CHAPTER - 4
SUMMARY AND CONCLUSION

Improving maternal health is one of the eight millennium development goals of India (WHO, 2005). The maternal health status is influenced by several factors like early marriages, malnutrition, illiteracy, ignorance, lack of health services, and unavailability of transport facilities. One of the most important reasons for poor maternal health status is non-acceptance or non-utilization of reproductive child health care services. Approximately 80% of the maternal deaths globally occur due to haemorrhage, sepsis, unsafe induced abortion, hypertensive disorder of pregnancy, and obstructed labour (WHO, 2005). 47.12% provision of antenatal care and medically assisted delivery can reduce such deaths (Adam, Lim, Mehta, Bhutta, & Fogstad, 2005; McCaw-Binns, 2008). A number of literatures have high-lighted that utilization of maternal health care services varies with the socio-economic characteristics of the population (Kavita & Audinarayana, 1997; Bloom, Wypij, & Gupta, 2001; Navaneetham & Dharmalingam, 2002; Gymiah, Tykyi, & Addai, 2006; Dey, 2009) Some studies on health seeking behaviour have focused on the importance of availability and accessibility of services (Develay, Saverborn, & Diesfeld, 1996; Becker, Peters, Gray, & Gultiano, 1993).

Reproductive health is not evenly distributed despite important gains and progress in achieving good reproductive health. Tribal women are the most in need but they are the least well served. Disproportionate poverty of women, their low social status and their low reproductive role expose them to high health risks and preventable deaths especially in tribal areas. A very high proportion of tribal women do not receive any treatment for their problems. Socio-cultural, economic and educational aspects has a deep influence on health of tribals who on the other hand has its own unique customs, traditions, beliefs and practices. Reproductive morbidity of tribal women was not considered seriously as it was thought that it is a part of natural process. Tribals due to their habitation in places where modern health facilities are not available have distinct problems. Therefore, their reproductive health problems need special attention. In order to improve the condition of health care services in tribal areas, public health care services can play a very crucial role. Therefore, an attempt has been made to assess the health status of Bhunjia pregnant and
lactating women and estimate the level of utilization of health services among them in the area of Chhattisgarh region.

4.1 Bhunjia tribe

In Chhattisgarh region 42 groups have been identified as scheduled tribes. They form approximately 32 percent of the total population. Bhunjia is one of the vulnerable tribe of Chhattisgarh. Bhunjia is a declining population of Chhattisgarh (Tiwari V. K., 2001). The total population of Bhunjia is 10603, (male 5225 and female 5378). Urban population of Bhunjia tribe is scanty. Only 102 Bhunjia live in urban society (Census, 2011). Bhunjia inhabit the deep hilly and reserved forests, 30-100 km away from Gariyaband district of Chhattisgarh state and Nuapada district of Orissa. They comprise of two social groups viz. Chaukhutia and Chinda. Chaukhutia have been further sub divided into groups viz Kholarajiha and Chaukhutia on the basis of their area of living. The unique cultural feature of Choukhutia Bhunjia is that of “Lalbangla”.

4.2 Aims and objectives

The aims and objectives of the present study are the following-

1) To assess the health status of Bhunjia pregnant and lactating Bhunjia women.
2) To assess the level of utilization of reproductive and child health services among Bhunjia tribe of Chhattisgarh.
3) The present study will highlight prevailing practices for maternal health care namely antenatal care and delivery care among Bhunjias.

4.3 Material and Methods

4.3.1 Research Design

The research design of the present study is population based cross-sectional type. In this study approach of research was quantitative and descriptive. Present study was planned to analyze availability of health facilities and infrastructure and socio-cultural and biological factors on the utilization of reproductive child health services among Bhunjia tribe of Chhattisgarh. For data collection census method was adopted.
4.3.2 Area selection

Chhura, Gariyaband and Mainpur blocks of Gariyaband district of Chhattisgarh state were selected purposively, out of which Bhunjia dominated 7 villages were selected from Chhura, 9 villages from Gariyaband and 11 villages from Mainpur block for data collection. For the present study the data was collected from 223 households. 27 Bhunjia predominated Bhunjia villages were selected purposively from Chhura, Gariyaband and Mainpur block of Gariyaband district of Chhattisgarh. A census survey sampling design was adopted. From each selected village each and every lactating and pregnant Bhunjia women were selected for the study.

