INTRODUCTION

Health is a common theme in most cultures. In fact, all communities have their concept of health as part of their culture. Contemporary development in social sciences revealed that health is not only a biomedical phenomenon, but also one which is influenced by social, psychological, cultural, economic and political factors of the people concerned. The widely accepted definition of health is that given by the World Health Organization in the preamble to its constitution, which is as follows “Health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity”.

Social environment influences the health problems and health practices of any community. There are some universal perceptions of health and disease where all the human societies possess some common considerations and at the same time there are some social perceptions unique to a particular society. Primitive concept of health, disease and treatment is the integral component of overall environment of tribal community. The usual theory of disease in tribal society is that it is caused by breach of some taboo or by hostile spirits, the ghosts or the dead. Sickness is the routine punishment for every crime meted out by them by the spirits.
Very little work has been done on the health status of tribes in India. Most of the tribes inhabit in the forest regions, in close contact with nature. These tribes have been living in this state for centuries. They get hardly any modern health care facilities. It is also a fact that these people have a history of perfect healthy survival. Both disease and cure came from the environment in which they live. The tribes are homogeneous, culturally firm, have developed strong magico-religious health care system and they wish to survive and live on their own style, wherein common beliefs, customs and practices connected with the health and disease have been found to be intimately connected with the treatment of the disease. It is necessary for health functionaries not only to have knowledge about the culture and society of tribal people and the socio-cultural dimensions of their health and family welfare systems, but to examine constraints for the acceptance of modern health care facilities. The inadequate nature of facilities in many tribal areas, lack of respect for indigenous culture, lack of attention given to patients are the main factors responsible for the non-acceptance and distrust of tribal people towards modern medicine. Anthropological, sociological studies covering different facets of the society are urgently needed to understand some of the real health issues prevailing among the tribal populations. The wide spread poverty, illiteracy, mal nutrition, non-availability of safe drinking water and unhygienic living conditions and poor maternal and child health services have been reported
in several studies as the possible contributing factors for dismal health conditions prevailing among the tribal communities in India.

Large majority of the tribal population in India still depend on herbal medicine and indigenous method of healing practices to cure various diseases they get. The interior tribals are not access to modern health care facilities due to geographical isolation. In tribal areas, most of the primary health care centers are located at Mandal head quarters or road points. The interior tribals have to walk miles together to avail such facility in sick condition due to lack of proper transportation and approachable roads. Hence, they forcefully confined to indigenous methods of healing practices. For the cure of various kinds of diseases they approach the local medicine men or traditional healer and also use the home remedies. The tribals have their own knowledge about the medicinal plants which are available in forest environment where they inhabit centuries together.

Traditional medicine has a long history. It is the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures. Whether explicable or not, it has been used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses.
Health care services require the use of not only modern medicine approach but also culturally appropriate care. Any health care service model that excludes cultural features is rejected by the society. Recognizing the traditional attitudes and behaviours of the community in relation to health is an important factor in improving the effectiveness of health.

In spite of the continued efforts paid by the Central and State governments some sections of the people, particularly the tribals are not fully aware about the health services which were provided to them. The other important aspects which were keeping them away from these services are illiteracy, poverty and inaccessible health facilities. The traditional beliefs and misconceptions about modern medicine also play a major role in keeping them in dark.

Saving the millions of Women, new born and children who die each year from preventable causes presents a formidable challenge in developing countries. Although the interventions that could save their lives are known, they are often not available to those most in need. Creating a maternal-child continuum of care can result in considerable progress toward achieving the MDGS. The environment plays a great role in a child’s growth and health. Micro environmental conditions such as poor housing and sanitation have been implicated in the synergism of
malnutrition and infection (Mata, 1979). The influence of macro-environment, including social, economic and cultural variables on child rearing practices is well established. In addition to these, various maternal attributes have been shown to be the most important cause of Malnutrition (Cravioto et.al., 1974 and Pollitt, 1975). It has been reported that growth faltering begins among Indian children around 6 months of age and that the combined effect of environmental factors and maternal attributes is primarily responsible for the poor growth of children apart from morbidity levels.

Maternal and child care are an important aspect of health care practices which are largely neglected among the tribal groups. The whole body of data on traditional medical beliefs and practices which has been gathered by Anthropologists in terms of cultural values and social beliefs, and their knowledge about the dynamics of social stability and change provide useful key to many of the problems encountered in public health programmes.

On the basis of the studies of cultural values and social norms, the Anthropologists were in a position to explain to health personnel and administrators that how these traditional beliefs and practices conflicted with western medical assumptions; how socio-cultural factors influenced health, diseases; how cultural factors took care of health and cured illness;
and how health and diseases are just aspects of total cultural patterns, which change in the company of broader and more comprehensive socio-cultural change.

Problems of health and illness are inextricably related to physical, behavioural and environmental factors. Each of these factors contributes to the kinds of problems encountered in medical management. The growing recognition of the value of the behavioral sciences to medicine and public health during the past few years has brought about diversified studies along the socio-cultural and psychological aspects of community health. How these forces are related to the acceptance of health measures being introduced from time to time under various programmes of Government of India and State Government will also be useful in effectively improving the health status of tribal people.

Government of India has implemented various public health programmes through family welfare programme for providing free and qualitative health care services to its people both in rural and urban areas. Maternal and child health has remained an integral part of the Family Welfare Programme of India since the time of the First and Second Five Year Plans (1951-56 and 1956-61) when the government of India took steps to strengthen maternal and child health services. As part of the Millennium Needs Programme initiated during the Fifth Five Year Plan
(1974-79), maternal health, child health and nutrition services were integrated with family planning.

During the 9\textsuperscript{th} plan, the RCH programme, accordingly, integrates all the related programmes of the 8\textsuperscript{th} plan. The concept of RCH is provide to the beneficiaries need based, client centered, demand driven, high quality and integrated RCH services. Reproductive health includes the age at marriage, reproductive performance and fertility regulation, care during prenatal, natal and postnatal period, breast feeding and infant care practices.

