

## **Scenario and Magnitude of Maternal Healthcare of Women in Papanasam Taluk, Tamil Nadu, India**

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### **Abstract:**

**Introduction:** Socio-economic status is an important factor in determining the quality of life of women. It has been observed that women of lower socio-economic status often do not avail the existing reproductive health care services, particularly delivery care services. Socio-economic factors have great influence on the use of healthcare services. Educational levels influence the use of health services in several ways such as antenatal check-ups, institutional deliveries, consulting the doctors, contraceptive usage and sexual health care.

**Study Area:** The Papanasam taluk chosen as a study area is located in the northern part of Thanjavur district, Tamil Nadu, India.

**Objectives:** 1) to examine the socio-economic characteristics and the living conditions of pregnant women, 2) to investigate the pregnancy, abortion, preference of child and mind-set of pregnant women and 3) to identify and analyse the factors responsible for maternal care of women in Papanasam Taluk.

**Methodology:** This study is based on a questionnaire survey by direct observation method. 520 pregnant women were selected by random sampling method. Women who come for health check-ups to the seven primary hospital and two general hospitals are interviewed. The frequency, percentage and factor analysis are used for the analysis and interpretation.

**Conclusion:** The socio-economic, demographic and psychological conditions are influencing the maternal healthcare of women. However, during pregnancy they have taken maximum effort and utilized the available healthcare facilities in this area. Therefore, the health problems of pregnant women are prevented by proper and regular health check-ups to avoid infant death in this taluk. Further, the emergency unit should run round the clock in all the health centres. The hospitals should introduce new technological instruments in all the health centres.

**Key words:** Maternal health, Reproductive health, Healthcare of women

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### **I. INTRODUCTION**

Socio-economic status is an important factor in determining the quality of life of women. It has been observed that women of lower socio-economic status often do not avail the existing reproductive health care services, particularly delivery care services. Socio-economic factors have great influence on the use of healthcare services. Educational levels influence the use of health services in several ways such as antenatal check-ups, institutional deliveries, consulting the doctors, contraceptive usage and sexual health care. The Indian government established the Reproductive and Child Health (RCH) Programme in 1997 to improve national health indicators. The main focus of the program is on preventive services, providing essential obstetric services for all and detecting and treating pregnancy complications early. The program is operated through a network of first referral units located at sub-district health facilities. The Indian government has achieved greater success in encouraging the use of the delivery care services. Thus, the present study analyse the Scenario and Magnitude of Maternal Healthcare of Women in Papanasam Taluk, Tamil Nadu, India and the objectives are following:

## **Overview**

Geographers have done much to emphasize the importance of relationships between health and the places and spaces which produce and reproduce experiences of health or are constructed through policy to respond to ill-health (Jones and Moon 1993; Litva and Eyles 1995; Kearns and Moon 2002). Contemporary research includes identification of determinants of spatial inequalities in health (Graham 2000; Curtis et al. 2002, 2004; Boyle et al. 2004; Fagg et al. 2006), the importance of particular spaces and places such as neighbourhoods (Cummins and Macintyre 2000; Diez-Roux 2003; Wilson et al. 2004) or therapeutic landscapes (Andrews 2004; Gesler et al. 2004; Milligan et al. 2004; Conradson 2005; Smyth 2005); impacts of different health experiences on the construction of places (Bush et al. 2001; Smith and Easterlow 2005; Wakefield and McMullan 2005) and contextualized analyses of policy responses (Moon and Brown 2001; Atkinson 2002; Kearns and Barnett 2002).

An important proximate determinant of maternal mortality is access to and use of quality health care services (Fauveau et al., 1991; McCarthy and Maine, 1992; Bhatia, 1993). Access to quality reproductive health services is also crucial for improved child survival and increased contraceptive use and consequent fertility decline in the developing countries (Ramachandran, 1989; United Nations, 1994; Phillips et al., 1998). Utilization of reproductive health services is in turn related to their availability and socio-economic, demographic and cultural factors such as women's age, education, employment, caste and autonomy (Obermeyer, 1991; Stewart and Sommerfelt, 1991; Elo, 1992; Obermeyer, 1993; Becker et al., 1993; Bhatia and Cleland, 1995; Pebley et al., 1996; Raghupathy, 1996; Dharmalingam et al., 1999; Addai, 2000; Acharya and Cleland, 2000).