4.3.3 Tools and Techniques used for data collection

For the achievement of objective of the study a number of tools and techniques were used viz. interview schedule, observation, group discussion, and case studies. The ethical approval for the present study was taken from Institutional ethical committee (IEC) for human research, Pt. Ravishankar Shukla University, Raipur, Chhattisgarh. Oral and written consents were taken from respondents before data collection.

A comprehensive research design is very essential to channelize the course of research work and keep it on right track. In order to achieve the above mentioned objectives a total of 227 informants were selected by census method from 27 villages of Gariyaband district of Chhattisgarh state. Gariyaband district of Chhattisgarh state was selected for data collection. Data was collected from 7 villages of Chhura block, 9 villages from Gariyaband block and 11 villages from Mainpur block through purposive sampling method. 49 pregnant women and 178 lactating women were selected for data collection. For assessment of maternal health of Bhunjia women, BMI, blood pressure and Hb were assessed. The techniques followed for Hb estimation was according to hemocue 301. Height and weight were measured following (Weiner & Lourie, 1981). Electronic blood pressure instrument was used for recording the blood pressure.

For collection of primary ethnographic data, interview schedule was used. The data was supplemented by case study, semi participatory observation and group discussion. For statistical analysis SPSS version 16 was used. Correlation matrix and multiple regressions were computed to identify the independent predictor variable for dependent variables. The dependent variables were Hb level, BMI, ANC checkups, place of delivery and
immunization status. The independent variables were standard of living index, education, current age, consumption of IFA tablets, No. of conceptions, presence of health centres in the village, availability of mobile network, approachable road, active mitanin, age at marriage, subcaste, distance from village to district head quarter and availability of mahtari express.

4.4 Rationale of the study

The current maternal mortality ratio (MMR) in India is 301 (Registrar General of India, 1997-2003). The fifth Millennium Development Goal (MDG-5) to reduce maternal mortality by 75% between 1990 and 2015 posed a huge challenge due to discrepancy and inequality in distribution, access, and outcome of maternal care services. There is wide gap of study regarding maternal health status and utilization of reproductive child health services among the Bhunjia tribe of Chhattisgarh.

4.5 Findings

The population under study comprised of 1123 individuals out of which 563 were males and 560 were females. Household study of Bhunjia population revealed that it is a relatively young population with 38.65% in 0-14 year age group as opposed to 58.24% in 15-59 years age group. Dependency ratio was observed to be 71.71% due to high young age dependency ratio (66.36%). However, the present study showed a low old age dependency ratio of 5.35%. Literacy rate was observed to be 67.16% which indicated that almost half of the population was illiterate. Very few women attained high school and higher secondary education. The Bhunjia women not only work as housewives but assist the family in other economic activities as well. 96.86% of the families had kachcha type of house. They used water from hand pumps, boring or tube wells for drinking purpose. 3.59% of the Bhunjia families used river or canal water for drinking. Electricity was available to 65.92%. Only 7.17% had their own toilet facility, the studied population showed that the standard of living index was lower class in 97.13% families. Out of the three blocks selected for the study Mainpur block had lower level of infrastructural facilities as compared to the other two blocks.

Infant mortality rate among the Bhunjas was observed to be 124 and maternal mortality was recorded to be very high among the Bhunjias. The mean body mass index (BMI) was observed to be 17.76±2.53 and the level of hemoglobin was recorded to be 9.58±2.30.
The blood pressure of the Bhunjias was in the normal range i.e. (systolic blood pressure 116.53±13.37 and diastolic blood pressure 77.85±20.83).

Only 26.14% of the Bhunjia women were classified under normal category and almost 53.98 percent lactating women were classified under underweight category. More than 90 percent of Bhunjia lactating women and 85 percent pregnant women were anaemic. However, majority of the women of both categories belonged to moderate anaemia. 20.45 percent of lactating women and 16.33 percent pregnant women were observed to be severe anaemic. Normal BP was recorded in 71 percent of pregnant women and 65.14 percent lactating women. The population under study recorded 45.45 percent infant deaths due to pneumonia and 18.18 percent due to “Kala Chhir” (local name).

Among the Bhunjia only height, weight, Hb level and blood pressure were checked during antenatal care visits by the ANM/MPHW in anganwadi centre and Sub health centre. The examination of urine was recorded to be very low in the studied population.