If viewed holistically, Reproductive and Child Health (RCH) is a crucial development issue. Its importance as a development issue has been elaborated way back in Cario International Conference on Population and Development in 1994. With over half a million women dying every year during pregnancy and child birth from largely preventable causes, international concerns need to take urgent action to reverse the global trend of deteriorating levels of reproductive health, as these have obvious repercussion on the health of surviving children. When the International Conference on Population and Development in Cario recommended that the particular countries should implement unified programmes for Reproductive and Child Health (RCH). The Reproductive and child health (RCH) approach means a holistic and integrated approach of
contraception issues, maternal health issues. RCH has been defined as ‘people have the ability to reduce and regulate their fertility, women are able to go through pregnancies and child delivery safely, the outcome of pregnancies is successful in terms of survival and wellbeing and couples are able to have sexual relationship free of fear of pregnancies and of contacting diseases (Basic guide to RCH programme, 2007).

Appreciable importance is being given in recent times to the study of maternal and child health care practices in different settings in developing and developed nations. Breast feeding is important, particularly in developing countries, because of its relationship with child health and birth spacing. It is well established that mother’s milk is the best food for the new born and it has a significant impact on reducing morbidity and mortality among infants. Further, breast feeding also plays an equally important role in controlling fertility in developing countries. Post-partum infecundity associated with the practices of breast feeding is a major determinant of spacing between births, which result in a reduction in overall fertility levels. However recently, it has been observed that, as some developing countries modernize, the breast feeding practice is declining. This phenomenon is a matter of concern as it could cause considerable adverse consequences not only for child survival and
development, but also for fertility control programs, particularly in less developed countries where use of contraception is still not common.

In India, although breast feeding is still almost universal, particularly in rural and tribal areas, some of the traditional beliefs and practices are leading to increase the morbidity and mortality levels of infants and children.

Tribal groups have developed strong magico-religious health care systems and they wish to survive and live in their own style. They live and interact within their own homogenous and culturally firm system wherein common beliefs, customs and practices connected with health and disease has been found to be intimately connected with the treatment of disease. It is necessary for health functionaries not only to have knowledge about the culture and society of tribal people and the socio-cultural dimensions of their health and family welfare systems, but to examine constraints for the acceptance of modern health care facilities. The inadequate nature of facilities in many tribal areas, lack of respect for indigenous culture, lack of attention given to patients are the main factors responsible for the non-acceptance and distrust of tribal people towards modern medicine. Anthropological, sociological studies covering different facets of the society are urgently needed to understand some of the real health issues prevailing among the tribal populations.
The health status of the tribals in lower and inferior compared to that of the general population. Several studies have suggested higher infant mortality rate, higher fertility rate and greater malnourishment. It has been seen during the last three decades that the increase in the per capita income was associated with improved health indicators and there were also some evidences that economic decline had some association with the decline in health indicators. On almost all the indices of health, the status of tribals was poor. The report of the working group on Development and Welfare of ST during Eight Five Year Plan (GOI, 1989) indicated that diseases like goiter, yaws, malaria and guinea-warm were endemic in tribal pockets.

The health nutrition problems of the vast tribal population of India are as varied as the tribal groups themselves who present a bewildering diversity and variety in their socio-economic, socio-cultural and ecological settings. The nutritional problems of different tribal communities located at various stages of development are full of obscurities and very little scientific information on dietary habits and nutritional status are available due to lack of systematic and comprehensive research investigations. Malnutrition is common and has greatly affected the general physique of the tribals. Good nutrition is required throughout life and is vital to women in terms of their health and work. Nutritional anaemia is a major problem
for women in India and more so in the rural and tribal belt. In developing countries it is estimated that at least half of non pregnant and two thirds of the pregnant women are anaemic (U.N.1984). This is particularly serious in view of the fact that both rural and tribal women have heavy work load and anaemia has a profound effect on psychological and physical health.

**Relevance of the study**

The present study will expected to bring out the various levels of health care practices in relation to social environment among Savara tribal community in Srikakulam district of Andhra Pradesh. It is primarily intended to study the tribal women about their attitudes and practices at various stages of maternal and child health care practices along with indigenous health practices and also their perceptions towards family planning etc. In the study area, we have found Savara as a major tribe. The Savaras are the dominating tribe of the study area. The study will concentrate on this tribe. They are also not practicing modern health care. The changing trend in health care practices of the tribals in the study area is mixed in nature. They do not entirely depend on traditional medicine as well as on modern medicine. In this study state briefly the primitive concept of disease and treatment among the Savaras to have a clear perspective of the changing trend of health care practices of the tribals and factors responsible for these changes.
Due to the poor perception levels of the health care providers towards the Reproductive and child health (RCH) programme and also due to the lack of proper motivation and other administrative problems they are unable to scatter the services to the needy tribals and also failed to motivate the tribal people towards modern health care services because of the deep rooted traditional belief systems of the people. In the present study the awareness towards RCH programme and the gaps in delivering the services are also aimed to identify.
REVIEW OF LITERATURE

Maternal health received greater attention after the safe motherhood initiative was launched at an international conference held in Nairobi in 1987 (Mahler, 1987). Pregnancy constitutes a high risk of morbidity and mortality due to associated physiological stress. This is more severe in developing countries where the risk of dying as a result of pregnancy is 10 to 20 times higher than that in the developed countries. There are a few studies on the specific problems of women specially maternal health. Most of the available studies are hospital based. However hospital based studies are not reliable because relatively a few women in developing countries deliver their infants in hospitals. These results thus are not representative of the population. Moreover, hospital based studies shed light only on the acute complications of pregnancy. Long-term consequences of pregnancy are not considered in hospital-based studies and, indeed are missing from almost all research. Very few longitudinal studies are available on the pattern of general morbidity amongst the rural pregnant women.

I. Magico-religious practices

The spiritual aspects of health and sickness has been, an integral component of ethno-medicinal practice for centuries, a dimension ignored
by bio-medicine practitioners, because of the difficulties involved in validating its success using scientific principles and experiments. The ethno-medical system (Primitive Medicinal System or Traditional Medicine) has two universal categories of disease. Natural illness explains illness in impersonal systemic terms. Thus, disease is thought to stem from natural forces or conditions such as cold, heat and possible by an imbalance in the basic body elements (Foster, 1976), unnatural illnesses are caused by two major types of supernatural forces: occult causes which are the result of evil spirits or human agents using sorcery and spiritual causes which are the results of penalties incurred for sins, breaking taboos or caused by God (Foster, 1976).

However, despite the lack of scientific validation of the usefulness of the spiritual component in ethno-medicine, some institutions in the USA are incorporating it into their services (O Connor, 1995). Similarly, spiritual practitioners working in the Puerto Rican and Balican hospitals have indicated positive results, based on the fact that patients spent reduced time in these institutions (Krippner et al., 1993). Today, ethno-medical practices and beliefs are part of a total belief system that transcends class, ethnicity and religious belief in such a manner that the terms “fold or traditional” can be used to describe practices that are truly universal (Lowe et.al, 2000). In North America, Europe and the Caribbean, the return to
the traditional (ethno-medicinal) aspects of health care is not restricted to
the poor, but extends to all social classes (Lowe et al. 2000).