## **Objectives**

1. To examine the socio-economic characteristics and the living conditions of pregnant women.
2. To investigate the pregnancy, abortion, preference of child and mind-set of pregnant women and
3. To identify and analyse the factors responsible for maternal care of women in Papanasam Taluk.

## **Study Area**

Papanasam taluk is chosen as a study area, it is located in the northern part of Thanjavur district, Tamil Nadu, India. It is one of the eight taluks of Thanjavur district. The distance between Thanjavur towns to Papanasam is about 23km and 304km from Chennai. The latitudinal and longitudinal location is 10° 93'.33" N and 79.28.33" E. It has been divided into 120 revenue villages. According to the 2011 census, the taluk had a population of 272,871 with 133,814 males and 139,057 females. There were 1039 women for every 1000 men, up from 1027 per 1000 males in 2001. The taluk had a literacy rate of 72.72.

## **II. METHODOLOGY**

This study based on a questionnaire survey by direct observation method. 520 pregnant women were selected by random sampling method. Women who come for health check-ups to the seven primary hospital and two general hospitals are interviewed. The questions are mostly closed and open-ended. Hence, the present study examines the Scenario and Magnitude of Maternal Healthcare of Women in Papanasam Taluk with selected socio-economic, demographic characteristics, pregnancy, health problem and mind-set of pregnant women. Frequency, percentage and factor analysis are used for the analysis and interpretation.

## **III. FINDINGS**

### **Socio-Economic Background of Maternal Women in Papanasam Taluk**

Of the 520 respondents 81.2, 4.8, 3.7 and 10.4 percent are Hindus, Christians, Muslims and other religions respectively. They belong to most backward class (32.7%), scheduled caste (31.7%), scheduled tribe (22.3%), backward class (10.0%) and other castes (3.3%). Their age between 18 to 38 years and age at marriage was between 18 to 31 years. The respondents expressed that their husbands are not relative (97.7%), relative (31.7%) and inter-caste/religion (2.3%). They also revealed that their marriage was decided by parents (67.9%), love marriage with the help of their parents (27.3%), love marriage with the help of friends (2.5%) and love marriage by themselves without the approval of parents (2.3%).

The respondent's family income less than 100,000 was 2.1 percent, 100,001 to 200,000 was accounted by 28.8%, 200,001 to 300,001 shared by 39.2%, earning of 300,001 to 400,000 was 23.8%, 400,001 to 500,000 was experienced by 5.8% and more than 500,001 was enjoyed by 0.2%. Their family structure shows that 73.7 percent are living as joint family and the remaining 26.3 percent are living separately. 86.9 percent of respondents reported that they are living in own house and 13.1 percent dwells in rented house. 27.5 percent of the respondents informed that they are living in concrete building, tiled with red bricks-wall (26.5%), green house (16.0%) built by the state government for poor people, thatched roof with red bricks-wall (15.6%), tiled house with mud-wall (9.2%), thatched roof with mud-wall (3.3%) and multi storied building (1.9%).

Their family size was small (23.5%), medium (33.3%) and large (43.3%). Their main source of family income has from private job (38.1%) agriculture (26.25%), agricultural labour (13.1%), and business (12.3%), government job (7.7%), and menial labour (1.7%) and by pension (1.0%). Contributions to the respondent's family income were by- their husband (62.9%), father-in-law and mother-in-law (16.0%), father-in-law (8.3%), father-in-law, mother-in-law and brother-in-law (6.5%), husband and by themselves (2.5%), mother-in-law (1.9%) and father-in-law, mother-in-law, brother-in-law and sister-in-law (1.9%).

Educational background of women respondents are - high school (40.8%), middle school (19.4%), higher secondary (19.2%), elementary (13.3%), bachelor degree (4.4%), master degree (1.5%) and illiterate (1.3%). In contrast, their life partner's educational status shows that - high school (38.1%), higher secondary (25.2%), middle school (14.4%), elementary (11.0%), bachelor degree (6.0%), illiterate (4.8%) and master degree (0.6%).

71.0 percent of the respondents informed that they do not have any male children, 24.2 and 4.0 percent are having one and two male children respectively and the remaining 0.8 percent is having three male children. However, 78.3 percent of the respondents reported that they do not have any female children, 19.0 and 2.7 percent of them having one and two female children respectively.