Only 38.33 percent Bhunjia women had complete antenatal care checkups. The Bhunjias did not avail all the four antenatal checkups as required for safe motherhood only 68.28 percent of the pregnant women had their first trimester antenatal check up and 66.96 percent had their second trimester ANC check up and only 47.14 percent had visited the health centre during their third trimester for their ANC check up. Lack of infrastructure facility and lack of financial assistance were the major causes for not availing the facility of ANC from the health centres.

Even with regard to consumption of IFA tablets Bhunjia women are lagging behind. They did not feel it necessary and the major reason for not consuming the complete dose was due to disliking of its odour and a feeling of vomiting sensation.

The present investigation showed that the reason for not receiving supplementary food from anganwadi centre was mainly due to disliking for its taste (14.29%). Very few (1.79%) reported that anganwadi centre is away from home and 0.89 percent reported abdominal pain after its consumption. It was quite surprising to note that 73.21 percent of the women did not accept the supplementary food as they were not allowed to accept roasted or fried food from outside. It was also noted that 9.82 percent did not accept it due to its poor quality.
71.8 percent Bhunjia women preferred home delivery and only 19.38 percent had institutional delivery. They reported that they could not avail the facility of institutional delivery due to lack of approachable road and non availability of transport facility. However, they reported that 65.64 percent could not avail the facility due to financial constraint for transportation. With regard to personnel to attend child birth 59.03 percent reported that their delivery was conducted by untrained dai, 12.78 percent by trained dai and 18.50 percent deliveries were attended by ANM/Nurse. The Bhunjia women have started using new shaving blade for cutting the umbilical cord (71.8%) and only 20.70 percent reported that delivery kit was used for the purpose. The study revealed that 81.82 percent of the respondents received cheque as financial assistance for institutional delivery although 13.64 percent reported that they did not receive any cheque. Others reported that either they did not go to receive the cheque or were unaware of the facility. 9.09 percent failed to avail the facility as they did not have their account in bank. The use of mahtari express was quite low. The post natal care was also observed to be very low i.e. 3.08 percent. Colostrum was given to their children by 73.57 percent women.

Immunization status showed that only 33.01 percent of the children were fully immunized. They availed the immunization facility from anganwadi centres. Reason for incomplete immunization was non awareness (43.24%) and absorption in household job. Some even reported incomplete immunization due to fear of fever and injection. It was observed that the treatment for complication during pregnancy was sought from either local medicine man or from traditional healers and some of them have approached the ANM (40%) also.

Almost 60 percent of the Bhunjia knew about the use of ORS as treatment for diarrhoea. Majority of them sought treatment from local medicine man or traditional healer for the ailment of diarrhoea, cough and cold. With regard to adoption of family planning measures the health centre workers reported that the Bhunjias were strictly prohibited to practice family planning by the government as Bhunjia was a declining population even few years ago. But after deeply probing into the matter the respondents disclosed that the use of oral pills was 16.67 percent, use of condom by 8.89 percent and a very high percentage of traditional women used the traditional contraception method too.
4.6 Discussion

4.6.1 Maternal Health Status

Maternal mortality rate was estimated to be very high among SC and ST of India (HDPS, 1994). Assam reported highest MMR followed by Uttar Pradesh and Madhya Pradesh till 1996 (Bhat et al., 1995) and lowest was reported from Tamil Nadu and it ranged from 95-480 in India. Chauhan 2012, reported MMR to be very high in tertiary level of care of Bastar which was more than 1600 per 1,00,000 live birth. The present study also reported the MMR of Bhunjias to be 1031, which was closest to that reported by Chauhan.

Joshi, 2011 reported a very high prevalence of anaemia among the tribal women. Prabhakar & Gangadhar, 2009 also reported a very high prevalence of anaemia among Jenukurumba tribe of Mysore. Balgir, Mishra and Murmu, 2003 also reported 89.9 percent of anaemia among the Bhuiya and Kharia tribe of Orissa. The prevalence of anaemia among the women of Kamar tribe of Raipur district was found to be 50 percent (Kumar et al., 2015). The present study showed a very high prevalence of anaemia among the Bhunjia lactating women (90.34%) and pregnant (87.76%) and was observed to be very close of tribal population of Orissa reported by Balgir et al., (2003). Prevalence of anaemia among the Bhunjias was reported in women who were under weight as reported by Shrinivasa et al (2014). The present population also showed that higher BMI also show higher haemoglobin level.