In Borno state it is common among the Muslim ethnic groups for
religious rituals to be performed in order to assist a woman in labour.
Mallams and their grown up students (Almarjirais) will come and read the
Holy Quran to the woman for protection against all evils relating to
pregnancy and childbirth. And after that, a drink of Quranic verses
particularly Aya-tul Kursiyu are written on plate and washed and given to
her to drink for safe delivery (Waziri 2004 and El-Nafaty, 1998). Adamu
(2001) also revealed similar rituals among the Hausa people of Kano state
in Northern Nigeria. Consequently, women tend to remain in the house
instead of going to the health facilities for delivery because of the
psychological satisfaction and assurance of nothing wrong will happenened
derived from the rituals.

II. Ethno-Medicine Practices

The Rigveda, the oldest document of human knowledge mentions
the use of medicinal plants in the treatment of man and animals. Ayurveda
gives the account of actual beginning of the ancient medical science of
India, which according to western scholars was written between 2500 to
600 B.C. Charaka and Susruta wrote around 1000 B.C. Charaka
concentrates more on medicine while *Susruta* deals with surgery in details along with therapeutics.

Ethno-medicine refers to “those beliefs and practices relating to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual frame work of modern medicine” (Hughes, 1968, cited from Misra et al, 2003). Various institutions are now concerned with the traditional health care system and means of traditional treatment.

The tribal people are the real custodians of the medicinal plants. Out of 45,000 species of wild plants, 7500 species are used for medicinal purposes. The World Health Organization (WHO) has been promoting a movement for ‘Saving plants for saving lives’. This is because of the growing understanding of the pivotal role medicinal plants play in providing herbal remedies to health maladies.

Over 550 tribal communities are covered under 227 ethnic groups residing in about 5000 villages of India in different forests and vegetation types (Sikarwar 2002).

India is the home of several important traditional system of health care like Ayurveda. This system depends heavily on herbal products. Several millions of Indian households have been using through the ages
nearly 8000 species of medicinal plants for their health care needs. Over one and half million traditional healers use a wide range of medicinal plants for treating ailments of both humans and livestock across the length and breadth of the country. Over 800 medicinal plant species are currently in use by the Indian herbal industry.

In recent times with the increased knowledge of life and culture of the tribal communities, the social scientists are taking interest in ethno-medicinal studies. Many works have been reported especially from among the rural and tribal communities of India (Choudhary, 1986; Bhadra and Tirkey, 1997; Sharma, 1997). Ray and Sharma (2005) have given a description of ethno-medicinal beliefs and practices prevalent among the Savaras, a tribal community of Andhra Pradesh.

Kumari (2006) gave an account on the concept of illness and disease and the application of folk medicine among the Saureas of Jharkhand. However, ethno-medicinal studies are relatively less in Northeast India. Guha (1986) has reported from among the Boro-Kachari tribe of Assam. A glimpse of indigenous health practices among the plain tribes of Assam is given by Sharma (1999). The socio-economic condition of some of the tribes of Arunachal Pradesh and their problems of health and indigenous methods of treatment has been reported by Choudhary

Ethno medicine a sub-division of medical anthropology refers to those beliefs and practices relating to disease which are the products and indigenous cultural development and are not explicitly derived from the conceptual frame work of modern medicine (Hughes, 1968). Etymologically speaking, the term refers to the medicines that are traditionally associated with specific ethnic groups. Thus, it can also be conceived of as Folk medicine, traditional medicine or indigenous medicine etc (McBang and Choudhari, 2003).

In anthropology discipline Rivers (1924) who first developed the idea that the indigenous medical systems are social institutions to be studied in the same way as social institutions in general, and that indigenous medical practices are rational actions when viewed in the light of prevailing causation beliefs. Anthropologists, working in the health fields in recent times have, in fact recaptured and given a formal name ‘ethno medicine’ to
the study of traditional, non-western medicine, and made it a part of their specialty.

As medical anthropology has developed, especially in the broad areas of international public health and Tran’s cultural psychiatry, the practical as well as the theoretical importance of knowledge about non-western medical systems has become apparent, this recognition has sparked renewed interest in ethno-medical research, elevating it to major importance in medical anthropology.

Ethno medicine refers to the study of traditional medical practice which is concerned with the cultural interpretation of health, diseases and illness and also addresses the health care-seeking process and healing practices (Krippners, 2003). The practices of ethno-medicine are a complex multi-disciplinary system constituting the use of plants, spirituality and the natural environment and has been the sources of healing for people millennia (Lowe and Payne, 2000).

Research interest and activities in the area of ethno-medicine have increased tremendously in the last decade. Since the inception of the discipline, scientific research in ethno-medicine has made important contribution to the understanding of traditional subsistence medical knowledge and practice. The explosion of the ethno-medicine literature has been stimulated by an increased awareness of the consequences of the forced displacement and or acculturation of indigenous people, the
recognition of indigenous health concepts as a means of maintaining ethnic identities, the search for new medical treatments and technologies (Krippner, 2003). The components of ethno-medicine have long been ignored by many bio-medical partitions for various reasons. For example, the chemical composition, dosages and toxicity of the plants in ethno-medicine are not clearly defined (Lowe and Payne, 2000). However, it is interesting to note that the ethno-medicinal uses of plants is one of the most successful criteria used by the pharmaceutical industry in finding new therapeutic agents for the various fields of bio-medicine (Cox and Balick, 1994) some outstanding medicinal drugs which have been developed from the ethno-medicinal uses of plants include vinblastine and vincristine from catharanthus roseus (the periwinkle) used for treating acute lymphoma, acute leukemia’s etc, reserpine from Rauwolfia serpentine (Indian snake root) used for treating hypertension, aspirin from Salix purpurea (willow) used for treating inflammation, pain and thrombosis and quinine from cinchona pubescens (cinchona) used for treating Malaria.