### **Pregnancy**

74.8 percent and 21.9 percent of the respondents revealed that they confirmed their pregnancy at government hospital and private hospital respectively and 3.3 percent not confirmed in any centre. 50.6 percent of the pregnant women conveyed that they become first time pregnant. 29.8 percent are second time, 18.8 percent are third time and 0.8 percent fourth time. Their month of pregnancy were second months (2.9%), third months (14.0%), fourth months (11.7%), fifth months (8.1%), sixth months (6.5%), seventh months (13.8%), eighth months (11.0%), ninth months (17.3%) and tenth months (14.6%).

### **Abortion**

11.9 percent of the pregnant women reported that they have got abortion, of them 11.2 percent first time and 1.9 percent second times. They also informed that the abortion was unfortunate (10.8%), to keep gap between the children (1.9%), do not like to have (0.4%) and due to work (0.2%). The abortion was done in government hospital (8.3%) and private hospital (4.2%).

### **Preference of Child**

It is interesting to note that 79.2 percent of the respondents revealed that they want either male or female child, 13.5 percent like to have female child and 7.1 percent wish to have male child. However, their husband's (71.9%) like to have either male or female child (71.9%). 99.6 percent of the pregnant women are living with the husband and leading their life delightfully and the left over 0.4 percent are not.

### **Mind-Set**

27.5 per cent and 71.2 per cent of the pregnant women revealed that they are extremely joyful and cheerful to experience motherhood and the remaining 0.6 per cent disclosed that they are unhappy. However, 71.3 percent of their husbands are very happy to become parenthood. 98.3 per cent of their family members are also incredibly glad. In contrast, 97.5 per cent of the maternal women are fearful to give birth and they desired to deliver well birth. 96.0 per cent of the women confirmed that they enthusiastically waiting to see their child's face. After child birth 51.0 per cent of the women liked to have tubectomy.

## **IV. DISCUSSION**

The SPSS software was used to run the factor analysis to extract major dimensions and it is very useful to explain the maternal care for women. Therefore, six dimensions were identified from the data set, contributing a total variance of 52.93 per cent. An Eigen value of 1.0 is taken as a cut-off point to determine the number of dimensions. Correlation matrix revealed the presence of many coefficients of 0.4 and above. The Kaiser-Meyer-Oklin (KMO) value was 0.830, greater than the recommended value of 0.6 and the Barlett's Test of Sphericity reached statistical significance (0.001), supporting the factorability of the correlation matrix. Principal components analysis revealed the presence of six components with Eigen values exceeding 1.0.

### **Factor I: Healthcare Management**

During pregnancy, healthcare management is more important as it is a very crucial period. "Healthcare Management" has been emerged as a single most vital factor with an Eigen value of 6.451 and the total variance of 11.947 percent (Table 1).

**Factor I: Healthcare Management**

Factor	Name of the Factor	Variable Number	Name of the Variable	Factor Loading
I	Healthcare Management	Ch 9	Measuring Weight	0.745
		Ch 8	Preventive Injection on Time	0.711
		Ch 6	Following Physician Advice	0.708
		Ch 11	Measuring Urine Sugar	0.700
		Ch 10	Measuring Blood Pressure	0.698
		Ch 5	Eating Fruits	0.685
		Ch 7	Taking Medicine on Time	0.641
		Ch 12	Measuring Blood Sugar	0.640
		Ch 4	Eating Nutritious Food	0.602
		Ch 2	Following Diet Control	0.584
		Ch 13	Observing Child Growth-Ultra Scan	0.546
		Ch 1	Special Care for Child Birth	0.537
<b>Eigen value: 6.451</b>		<b>Total Variance: 11.941</b>		

**Table 1**

It has been clearly indicating that the variables measuring weight (0.745), preventive injection on time (0.711), following physician advice (0.708), measuring urine sugar level (0.700), measuring blood pressure (0.698), eating fruits (0.685), taking medicine on time (0.641), measuring blood sugar (0.640), eating nutritious food (0.602), following diet control (0.584), observing child growth by ultra -scan (0.546) and special care (0.537). This is clearly indicating that 98.5 per cent of the respondents measuring their weight, 99.0 per cent have been taking preventive injection on time, 96.7 per cent following physician advice, 95.4 percent measuring sugar level, 97.54 per cent are measuring blood pressure, 95.4 percent are eating fruits, 97.9 per cent are taking medicine on time, 98.8 per cent are measuring blood sugar level, 96.7 per cent are eating nutritious food, 89.2 per cent follows diet control, 93.7 per cent are observing child growth by ultra- scan and 96.5 per cent takes special care for child birth. Therefore, the healthcare management of pregnant women in Papanasam taluk is very satisfactory.