Karbi women of Kamrup district of Assam showed the range of BMI to be 21. 53 to 23.39 (Goswami & Bhattacharyya, 2015). Bose et al reported the BMI of Kora Mudi tribe of Bankura District, West Bengal to be 18.3 (Bose, Ganguli, Hasina, Mokhopadhyay, & Bhadra, 2006b). Ghose and Bharati however, reported the BMI to be 17.7 among the Munda tribe (Ghosh & Bharati, 2006). The range of variation among the Oraon and Santhal tribe of West Bengal was observed to be 18.7-19.7 (Bose,Ganguli, Hasina, Mokhopadhyay, & Bhadra, 2006c; Ghosh & Bharati, 2006; Ghosh & Mallik, 2007; Mukhopadhyay, 2009). Varadarajan and Prasad observed the range of BMI to be from 21.55-23.68 among the tribal women of Andhra Pradesh (Varadarajan & Prasad, 2009). The mean BMI among women of Sahariya tribe of Madhya Pradesh was 19.23 Kg/M² as reported by Ghosh-Jerath 2017 (Ghosh-Jerath, Singh, Bhattachariya, Ray, Yunus, & Zodpey, 2017) The mean BMI of the studied tribes of India showed that the Car Nicobarese (21.9Kg/M²) of Andman Nicobar (Kapoor, Saluja, Verma, & Kapoor, 2012)
have highest BMI and Garasia males of Rajasthan have the lowest mean BMI i.e. 15.9 Kg/M^2 (Bhasin & Jain, 2007). The present population showed the BMI to be 17.76 which falls within the range of the BMI of tribal women of India as reported so far.

The prevalence of CED among non pregnant and non-lactating tribal women of India was found to be 56 percent and 58 percent among lactating tribal women (Rao et al, 2010). Khan and Khan reported prevalence of CED to be 56.4 percent among women of Jammu, Kashmir and Ladakh. Ghosh-Jerath et al, (2013) also reported 42.4 percent CED. The present study showed high (53.98%) prevalence of CED among Lactating Bhunjia Women.

The present study showed the prevalence of high normal BP in 11.43 percent among lactating women and 6.12 percent among pregnant Bhunjia women. It was also observed that 5.71 percent Bhunjia lactating women showed grade-I hypertension which was quite low compared to all the tribal populations reported so far. The prevalence, awareness, treatment and control of hypertension were reported by Yuvaraj et al. (2010) from rural areas of Devanagere of Karnataka. The prevalence of hypertension was reported to be 18.3 percent and prevalence was higher in males. About 6.9 percent of the total hypertensions had severe hypertension (Yuvaraj, Nagendra Gowda, & Umakantha, 2010). The result of the study indicated that overweight women had high mean arteriole Pressure (MAP) irrespective of any background characteristic and education was considered as one of the most important predictors of hypertension. (Anand & Singh, 2017). Correlation between BMI and BP results of present study is in conformity with the study conducted by Sachdev (2011) among a nomad tribal group of Rajasthan, India.

4.6.2 Utilization of services

The role of socioeconomic and demographic factors are influencing demand for utilization of maternal and child health services as shown by a number of scholars (Kanitkar & Sinha, 1998; Elo, 1992; Swenson, Thang, Nham, & Tieu, 1993; Abdalla, 1993; Govindasamy, Poverty, 2000; Khan, Soomro, & Soomro, 1994; Barlow & Diop, 1995; Ahmed & Mosley,1997; Regmi & Manandhar, 1997; Govindasamy & Ramesh, 1997; Gupta, et al., 2016; Dey & Mishra, 2014; Kanikar and Sinha 1989; Elo 1992; Swenson et al. 1993; Abdalla1993; Govindasamy 2000; Khan et al., 1994; Barlow and Diop 1995; Ahmed and Mosley 1997; Regmi and Manandhar 1997; Govindasmy and Ramesh 1997; Sharma, Ranjan, Kumar, & Pandey, 2007; Negi, Sekher, & Ganguly,
2010; Mondal, 1997; Nayak & Babu, 2001; Mumbare & Rege, 2011; Deshpande, 2011; Lahana, Pappa, & Niakas, 2011; Rejoice & Ravishankar, 2011; Adhikari et al 2016; Gupta et al 2016; Kushwah, Mehnaz, Ansari, & Khalil, 2016; Hamid et al., 2017). The present study failed to show any association of utilization of RCH services with socio-economic status as the population was a homogenous group with regard to SES status.

