that a serious illness might develop gradually and only be detected when it is too late for effective treatment. As long as their bodies function normally, they consider themselves healthy, making the concept of preventive measures before disease onset alien to their medical logic. Consequently, traditional people are not ideal candidates for preventive medicine, which aims to prevent illness through vaccination or early detection. Preventive medications clash with their worldview, and they do not embrace them with the same enthusiasm as Europeans and Americans (Shimray, 2024). The tribal concept of health is more inclined toward the functional perspective. For them, as long as they can walk and are not bedridden, they are considered healthy. It emphasizes the ability to perform daily activities without pain or suffering rather than focusing on the absence of underlying or slowly developing illnesses.

This perception is significantly reflected in these mothers' attitudes towards prenatal, institutional delivery, and postnatal care. As the finding suggested, although 86 of the 89 mothers received prenatal care, it was mostly limited to Tetanus Toxoid (TT) injection contrary to the advice from the Reproductive and Child Health (RCH) India to administer at least three prenatal care: iron, folic acid tablets and tetanus toxoid injections (MoHFW, 2010). 66 mothers delivered at home, compared to 23 who delivered in hospitals. Additionally, only 12 mothers received postnatal care from professionals, while 77 relied on home remedies.

For these mothers, whether it is the prenatal, childbirth, or postnatal period, they do not seek external assistance unless they face serious health complications. Their initial choice of care is always home remedies, and they only seek other methods when their condition exceeds their ability to manage. They have access to multiple treatment options beyond self-treatment, organized in a 'hierarchy of curative resorts' that they can try (Kleinman & Benson, 2006). This finding aligns with other studies, which show that antenatal or postnatal care is considered customarily unnecessary compared to non-tribal women (Maiti et al., 2005). Many women seek care only when they are sick or experience new discomfort or pain (Shiferie et al., 2023). Some may believe there are no benefits to attending ANC during the first trimester as it is perceived primarily as curative rather than preventive (Akeju, 2016). The finding is also similar to the case of Tangsa women who lack a clear understanding and knowledge of the importance of ANC and postnatal services from PHCs unless they face serious problems (Sarmah & Dutta, 2019). Emergencies drive their health-seeking Behaviour, and they only seek professional help when they perceive a high risk. Consequently, there is low preventive-driven health-seeking Behaviour for ANC and PNC (Sychareun et al., 2016). Likewise, studies in other tribal societies indicated pregnancy and childbirth are seen as normal and natural processes not associated with

disease or health problems, requiring external intervention only in prenatal or postnatal emergencies and high-risk births or complications (Shahabuddin et al., 2017; Contractor et al., 2018; Ahmad, 2019; Cáceres et al., 2023). For instance, these mothers did not stop working or performing their daily routine because they were pregnant, often resting only when labour began. After childbirth, it is common for them to rest for a week or two at most before resuming their normal routine. For most mothers, childbirth is peacefully carried out at home with family members, and postnatal care is managed through the well-developed traditional care system of vaphü.

While the tribal understanding of health significantly impacts their health-seeking Behaviour, it is not the sole determinant. It could also be affected by various other factors such as their perception of the quality of health services, strong belief in traditional medicine due to its availability and religious affiliation, geographical access challenges, education, finances, accessibility, and availability, and the rude and unfriendly Behaviour of staff in government hospitals (Bhattacharjee et al., 2013; Tiwari et al., 2014; Jose et al., 2014; Srivastava et al., 2014; Mahapatro et al., 2015; Khound et al., 2016; Patel et al., 2016; Jain et al., 2017; Gandhi et al., 2017; Sengupta and Dutta, 2018; Raj and Nayak, 2018; Mazumder et al., 2021; Taraphdar, 2022).

In terms of decision-making regarding whom to seek and when to seek, though Naga is a patriarchal society, the result of this study indicates otherwise that these mothers have a high degree of autonomy in healthcare decision-making, which is essential to improving their access to healthcare. Unlike many other societies, for instance, within Sub-Saharan Africa, culture and patriarchal norms significantly impact various facets of social life and relationships. These cultural elements have been observed to bestow disproportionate authority and control upon men in women's healthcare (Wado, 2013; Ononokpono, 2013; Ameyaw et al., 2016; Ameyaw, 2017; Budu et al., 2020). Azuh (2011) also noted that in many parts of Africa, women have limited influence in decisions about reproduction and sexuality. Their low status in the household power structure is manifested in who decides where the household, including the pregnant mother, should go for treatment as well as the payment of treatment costs. In the case of many Indian societies, men also play a paramount role in determining the health needs of a woman. Since men are decision-makers and control all the resources, they decide when and where women should seek health care (Rani & Bonu, 2003; Ahmed, 2000; Okojie, 1994). They are not allowed to visit a health facility or health care provider alone or to make the decision to spend money on health care. Thus, women generally cannot access health care even in emergencies (Uchudi, 2001; Navaneetham & Dharmalingam, 2002; Fatimi & Avan, 2002; Shaikh & Hatcher, 2005). However, unlike many of these studies in which men control the health-seeking power over women, the study shows women enjoying a considerable degree of autonomy in deciding whom to seek when illness occurs.

It is also important to note that 21 mothers reported making the decision jointly with their husbands, while another 20 reported making the decision jointly with their family members. Kinship relations and patriarchal structure being actively strong in the Naga society, it is expected that their husbands and family members will hold some degree

of influence in their decision-making process, similar to the Indonesian elderly care where a family has an important role in making a decision, one of which related to the choice of health care (Santoso & Ismail, 2009; Pradnyani & Suariyani, 2016). It also suggests that while mothers may have some decision-making power, they are still influenced by their social and cultural context and may need to consult with others before making decisions about their healthcare. The figures highlight the importance of taking a nuanced approach to healthcare decision-making, recognizing that various factors influence women's decisions and that interventions need to consider the social and cultural context in which they are implemented. A person's decision to select a specific healthcare system, facility, or Behaviour is a complex process influenced by many interconnected factors. These decisions cannot be attributed solely to any single factor, such as social, cultural, economic, or environmental influences. Instead, they emerge as a composite result of various elements, making the decision-making process intricate and multifaceted (Das & Das, 2017). For instance, mothers in Northeast India exhibit health-seeking Behaviour influenced by interconnected social, economic, cultural, geographic, and political factors (Caceres et al., 2023). However, the present findings somewhat contradict the works of Celik (2000) and Hassan et al. (2021), who concluded that decision-making authority over reproductive health affects health-seeking Behaviour. In contrast, the mothers in this study had a high degree of autonomy over their reproductive health, yet this autonomy did not lead them to seek professional care. Instead, their Behaviour appears to be more strongly influenced by their perception of health.

Conclusion

The qualitative study conducted in Rüzazho village sheds light on maternal health-seeking Behaviour and decision-making processes. Their traditional understanding of being healthy mainly drove their seeking Behaviour, besides other factors. Efforts should focus on addressing breaking the barriers to access and enhancing awareness of maternal health services.

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