**Factor II Gratification**

To become motherhood is a delightful experience and it leads to increase the level of gratification of an individual and the family. There were eight variables positively loaded on this factor with an Eigen value of 5.519 and the total variance of 10.220 per cent (Table 2). The variables - longing to see my child’s face (0.821), happiness of husband’s family (0.802), happiness of mother (0.791), happiness of maternal parents (0.790), husband’s happiness (0.775), desire to give well-birth (0.770), afraid of giving birth (0.729) and delight of pregnancy (0.725). These variables are having interrelationship with each other when a women become pregnant and they are rejoicing a festive environment. This is also undoubtedly proved that 96.0 percent of motherhood respondent reported that they longing to see her child, 96.3 per cent of their husband family are feeling happy, 98.7 per cent of the pregnant women themselves are happy, 98.1 per cent of parents blissful, 97.3 per cent of husband in high spirits, 98.3 per cent desired to give well birth, 97.5 per cent are afraid to give birth and 84.4 per cent delight of pregnancy. As a result, the pregnant women are living in a very happy and enjoyable family environment.

**Factor II Gratification**

Factor	Name of the Factor	Variable Number	Name of the Variable	Factor Loading
II	Gratification	Ap 8	Longing to see my child’s face	<b>0.821</b>
		Ap 4	Husband’s Family Happiness	<b>0.802</b>
		Ap 2	Happiness of mother	<b>0.791</b>
		Ap 5	Happiness of Maternal Parents	<b>0.790</b>
		Ap 3	Husband’s Happiness	<b>0.775</b>
		Ap 7	Desired to give Well-Birth	<b>0.770</b>
		Ap 6	Afraid of Giving Birth	<b>0.729</b>
		Ap 1	Delight of Pregnancy	<b>0.725</b>
<b>Eigen value: 5.519</b>		<b>Total Variance: 10.220</b>		

**Table 2**

**Factor III: Physiological Problem**

Physiological changes have been occurring from the positive sign of pregnancy to the child birth. It makes several changes in the body and makes several health problems. The third factor “Physiological Problems” emerged as a most important factor with an Eigen value of 5.132 and the total variance of 9.503 per cent (Table 3). The variables - breathing trouble (0.776), drowsiness (0.700), pain in abdomen (0.693), increasing weight (0.679), vomiting while eating (0.584), unable to walk (0.549), itching in abdomen (0.523), can’t eat properly (0.504) and money problem (0.489) are positively loaded on this factor. This clearly shows that these variables have interrelationships with each other. This is also evidently proved that 94.4 per cent of the respondents confirmed that they have breathing trouble after attaining motherhood. 95.4 per cent have drowsiness, 23.5 per cent have pain in abdomen, 97.7 per cent of their weight have been increased, 95.8 per cent feels vomiting while eating, 95.2 per cent finds unable to walk, 73.5 per cent experience itching in abdomen, 88.5 per cent can’t eat properly on time and 10.4 per cent are exposed to money problem. Hence, this factor explains that the pregnant women in Papanasam taluk experience embarrassing problems and discomforts. In contrast, the variable - I regret born as a female child (-0.455) and no quality medicine (-0.440) are negative relationship with this factor. Only few respondents confirmed that they are regret to born as a female child and there is no quality medicine in General Hospitals 6.7 and 7.7 per cent respectively. Thus, these physiological problems are observed during pregnancy period in Papanasam taluk.

**Factor III: Physiological Problem**

Factor	Name of the Factor	Variable Number	Name of the Variable	Factor Loading
III	Physiological Problem	Hp 8	Breathing Trouble	0.776
		Hp 9	Drowsiness	0.700
		Hp 14	Pain in Abdomen	0.693
		Hp 7	Increasing Weight	0.679
		Hp 1	Vomiting while Eating	0.584
		Hp 10	Unable to Walk	0.549
		Hp 15	Itching in Abdomen	0.523
		Hp 3	Cannot Eat Properly	0.504
		Cp 4	Money Problem	0.489
		Ps 17	I regret born as a female child	-0.455
		Cp 10	No Quality Medicine in GH	-0.440
		Eigen value: 5.132		Total Variance: 9.503