Education and women status are related to utilization of RCH services as observed by (Caldwell, 1979; Caldwell, Reddy, & Caldwell, 1983; Mosley & Chen, 1984; Raghupathy, 1996; Govindasamy & Ramesh, 1997; Sahu & Kushwah, 2007; Merged, Katti, Mallapur, & Wantamutte, 2009; Sen, 2009; Chandrakar et al., 2009; Ahmed et al, 2010; Roy, Saha, & Abbad, 2010 Amin, Shah, & Becker, 2010; Shah & Belanger, 2011; Rejoice & Ravishankar, 2011; Jat, Nawi, & Sebastian, 2011; Digambar, Chimankar, & Sahoo, 2011; Mumbare & Rege, 2011; Goland, Hoa, & Målqvist, 2012; Onasoga, Afolayan, & Oladimeij, 2012; Singh & Patra, 2013; Javali, Wantamutte, & Mallapur, 2014; Dey & Mishra 2014; Adhikari et al 2016; Kushwah, Mehnaz, Ansari, & Khalil, 2016; Hamid et al, 2017). Present study did not show any significant difference of utilization of health services with education but on other hand showed significant difference between utilization of health services and status of women.

Ethnicity, socio-cultural beliefs and place of residence are the factors which influence the utilization of maternal health care services (Ratherford & Mishra, 1997; Rao, Mishra, & Ratherford, 1998; Pandey & Abbad, 2002; Digambar, Chimankar, & Sahoo, 2011; Lahana, Pappa, & Niakas, 2011; Rejoice & Ravishankar, 2011; Goland., Hoa, & Målqvist, 2012). Bhunjia population has shown significant result of utilization of RCH with home delivery, ANC services, distance of health care and approachable road.

Lack of awareness also was observed to be associated with utilization of health services (Pandey & Abbad, 2002; Sharma, 2004; Chandrakar et al, 2009; Deshpande, 2011; Kumar, Goel, & Verma, 2015; Mishra, Kusuma & Babu, 2015; Kushwah, Mehnaz, Ansari, & Khalil, 2016). The present study also showed that lack of awareness might be a possible reason for low utilization of health services.

The present study also showed that lack of transport facility and unavailability of health facility was associated with utilization of RCH services as shown by (Navaneetham & Dharmalingam, 2000; Sharma 2004; More, et al., 2009; Mishra, Kusuma, & Babu, 2015; and Gupta et. al. 2016).
Gupta et al. (2014) reported 14.6 percent prevalence of pneumonia among children less than five years of age in slum of Bankura of West Bengal. Prajapati, Talsaniya and Sonaliya (2011) also reported 22 percent prevalence of pneumonia from Ahmedabad. Deb, (1998) reported high prevalence of pneumonia from West Tripura. Chopra and Makol, (2004) reported 49.5 percent suffered from cough and cold among children of Bastar district of Chhattisgarh. The present study showed 56.99 percent children suffered from cough and cold during last 12 months of survey.

UNICEF (2013-14) reported very high (58%) prevalence of diarrhoea in India, NFHS-reported 67.9 percent children with diarrhoea received ORS in Chhattisgarh. Chopra and Makol (2004) also reported 39.0 percent children suffered from diarrhoea among the tribes of Bastar district. Kurrey (2017) reported 6 percent prevalence of diarrhoea among children of Birhor tribe of Chhattisgarh. Shrivastava and Kanungo (2014) identified 17 plants use for the treatment of diarrhoea among Oraon tribe of Sarguja district of Chhattisgarh. The present study showed 22.77 percent of Bhunjia children suffered from diarrhoea during 12 months prior of survey. The case studies revealed that some local plants were also used for the treatment of diarrhoea.

Knowledge about any method of contraceptive was found to be very high among tribal and non tribal women. Most popular method of contraceptive was female sterilization and very less uses of other modern methods of contraceptive (Basu, Kapoor, & Basu, 2004; Jain, 2006; Sen, 2009; Verma, 2012; Prusty, 2014; Bhandhi, Bhawnani, Verma, & Soni, 2014; and Bais, 2014). The present study showed knowledge regarding contraceptive methods was high and traditional method was popular contraceptive.