Today about 80% of the world population predominantly on plants and plant extracts for healthcare (Setzer et al., 2006). In addition, of the top 150 proprietary drugs used in the United States of America (USA), 57% contain at least one major active compound currently or once derived from plants (Grifo and Rosenthal, 16997).
The spiritual aspects of health and sickness has been, an integral component of ethno-medicinal practice for centuries, a dimension ignored by bio-medicine practitioners, because of the difficulties involved in validating its success using scientific principles and experiments. The ethno-medical system (Primitive Medicinal System or Traditional Medicine) has two universal categories of disease. Natural illness explains illness in impersonal systemic terms. Thus, disease is thought to stem from natural forces or conditions such as cold, heat and possible by an imbalance in the basic body elements (Foster, 1976), unnatural illnesses are caused by two major types of supernatural forces: occult causes which are the result of evil spirits or human agents using sorcery and spiritual causes which are the results of penalties incurred for sins, breaking taboos or caused by God (Foster, 1976).

However, despite the lack of scientific validation of the usefulness of the spiritual component in ethno-medicine, some institutions in the USA are incorporating it into their services (O Connor, 1995). Similarly, spiritual practitioners working in the Puerto Rican and Balican hospitals have indicated positive results, based on the fact that patients spent reduced time in these institutions (Krippner and Welch, 1992; Thong et al., 1993). Today, ethno-medical practices and beliefs are part of a total belief system that transcends class, ethnicity and religious belief in such a manner that the terms “fold or traditional” can be used to describe practices that are
truly universal (Lowe et.al, 2000). In North America, Europe and the Caribbean, the return to the traditional (ethno-medicinal) aspects of healthcare is not restricted to the poor, but extends to all social classes (Lowe et, al. 2000).

According to data released by the World Health Organization (WHO), ethno-medicine has maintained its popularity in all regions industrialized countries (WHO, 2008). For example, in China traditional herbal preparation account is for 30%-50% of total medicinal consumption. In Ghana, Mali, Nigeria and Zambia, the first line treatment for 60% of children with malaria is the use of herbal medicine. In San Francisco, London and South Africa, 70% of people living with HIV/AIDS use traditional medicine. Today annual global market for herbal medicine stands at over US$60 billion (WHO, 2003). Western trained physicians should not ignore the impact of ethno-medicine on their patients.

Globally, about 85% of the traditional medicines used for primary healthcare are derived from plants. Herbal drugs obtained from plants are believed to be much safer; this has been proved in the treatment of various ailments (Mitalaya et al., 2003). Traditional medicine and ethno botanical information play an important role in scientific research, particularly when the literature and field work data have been properly evaluated (Awadh, et al., 2004).

III. Maternal and child health care practices

ANTENATAL CARE (ANC)

The studies regarding reproductive and child health components have been surveyed by various researchers on different communities in India and abroad. Safe motherhood interventions by the health care delivery system have been examined in various settings and the findings are reviewed as below.

According to Mai do (2008) nearly half of the rural Vietnam pregnant women received the first ANC (Antenatal care) visit during the first trimester of their pregnancy and nearly a quarter of them had their first ANC visit during the second trimester, while a few waited until the last
trimester to initiate antenatal care. Suman and Asari (2001) have observed that 58.6% tribals of Tamilnadu have received antenatal care and 87.8% women have utilized the immunization services provided by the PHC (primary health center). About 62 percentage of households of Muthalamada village, Kerala in both Scheduled Caste and Scheduled Tribes had regular antenatal checkups by doctors. 30 percentage of deprived sections did not go for any specific antenatal care while 37 percentage among non deprived consulted doctor only during illnesses (Padmanabhan, et.al., 2004). About 70 percent of tribal pregnant women of Rajasthan did not receive antenatal care (Gandhi Manav Kalyan Society, 2007). Most discouraging situation was found among Khairwar women of Madhya Pradesh (Roy, et.al. 2010), they do not feel any necessity for antenatal care. Nobody is consulted or contacted during pregnancy. They do not avail the PHC services due to misconception. Relatively a better condition was observed among the tribal women, where 44 percent of them received antenatal care services (Ravindra Sharma, 2010).

Mothers in rural areas of Andhra Pradesh not provided with antenatal care (Nagdeve and Bharati, 2003). In another study by Satyashekar, et.al., (2007) the median number of antenatal care visits in the Andhra Pradesh has been 5.8 visits (5.0 in rural and 6.0 in urban
areas). The timing of the first ANC check-up is important for health of mothers and outcome of pregnancy. Mallikarjuna Rao (2008) indicated that about 87.0% of the women were registered for antenatal check up either by Auxiliary Nurse Midwife (65.0%) or through anganwadi worker (15.2%).

Save the Children (2010) revealed that the tribal women of FATA belt area, the border between Pakistan and Afghanistan reported that 40-50 percent have not received the Tetanus Toxoid (TT) vaccination. Overall, 69.0% of mothers had protective tetanus antibody titers at the time of delivery. The rates of protection for mothers who had received no vaccination, one TT dose, or two TT doses during pregnancy were 46.4, 93.5, and 95.6%, respectively. Vaccinating every pregnant woman with at least one dose of TT would be an affordable and effective way to protect against neonatal tetanus, and would be a step toward eliminating the deaths that continue to occur due to this preventable disease in Turkey (Maral, et.al., 2001). The study in Bangladesh represents that 88 percent urban mothers and 84 percent rural mothers receive tetanus toxoid injection during their pregnancy period (Rahman, 2009).

Providing the TT injection is one of the common components of antenatal check-ups in the tribal blocks of Meghalaya (Deb, 2008), where 77 percent have received the TT injections. Majority of the women who received TT injection twice were from Mawplang (94.5 percent) and the
least number of women for receiving this injection were from Pynursla (76 percent). In East Khasi hills 69.9 percent women received TT injection only once. Similarly, about 67 percent urban slum of Greater Mumbai received two or more T.T. injections (Vijay Sarode, 2010). Savara and Jatapu women of Srikakulam district were provided with 2 TT injections during the pregnancy period are 93.8% and 86.3, respectively. Majority (55.0%) of the women have provided with 1st dose of TT injection during 5th month and the subsequent does mostly (52.1%) given in 7th month as reported by Lakshmi (2011).

The World Health Organization estimates that 58% of pregnant women in developing countries are anemic. Christiana, et.al., (2009) revealed that iron and folic acid (IFA) supplementation and tetanus toxoid vaccination had a protective effect against death during the entire neonatal period (i.e. within the first 30 days of life). Women in Atlanta who receive daily antenatal iron supplementation are less likely to have iron deficiency and iron-deficiency anaemia at term as defined by current cut-off values (Pena-Rosas and Viteri, 2006). Antenatal anaemia results directly in maternal death due to the increased circulatory demands of pregnancy (Palllikadavath, et.al., 2004). The iron folic acid supplementation is very important during pregnancy since it is very effective in improving the
haemoglobin level which normally falls due to the expansion of blood volume and demand of the growing foetus (Agarwal, et.al. 2008).