Table 3

**Factor IV: Psychosomatic Status**

The psychological factors are playing an important role in day to day life which affects the mental health condition of pregnant women but also the growth of embryo/zygote/baby. Consequently, the fourth factor “Psychosomatic Status” appeared (Table 4) with an Eigen value of 3.984 and the total variance of 7.378 per cent . The following variables are positively loaded on this factor: husband’s alcoholic habit affects my work and mind (0.645), psychologically affected by mother-in-law (0.590), I am under stress (0.569), I regret married in poor family (0.555), psychologically affected by sister-in-law (0.547), husband having relationship with other women (0.475), measuring blood sugar level (0.458) and I am unable to fulfil my desire due to economic condition (0.452). The variables - physical exercise for child birth (-0.563) and swelling of leg and pain (-0.504) are having negative relationship with this factor. 25.8 per cent of the respondents revealed that their husbands are consuming alcohol which affects the pregnant women health. 28.5 percent of women affected by mother-in-law, 7.7 per cent and 11.9 per cent are under stress and they regret married in poor family respectively. 12.1 per cent women are psychologically affected by sister-in-law and 14.6 per cent of their husbands are having relationship with other women. 98.6 per cent of the respondents measuring blood sugar level and 14.6 percent of the respondents confirmed that they are unable to fulfil their desire due to economic conditions.

**Factor IV: Psychosomatic Status**

Factor	Name of the Factor	Variable Number	Name of the Variable	Factor Loading
IV	Psychosomatic Status	Ps 10	Husband’s alcoholic habits affects my work and mind	0.645
		Ps 6	Psychologically affected by mother-in-law	0.590
		Ps 14	I am under stress	0.569
		Ch 3	Following Physical Exercise for Child Birth	-0.563

	Ps 16	I regret married in poor family	<b>0.555</b>
	Ps 8	Psychologically affected by sister-in-law	<b>0.547</b>
	Hp 4	Swelling of Leg and Pain	<b>-0.504</b>
	Ps 12	My husband having relationship with other woman	<b>0.475</b>
	Ch 12	Measuring Blood Sugar Level	<b>0.458</b>
	Ps 13	I am unable to fulfil my desire due to economic condition	<b>0.452</b>
<b>Eigen value: 3.984</b>			<b>Total Variance: 7.378</b>

Table 4

**Factor V: Complications**

The factor “Complications” emerged as a fifth factor (Table 5) with an Eigen value of 3.795 and the total variance of 7.028 per cent. The variables – waiting for a long time in general hospital (0.768), accompany with a person (0.693), distance is a problem (0.650), I regret born in poor family (0.612), I regret myself to husband (0.531), I am unable to fulfil my desire due to economic condition (0.487), medicinal allergy (0.407), I regret born as a female child (0.407) and taking medicine on time (0.431) have positive relationship with this factor. This is clearly indicating that 84.4 percent waiting for a long time in general hospital, 82.7 per cent accompanying with a person to the hospital, 81.7 per cent states that distance is a problem, 7.7 per cent they regret for born in poor family, 6.5 per cent myself to husband, 14.6 per cent unable to fulfil their desire due to economic condition, 56.7 per cent having medicinal allergy, 6.7 percent regret born as a female child and 97.9 per cent taking medicine in time. These are the complications observed by the women respondents in Papanasam taluk.

**Factor V: Complications**

Factor	Name of the Factor	Variable Number	Name of the Variable	Factor Loading
<b>V</b>	<b>Complications</b>	Cp 15	Waiting Long Time in GH	<b>0.768</b>
		Cp 5	Accompany with a Person	<b>0.693</b>
		Cp3	Distance is a Problem	<b>0.650</b>
		Ps 15	I regret born in poor family	<b>0.612</b>
		Ps 11	I regret myself to Husband	<b>0.531</b>
		Ps 13	I am unable to fulfil my desire due to economic condition	<b>0.487</b>
		Hp 17	Medicine Allergy	<b>0.407</b>
		Ps 17	I regret born as a female child	<b>0.407</b>
		Ch 7	Taking Medicine in Time	<b>0.431</b>
<b>Eigen value: 3.795</b>			<b>Total Variance: 7.028</b>	