In order to reduce MMR, intrapartum care strategy has to be developed and focused on promoting institutional deliveries. There is a strong need to upgrade the obstetric care skills of ANM’s and mitanin of the area under study. There should be compulsory reporting of maternal deaths.

(i). The present study showed a positive correlation of Hb level with age at marriage and consumption of IFA tablet. This indicates that if the age at marriage is less than 18 years then the Hb level decreases and higher the age at marriage higher will be the Hb level. The present study also showed negative correlation with number of conception i.e. as the numbers of conception is higher the level of Hb decreases. The most important predictor
was SLI, age at marriage, number of conception and consumption of IFA tablet as revealed by $\beta$ coefficient value in multiple regression analysis.

(ii). Correlation matrix observed between BMI and Hb level also showed positive correlation (0.01 level) which indicates that higher BMI individuals showed higher Hb level and lower BMI individuals showed lower Hb level. The association between BMI and number of family member showed negative correlation (0.05 level) which indicates that higher the number of family members lower the BMI. The results obtained by $\beta$ value of multiple regression analysis showed that Hb level is the most predicted variable for BMI.

(iii). Correlation matrix of ANC use showed positive correlation (0.05 level) with availability of health centre in village increased the level of utilization of ANC checkups. The present study also showed that presence of active mitanin and approachable road are positively correlated (0.01 level) with utilization of ANC checkups. It was very surprising to that as the distance of district head quarter increased the level of utilization of ANC checkups also increased. This might be due to the cultural barriers. It has been observed that the Chinda Bhunjia reside at distant place from the district head quarter as compared to Choukhutia Bhunjias but the Choukhutia Bhunjia are more rigid and their social barriers restricted their use of ANC services. Women autonomy and decision making was also observed to be higher among Chinda Bhunjias. $\beta$-coefficient value of multiple regression analysis also showed approachable road and distance from village as the most important predictor variable.

(iv). Place of delivery: the present study showed a positive correlation (0.01 level) between institutional delivery and active mitanin, sub caste, distance of village from district head quarter and availability of Mahtari express. This indicates that institutional delivery is higher with the presence of active mitanin, distance of district head quarter and availability of mahtari express. The association of institutional delivery showed a negative correlation with approachable road i.e. inspite of having approachable road they preferred home delivery which might be due to the rigidity of cultural norms among the Choukhutia Bhunjias which prohibited institutional delivery. The most important predictor variable was observed to be availability of mahtari express, distance from
district head quarter and sub caste (Chinda Bhunjia) with respect to β-coefficient value of multiple regression analysis.

(v). Immunization status on the other hand has shown positive correlation with approachable road which shows that with good approachable roads the immunization status has been found to be high and with less approachable road the level of immunization status was low. Approachable road has been also proved to be an important predictor variable for immunization.

4.7 Conclusion

Maternal health was low among pregnant and lactating Bhunjia women. Quality of health services provided by health worker was poor. Cultural believes, availability and accessibility of health services was associated with utilization of reproductive child health.

4.8 Recommendations

- Reporting of the maternal deaths occurring in the area under study should be made compulsory.
- Intrapartum care strategy has to be developed and focused on promoting institutional deliveries.
- There is a strong need to upgrade the obstetric care skills of ANM’s and mitanin of the area under study.
- Improvement in quality of health-care services should be considered.

- Effective measures should be taken to make the mothers aware about the facilities through information, education and communication activities involving mitanin, anganwadi workers and ANM/MPHW.

- The low level of Hb could be avoided with the help of good antenatal, intranatal and post natal care and improvement in health care delivery system. The fact should be brought to light for planning appropriate nutritional interventions for the upliftment of health status of Bhunjia women of Chhattisgarh.
It is also suggested that local medicine man who are already working in that area, but regarded as illegal by the government, should be identified, trained and recruited as MPHW in the same area, so that they can gain their confidence level in order to avail the existing services.

Forest department should undertake a joint forest management programme with assistance of local people to grow vegetation (local herbs) which might be helpful to uplift the nutritional and anaemic status of Bhunjia women.

Maternal health and child health is a burning topic as after these many years of development we still lag behind in this field. Therefore it is required to explore the condition among other tribes of India. The present study suggests that more comprehensive intervention studies on utilization of RCH programmes should be conducted for improving the health status of tribal women of India.