About two-third Bhil tribal women of Madhya Pradesh (64 percent) also did not receive any IFA tablets or syrups as reported by Ravendra Sharma, (2010). Goswamy (2009) reported that 55.8% of Bhumija women of Orissa have consumed IFA supplementation. The percentage of women consuming IFA supplementation is relatively less due to insufficient supply of medicines reported by ANM. It is interesting to note that among the women who received antenatal check-up 88.1 percent of women consumed IFA tablets. Nearly 82.0 % of the Andhra Pradesh tribal women received iron and folic acid tablets while, only 35.0 % received stipulated number of tablets (90 -100) as reported by Mallikarjuna Rao (2008). The percentage supply of IFA tablets increased in both rural and urban areas in Andhra Pradesh, however, the urban-rural gap also increased during pregnancy time (Nagdeve and Bharati, 2003).

**ANTENATAL TESTS AND EXAMINATIONS:**

As per NICE guidelines in Bangladesh for a full schedule of assessments at each of the antenatal assessments and areas they should cover are: pelvic examination, breast examination, weight, urine, blood pressure, abdominal examination, ultrasound to determine gestational age, detect multiple pregnancies, and for **Down's syndrome** (NICE, 2008).
Although 73% of women in Rajasthan had contacts with health professionals during pregnancy, less than half underwent essential examinations, such as blood pressure and blood test for anaemia. Less than one-sixth of women received advice about danger-signs or place of delivery Iyengar, et.al., (2009). In particular, blood pressure, blood tests and urine tests were provided to less than 10% of Madhya Pradesh, Bihar and Uttar Pradesh women visited by health workers compared to 40% of those who visited a health facility. Those who both visited a health facility and were visited by a health worker had a higher rate of internal examination those who consulted in either setting alone (Saseendran, et.al., 2004).

**PREGNANCY COMPLICATIONS**

Each year, according to the WHO (2009), ill-health as a result of pregnancy is experienced (sometimes permanently) by more than 20 million women around the world. Furthermore, the "lives of eight million women are threatened, and more than 500,000 women are estimated to have died in 1995 as a result of causes related to pregnancy and childbirth". The problems are anaemia, back pain, carpal tunnel syndrome, constipation, braxton hicks contractions, oedema, regurgitation, heartburn, and nausea, haemorrhoids, pelvic girdle pain, postpartum depression, postpartum psychosis, round ligament pain, thromboembolic disorders,
increased urinary frequency, urinary tract infection, varicose veins, PUPPP (Pruritic Urticarial Papules and Plaques of Pregnancy).

The pregnancy-related health problems in India most commonly reported are excessive fatigue (48 percent) and swelling of the legs, body, or face (25 percent). Ten percent of mothers had convulsions that were not from fever and 9 percent reported night blindness. Only 4 percent had any vaginal bleeding. The reported prevalence of both kinds of vision problems, convulsions that were not from fever, and excessive fatigue is higher in rural than in urban areas. In contrast, swelling of the legs, body, or face is more prevalent in urban areas. Only 20 percent were told about prolonged labour as a sign of a pregnancy complication, and even fewer (15-17 percent) were told about convulsions and vaginal bleeding as signs of pregnancy complications. Urban women, more educated women, and women in households in the highest wealth quintile were better informed about each pregnancy complication. Overall, 41 percent of mothers were given advice on where to go if they experienced pregnancy complications. Women with at least 12 years of education and women in households in the highest wealth quintile were more likely than other women to get advice on where to go if they experienced pregnancy complications. Jain women were most likely to be informed about each pregnancy complication.
complication and about where to go if they experienced pregnancy complications (NFHS 3, 2005-06).

Among Andhra Pradesh tribes the most common health problems experienced by women during pregnancy period are anaemia (16%) and oedema (16%), excessive bleeding, breathlessness, blurring of vision, abdominal pain are some of the complications experienced by the pregnant women of Indore (Aggarwal, et.al., 2007). About 42 percent women in the Andhra Pradesh are found to be anaemic during pregnancy (Rama Padma, 2005). Anaemia (16.0%) and oedema (16.0%) were the main complications experienced during pregnancy among the tribal women of Andhra Pradesh. About 47.0% of women consulted private medical practitioner for treatment followed by PHC medical officer (26.0%), ANM (14.0%) and Taluk Hospital (11.0%). Only two percent of women with complications were referred by AWW to health personnel (Mallikarjuna Rao, 2008).

The most frequent health problems commonly faced by majority (75.2%) of Koya tribal pregnant women in West Godavari district of Andhra Pradesh are oedema of face and legs, fever, jaundice, frequent vomiting and nausea, high blood pressure, anaemia, malaria and morning sickness (Sambasiva Rao, et.al., 2011). In Andhra Pradesh, Madhya Pradesh and Orissa, women who did not seek care for complications experienced
during pregnancy cited lack of mobility and lack of resources as reasons while those who did not seek care for complications experienced in the postpartum stage cited lack of resources as the reason (Murthy and Barua, 2001).

**NATAL PERIOD**

Approximately 53 million women in the world give birth at home each year without the help or benefit of a skilled delivery attendant (Sibley & Sipe, 2003). These women often live in rural, isolated communities with little access to resources including a formal health care system and transportation. They often deliver their babies alone, with the help of a family member or with an untrained traditional birth attendant (TBA). Complications arising from pregnancy and childbirth are the leading cause of death and disability among reproductive age women in the developing world (Tinker, 2000). The WHO (2006a) advocates a skilled attendant for every delivery yet in developing countries with limited resources and a high number of home births this is a distant reality. Most rural western Kenya women (83%) delivered outside of a health facility. Of these, 80% delivered in their own house, 18% in the house of a TBA and 3% on their way to a health facility (Anna, et.al., 2006).