Table 5

**Factor VI: Healthcare Utilization**

Factor	Name of the Factor	Variable Number	Name of the Variable	Factor Loading
<b>VI</b>	<b>Healthcare Utilization</b>	Cp 6	Inattention of Husband-Physician	<b>0.663</b>
		Cp 12	Nurses are not Kind in GH	<b>0.637</b>
		Cp 11	Nurses are not giving proper advice in GH	<b>0.636</b>
		Cp 10	No Quality Medicine in GH	<b>0.529</b>
		Cp 1	Money Problem for Medicine	<b>0.497</b>
		Cp 18	GH Doctor's are not giving proper advice	<b>0.486</b>
		Cp2	Inattention of Husband for Medicine	<b>0.475</b>
		Cp7	Work is a Problem	<b>0.460</b>
		Cp 9	No Gynaecologist in GH	<b>0.437</b>
		Cp 4	Money is a Problem	<b>0.438</b>
		<b>Eigen value: 3.687</b>		

Table 6

#### **Factor VI: Healthcare Utilization**

The factor "Healthcare Utilization" comes out as the fifth important factor (Table 6) with an Eigen value of 3.687 and the total variance of 6.827 per cent. The variables - inattention of husband in the hospital during health check-ups (0.663), nurses are not kind in general hospital (0.637), nurses are not giving proper advice in general hospital (0.636), no quality medicine in general hospital (0.529), money problem for medicine (0.497), general hospital doctors are not giving proper advice (0.486), inattention of husband for medicine (0.475), work is a problem (0.460), no gynaecologist in general hospital (0.437) and money problem (0.438) are having positive relationship with this factor.

#### **V. CONCLUSION**

This present study has proven that the socio-economic, demographic and psychological conditions are influencing the maternal healthcare of women. However, during pregnancy they have taken maximum effort and utilized available healthcare facilities in this area. Therefore, the health problems of pregnant women are prevented by proper health check-ups to avoid infant death in this taluk. However, in this region the infrastructural facilities in the Primary Health centres and General Hospital should be improved further. Health workers should give proper advice to the maternal women on time. They should create awareness to the public about the necessity of pregnancy related healthcare. Health workers should not hesitate to look after the motherhood females. The emergency unit should run round the clock in all the primary health centres. The hospitals should introduce new technological instruments for assessing growth of the child in all the health centres.

#### **REFERENCES**

- [1]. Acharya, L.B., and Cleland, J. (2000): Maternal and child health services in rural Nepal: does access or quality matter more? *Health Policy and Planning* 15(2), 223-229.
- [2]. Addai, I. (2000): Determinants of use of maternal child health services in rural Ghana, *Journal of BioSocial Sciences* 32, 1-15.
- [3]. Andrews G (2004): (Re) thinking the dynamics between healthcare and place: therapeutic geographies in treatment and care practices. *Area* 36 (3), 307-18.
- [4]. Atkinson S (2002): Political cultures, health systems and health policy. *Social Science and Medicine* 55 (1), 113-24.
- [5]. Becker, S., David, H.P., Ronald, H.G., Connie, G., and Robert, E.B. (1993): The determinants of use of maternal and child health services in Metro Cebu, the Philippines. *Health Transition Review* 3(1), 77-89.
- [6]. Bhatia, J.C. (1993): Levels and causes of maternal mortality in south India. *Studies in Family Planning* 24(5), 310-318.
- [7]. Bhatia, J.C., and Cleland, J. (1995): Determinants of maternal care in a region of South India. *Health Transition Review* 5(2), 127-142.
- [8]. Boyle P.J, Curtis S, Graham E, Moore E (2004). *The Geography of Health Inequalities in the Developed World: Views from Britain and North America*. Ashgate, London.
- [9]. Bush J, Moffatt S, Dunn. C., (2001): 'Even the birds round here cough': stigma, air pollution and health in Teeside. *Health and Place* 7, 47-56.
- [10]. Conradson D (2005): Landscape, care and the relational self: therapeutic encounters in rural England. *Health and Place* 11, 337-48.
- [11]. Cummins S, Macintyre S (2000): A systematic study of an urban foods cape: the price and availability of food in Greater Glasgow. *Urban Studies* 39, 2115-30.
- [12]. Curtis SE, Cave B, Coutts A (2002): Is urban regeneration good for health? Perceptions and theories of the health impacts of urban change. *Environment and Planning C: Government and Policy* 20, 517-34.
- [13]. Curtis SE, Southall H, Congdon P, Dodgeon B (2004): Area effects on health variation over the life course: analysis of the longitudinal study sample in England using new data on area of residence in childhood. *Social Science and Medicine* 58, 57-74.
- [14]. Dharmalingam, A., Hussain, T.M., and Smith, J.F. (1999): Women's Education, Autonomy and Utilization of Reproductive Health Services in Bangladesh, In A.I.Mundigo (Ed.), *Reproductive Health: Programme and Policy Changes Post-Cairo*. Liege, Belgium: International Union for the Scientific Study of Population (IUSSP).
- [15]. Diez-Roux AV (2003): The examination of neighbourhood effects on health: conceptual and methodological issues related to the presence of multiple levels of organisation. In: Kawachi I, Berkman LF, eds. *Neighbourhoods and Health*. Oxford University Press, Oxford, pp. 45-64.
- [16]. Elo, I.T. (1992): Utilization of maternal health-care services in Peru: the role of women's education. *Health Transition Review* 2(1), 49- 69.