Further, that it was found 64% of the deliveries in slum areas of Islamabad were attended by trained personnel and the rest by untrained
dais. Since the health center does not have facilities for delivery, most of the women (59%) delivered at home (Ali, et.al., 2004). Seventy-seven percent of Cambodia women were delivered at home while only 23.2 percent were delivered at a health facility (IPSR, 2008). Recently, many studies conducted by Adams, et.al., (2005); Berry, (2006) and Chapman, (2006) revealed that majority of in Liberia women prefer to be attended in childbirth by indigenous healers who understand the community norms and customs. In Guatemala, (Berry, 2006 and Callister & Vega, 1996) found a strong desire among Guatemalan women to give birth at home surrounded by their families. The quality of their birth experience was highly influenced by where they gave birth. Most women preferred to remain in their villages and homes even when problems manifested during labor. Another qualitative study on childbirth beliefs and practices in Zambia (Mainbolwa, et.al., 2003) revealed that women who provided social support to laboring women lacked an understanding of the causes of obstetrical complications during childbirth and lacked knowledge of appropriate labor management. In addition they found indigenous knowledge and ways of knowing existed alongside modern medical care. Okafor (2000) in Nigeria found rural women hold a magico-religious perspective of childbirth and health care which collides with the biomedical system of care with its emphasis on risk assessment and modern scientific evidence. These beliefs contribute to the underutilization of prenatal and childbirth delivery services at the
hospitals and clinics. They also lead to delay in accessing services when a complication arises during pregnancy or birth.

Several anthropological studies in India have emphasized the importance of traditional beliefs surrounding child birth (Blanchet, 1984; Maloney, et.al., 1981; Aziz and Maloney, 1985). A cross sectional study was undertaken in three riverine and two non-riverine blocks of South 24 Parganas district, West Bengal to study the delivery practices and compare between two localities. Home deliveries were higher in the riverine blocks (95.07%) compared to non-riverine blocks (81.64%). 'Dai' conducted 58.36% and 90.62% of home deliveries in riverine and non-riverine blocks, respectively. Only 18.4% of the 'Dai' were trained (Sengupta, et.al., 2005).

Majority of the women in all the tribal groups of South India (Malayali, Irula, Muduga, Kurumba, Valmiki, Nooka Dora, Porja, Bagatha, Dhulia and Soliga) was found to have delivered their children at home as they follow their age old customs and traditions. The tribals were found to have had their delivery in the hospitals very rarely, only if complications arise. Majority of tribal women was found to have undergone delivery which was attended by the local women comprising of their neighbours and old people. The majority of the deliveries was seen by the relatives either it may be the mother, mother-in-law, grand mother or any relative.
Surprisingly, self delivery was also found in the tribes, where the women they themselves look after their delivery. This is found high among Irula and soliga (Naidu, 2002).


Home deliveries in different districts of Andhra Pradesh were reported by various researches as 61.48 % in rural areas of Guntur district (Pravin, and Keerti, 2010), 14.3% in Guntur and Krishna Districts (SERP, 2006), 7.7 % in urban slums of Visakhapatnam (Swamy, 2009), 34.5% in tribal areas of west Godavari district (Sambasiva, et.al., 2011), 85.0% in tribes of Andhra Pradesh (Mallikarjuna, 2008) and 71.7 % in tribal women of Visakhapatnam district and 6.4 % in slum women of Visakhapatnam (Sambasiva, 2008a). Institutional deliveries in different districts of Andhra Pradesh were reported as 10.37% in Guntur (Pravin, and Keerti, 2010). 43.2% in Adilabad (DLHS-3, 2007-08), 95.6% in Hyderabad(DLHS-3,
2007-08), 85.7% in Guntur and Krishna districts (SERP, 2006), 92.3% in urban slum of Visakhapatnam (Swamy, 2009), 65.5% in tribes of West Godavari district (Sambasiva, et.al., 2011), 93.6% in urban slums of Visakhapatnam district and 28.3% in tribal women of Visakhapatnam district (Sambasiva, 2008a).

**POSTNATAL PERIOD**

Postnatal is a word, *post* meaning "after" and *natalis* meaning "of birth", is the period beginning immediately after the *birth* of a child and extending for about six weeks. The health of a mother and her newborn child depends not only on the health care she receives during her pregnancy and delivery, but also on the care she and the infant receive during the first few weeks after delivery. Postnatal check-ups soon after the delivery are particularly important for births that take place in non-institutional settings. Recognizing the importance of postnatal check-ups, the Reproductive and Child Health Programme recommends three postnatal visits (Ministry of Health and Family Welfare, 1997).

In India, 61 and 35 percent of the women experienced delivery and post-delivery complications respectively. About 55 percent of the women sought treatment for pregnancy complications and 57 percent for post-delivery complications. In Bihar, Jharkhand, Himachal Pradesh, Sikkim, West Bengal, Tripura and Uttarakhand more than seventy percent of
women had delivery complications. In Assam, Uttarakhand, Sikkim, Uttar Pradesh, West Bengal, Jharkhand, Bihar, Jammu and Kashmir and Madhya Pradesh 40 to 57 percent of women suffered from one of the post-delivery complications. In the states where the incidence of pregnancy complications is high, the incidence of delivery and post-delivery complications are also high ((DLHS- 3, 2007-08). Majority (60 percent) of Todas and Kurumba women received postnatal care as reported by Suman and Asari (2001). During postnatal period, 41.8% believe traditional medicine as best for their health complications. Moreover the female health workers are not much bothered for postnatal complications in women (Goswamy, 2009). Further, Goswamy (2009) revealed that 32.7% Bhumija tribal women faced any one of the problems during six weeks after delivery. The postpartum complications reported by the women are lower abdominal pain (14.5%), severe headache (11.9%), high fever (10.6%), excessive bleeding (7.5%) and convulsions (2.9%).

**BREAST FEEDING**

Breast milk is made from nutrients in the mother’s bloodstream and bodily stores. Breast milk has just the right amount of fat, sugar, water, and protein that is needed for a baby’s growth and development. Because breastfeeding uses an average of 500 calories a day it helps the mother loses weight after giving birth. The composition of breast milk changes
depending on how long the baby nurses at each session, as well as on the age of the child (Health People, 2010 and Fisher, 2006).

According to WHO, exclusive breast feeding is the infants has received only breast milk from his/ her mother or a wet nurse, or expressed breast milk, and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines. Predominant breast feeding is the infant's predominant source of nourishment has been breast milk. However, the infant may also have received water and water based drinks (sweetened and flavoured water, teas, infusion, etc.) fruit juice, oral rehydration salts (ORS) solution, drop and syrup forms of vitamins, minerals and medicines and ritual fluids (in limited quantities). With the exception of fruit juice and sugar water, no food based fluid is allowed under the definition. Exclusive breast feeding and predominant breast feeding together constitute full breast feeding. Breast feeding is the child has received breast milk (directly from the breast or expressed). Breast feeding should be initiated within an hour of birth instead of waiting several hours as is often customary. Although there is a little milk at that time, it helps to establish feeding and a close mother-child relationship, known as “bonding”. The first milk which is called “colostrums” is the most suitable food for the baby during this early period because it contains a high concentration of protein and other nutrient the
body needs; it is also rich in anti-infective factors which protect the baby against respiratory infections and diarrhoeal diseases.

Initiation of breast milk:

A recent study from rural Ghana (Karen, et.al., 2006) (based on 10,947 breastfed singleton infants) has shown that initiation of breastfeeding within the first hour of birth could reduce neonatal mortality by 22%. Majority of mothers (74.8 percent) have realized the importance of colostrums and offering to their newborn; whereas 25.2 percent of mothers discarded the colostrums for one (47.2 percent) time or two times (30.5 percent) or three times (20.8 percent) before the initiation of first mothers milk. The main reasons for discarded the first milk (colostrums) given by the mothers were, they get advice from elders (42.2 percent), not pure (9.1 percent), not good for child (8.8 percent), stagnant (7.0 percent) and heavy (4.7 percent). Family restriction (38.8 percent), followed by social customs and religious beliefs prevalent in the community (25.2 percent), were mainly found to be responsible for the delay in initiating breast feeding (Kumar, et.al., 2006). The early breast milk of mother is squeezed out before the child is fed with breast milk (Durga Rao, et.al., 2006). Only 15.9 percent of mothers discarded colostrums. Family restrictions (30.2 percent), followed by social customs (25.6 percent) were the main reasons for discarding colostrums. Pre-lacteal feed was given in
40.0 percent cases; cow milk (64.8 percent) and honey (13.9 percent) came out to be the most common pre-lacteal feeds (Kumar, et.al., 2006). According to Goswamy (2009), Bhumija women of Orissa also breast fed their babies nearly 95%. Zodpey, et.al., (1996) in the study of breast feeding practices in a tribal community of Melghat region of Maharashtra State have observed that 69.69% of the children received their first breast feed after 24 hours of birth.

Breast feeding is nearly universal in Andhra Pradesh and eight out of ten (81 percent) of all infants born in the reference period preceding the survey had been breastfed. As compared to other socio-economic groups, higher percentage of Scheduled Caste and Scheduled Tribe community (85 percent) mothers breastfed their infants. Less than one-third mothers (28%) squeeze the first milk from the breast before they start breast feeding their newborns (31 percent in rural and 26 percent in urban areas). A substantial proportion (38 – 42 percent) of mothers squeeze out the first milk containing colostrums from the breast before breast feeding their infants in Srikakulam, Vizianagaram, Guntur, Nalgonda and Ranga Reddy districts (Satya Shekar, et.al., 2007). One-third (32 percent) of infants in the state were reported to be breastfed within one hour of birth. About 79.0% of the tribal mothers in Andhra Pradesh initiated breast feeding with
in 24 hours of delivery, while about 8.0% started breast feeding on 2nd day and rest did it only on third day or after. About 21% of the mothers stated that they discarded colostrums mainly on the elder’s advice (Mallikarjuna Rao, 2008).

**IMMUNIZATION OF THE INFANTS**

Vaccination against vaccine-preventable diseases is essential to reaching the Millennium Development Goal 4, on reducing under-five mortality by two thirds by 2015 in the world. Immunization is also a key strategy to ensure global health security and for responding to the threat of emerging infections such as pandemic influenza (WHO, 2009).

According to National EPI schedule, it was revealed that 58.2% of the children were fully vaccinated, 26.4% incompletely and 15.4% not vaccinated. The individual vaccine coverage was 84.6% for BCG, 68.1% for OPV and DPT, 58.2% for Measles. Considering the literacy, most of the respondents (78.3%) were illiterate and 21.7% had some basic education. None of the mother completed 5 doses of TT coverage. The individual TT coverage was found 78.3% for TT (1), 67.4% for TT (2), 17.4% for TT (3) and 1.1% for TT (4). This study observed that the vaccination status in the tribal children of Netrakona district, Bangladesh was satisfactory in relation to National coverage, but the vaccination status of the tribal mothers was not satisfactory in our national context (Rahman, et.al., 2007). The results
showed that there was low immunization coverage (46%) in the Butere-Mumias district, Kenya, below the expected levels of 90%. The drop out rate was noted to be high (40%) above the expected rate of below 10%. The determinants to this low level of immunization coverage include long distance to immunization sites (30%), low level of education of the mothers (80%), lack of knowledge on some childhood immunizable diseases like whooping cough (78%), tetanus (81%), and tuberculosis (64%). Other factors included shortage of staff at the health facilities, lack of health education at the health facilities, and mothers’ attitude towards immunizations among others (Rose and Mutuku, 2005)

Pandey & Tiwary (2001) reported that the Hill Korawas have no knowledge about immunization of the children. It was observed in their study that only 2.5% had received BCG, 2% received DPT and polio vaccines and only 1% was vaccinated against measles. Santhal and Mahali tribal Mothers in West Bengal were generally aware of the immunization programme for children administered by rural sub-centers or primary health centers. The study did not report a single case of mothers taking their children to local private doctors for vaccination. About 60% tribal women of both communities completed the immunization course for their children (Jashodhara and Anuradha, 2005). Only 5.26 percent of the Bheel, Gharasiya meena and Gamete children of Rajasthan received complete immunization even it was included after the consultant with
mother and based on their recall. And rest of the children received two or three type of immunization. The percentage of receiving immunization is very low as there are some myths exist (Gandhi Manav Kalyan Society, 2007).

For the Andhra Pradesh state as a whole, the coverage of full immunization was 82.7 percent which is on par with the PATH (2004) and IIHFW (2003) study of 71.4 percent. However, the NFHS-3 (2005-06) study recorded the coverage of full immunization as 46 percent (43 percent in rural and 57 percent in urban areas). The majority of mothers in tribal and rural areas of Visakhapatnam district were aware of vaccination of children, and usually the primary heath centres and their health workers were the source of vaccination. Vaccination cards were received by 79.2% of tribal and 71.3% of rural children. Some of the socio-demographic characters of mothers, such as habitat, caste and occupation, were associated with the reception of a vaccination card. The coverage of various vaccines was higher among the tribal than among the rural population. Of the eligible children aged above 9 months, 63.3% of tribal children and only 14.5% of rural children were fully vaccinated (three doses of diphtheria, pertussis and tetanus (DPT), four doses of oral polio vaccine, Bacille Calmette Guerin (BCG) and measles vaccine). The coverage of vaccination against measles and vitamin-A supplementation were very low among rural children (19.6% and 15.2%, respectively) when
compared to tribal children (69.2% and 64.2%, respectively). The qualitative data indicated that the community was not satisfied with regard to vaccination services, particularly in the rural area (Rajendra Varma and Kusuma, 2007). Mallikarjuna Rao (2008) has reported that among the AP tribes about 29% of children were either partially immunized or non-immunized. The respondents in the study reported that no body offers the services to them. This situation indicates the need for strengthening the immunization services among the tribal populations. Immunization status in tribal areas of Andhra Pradesh revealed that about 71.0% of children were fully immunized and only 36.0% and 8.0% of the children (1-3 years) were covered for vitamin A and National Nutritional Anaemia Prophylaxis programme respectively (Mallikarjuna Rao, 2008).

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FAMILY PLANNING

Improving the health status of the population will continue to be a major challenge for the Government, especially in the context of Millennium Development Goals (MDG) to reduce Infant and Maternal Mortality rates. Ever since the launching of Family Planning Programme in early fifties, the approaches in reducing population growth have taken variety of forms from target approach to the Target-free approach and inclusion of different health interventions over the years. A major emphasis has been laid on sterilization (vasectomy till mid-70s and later on female sterilization) covering higher parity older women without standard quality services. In the process, the young, higher fertile, lower parity woman were not covered by the programme. Over the years, even with below replacement level of fertility in Andhra Pradesh, Tamil Nadu and Kerala
states, female sterilization has been a dominant method same as compared to Uttar Pradesh and Bihar with TFR above four (Srinivasan, 2006).

Iran's government "declared that Islam favored families with only two children", as one historian put it. Iran's Health Ministry launched a nationwide campaign and introduced contraceptives- pills, condoms, IUDs, implants, tubal ligations, and vasectomies (Abrahamian, 2008; Sciolino, et.al., 2005). In India, during 2004-2005, the total number of family planning acceptors by different methods was as follows: sterilization (4.92 million), vasectomy (0.13 million), tubectomy (4.79 million), IUD insertion (6.25 million), condom users (18.28 million), oral pills users (7.6 million). However about 54% eligible couples are still unprotected against conception (GOI, 2007).

About 69% Santhal and 78% Mahali women of West Bengal preferred small families, 9% Santhals and 14% Mahalis preferred middle-sized families, and 22% Santhals and 8% Mahalis preferred large families. More Mahali women (about 54%) tended to accept family planning practices and preferred small-sized families more than Santhals (Jashodhara and Anuradha, 2005). In Saharia tribe of Madhya Pradesh, they are not aware to adopt any family planning contraceptive methods. Early age at marriage and family planning non-adoption usually influence
to perform frequent child birth (Biswas and Kapoor, 2003). About 69% Santhal and 78% Mahali women of West Bengal preferred small families, 9% Santhals and 14% Mahalis preferred middle-sized families, and 22% Santhals and 8% Mahalis preferred large families. More Mahali women (about 54%) tended to accept family planning practices and preferred small-sized families more than Santhals (Jashodhara and Anuradha, 2005).

The study revealed that 81.41 percent of the tribal women in Rajasthan are not using any method to avoid pregnancy which is very large number; it shows that the level of awareness is very low as well as there are not realizing the benefits of having three years of spacing. In additional to that use of traditional method is higher rather than modern method (Gandhi Manav Kalyan Society, 2007). Further the survey reported that female sterilization is highest, and vasectomy (male sterilization) is negligible. Around 77.12 percent of the eligible tribal couples in Rajasthan are not aware about the method, which is very high. Again 45.75 percent of people are afraid about going for sterilization. 22.22 women were accepted that their husband opposed for this and 15.03 eligible couples afraid about the side effects of the method. Half of the married women conceived between the ages of 15 to 18 years, thus it is quite clear that their health status would be alarming and in our intervention we should
give more focus to extend the age of first conception through promotion of birth spacing methods (Gandhi Manav Kalyan Society, 2007). Ramesh (2002) found that the use of contraception also varies substantially across the caste groups and contraceptive use is lowest among women belonging to SC/ST and highest among ‘other caste’ in Andhra Pradesh.

IV. Modern health care system

Traditional medicine, which is often preferred as a first source of health care is a cultural practice that is common among most of the Nigerian ethnic groups. For instance, according to Odebiyi (1989) among the rural Yoruba in Ile-Ife almost all sicknesses are first treated traditionally before modern medical treatment. In addition, the health status of most African societies can only be understood in the light of a given socio-cultural background of folk medicine and the environment of formal health system. Traditional Dominance traditional beliefs and practices highly enhance traditional healing systems. Although there is variation in the health practices within these systems in the respective societies, it tends to be the major source of health provider. In spite of the spread of formal health systems as well as the expansion of health services, one reason why women bypass the formal system in favour of folk medicine is seen in their negative attitude towards the former, which, in many cases, results from bad experiences as reported by many of them. The situation occurs especially in relation to childbirth, when it becomes so complicated that the traditional midwife cannot handle. The woman is therefore transferred to a
clinic, when, in most cases, it is too late. The resulting death/complications are consequently associated with the service providers at the clinic, hence the negative attitude towards it. In addition, the reason why they bypass the modern formal health institution for the traditional providers, is because of socio-cultural belief among most people/societies in the third world countries which favours traditional medication as against modern orthodox health care system - with its personnel’s (doctors, nurses and midwives) derived from different socio-cultural background, religion and tradition; the services they provide are associated with foreign alien culture of the west etc (El-Safty, 2001).

Many studies have shown that the use of modern health services is often influenced by individual perceptions of the efficacy of modern health services and the religious beliefs of the individual woman (Adetunji, 1991). Pate (2001) also found that residence is closely linked to the availability and utilization of health services in general and maternal health care in particular. That whether one resides in rural or urban areas will have implications for access to and utilization of health facilities.

According to Baley (1997) and Mekonnon (2002) there is a significant variation in the utilization of maternal health care by religion. Furthermore, Addai, (1998) and Mekonnon (1998) in their study in Ethiopia revealed that religion has emerged as an important predictor of maternal care utilization in rural Ethiopia.