- [17]. Fagg J, Curtis SE, Congdon P, Stansfeld S (2006): Psychological distress among adolescents, and its relationship to individual, family and area characteristics in East London. *Social Science and Medicine* 63, 636–48.
- [18]. Fauveau, V., Koenig, M., Chakraborty, T., and Choudhury, A. (1988): Causes of maternal mortality in rural Bangladesh: 1978-1985. *Bulletin of the World Health Organisation* 66(5), 643-651.
- [19]. Gesler W, Bell M, Curtis SE, Hubbard. P, Francis S (2004): Therapy by design: evaluating the UK hospital building program. *Health and Place* 10, 117–28.
- [20]. Graham H, ed (2000): *Understanding Health Inequalities*. Open University Press, Maidenhead.
- [21]. Jones K, Moon G (1993): Medical geography: taking space seriously. *Progress in Human Geography* 17, 515–24.
- [22]. Kearns R, Barnett R (2002): Happy meals in the Star ship Enterprise: interpreting a moral geography of health care consumption. *Health and Place* 6, 81–93.
- [23]. Kearns R, Moon G (2002): From medical to health geography: novelty, place and theory after a decade of change. *Progress in Human Geography* 26 (5), 605–25.
- [24]. Litva A, Eyles J (1995): Coming out: exposing social theory in medical geography. *Health and Place* 1, 5–14.
- [25]. McCarthy, J., and Maine. D., (1992): A framework for analysing the determinants of maternal mortality. *Studies in Family Planning* 23(1), 23-33.
- [26]. Milligan C, Gatrell A, Bingley A (2004): Cultivating health: therapeutic landscapes and older people in northern England. *Social Science and Medicine* 58, 1781–93.
- [27]. Moon G, Brown T (2001): Closing Barts: community and resistance in contemporary UK hospital policy. *Environment and Planning D: Society and Space* 19 (1), 43–59.
- [28]. Obermeyer, C.M. (1991): Maternal health care utilization in Jordan: a study of patterns and determinants. *Studies in Family Planning* 22(3), 177-187.
- [29]. Obermeyer, C.M. (1993): Maternal health care and women's status: a comparison of Morocco and Tunisia. *Studies in Family Planning* 24(6), 354-365.
- [30]. Pebley, A.R., Goldman, N., and Rodriguez, G. (1996): Prenatal and delivery care and childhood immunization in Guatemala: Do family and community matter? *Demography* 33(2), 231-247.
- [31]. Phillips, J.F., Wayne, S., Bhatia, S., Rahman, M., and Chakraborty, J. (1998): The Demographic impact of the family planning-health services project in Matlab, Bangladesh. In J.R. Foreit and T. Frejka (Eds.), *Family Planning Operations Research* (pp.83-102). New York: The Population Council.
- [32]. Raghupathy, S. (1996): Education and the use of maternal health care in Thailand. *Social Science and Medicine* 43(4), 459-471.
- [33]. Ramachandran, L. (1989): The effect of antenatal and natal services on pregnancy outcome, and health of the mother and child. *Journal of Family Welfare* 35(5), 34-46.
- [34]. Smith SJ, Easterlow D (2005): The strange geography of health inequalities. *Transactions of the Institute of British Geographers* 30, 173–90.
- [35]. Smyth F (2005): Medical geography: therapeutic places, spaces and networks. *Progress in Human Geography* 29 (4), 488–95.
- [36]. Stewart, K., and Sommerfelt, E. (1991): Utilization of maternal care Services: A comparative study using DHS data, *Proceeding of the demographic and Health Surveys, World Conference, Washington*.
- [37]. United Nations. (1994): *Report of the International Conference on Population and Development A/CONF. 171/13*. New York: United Nations.
- [38]. Wakefield S, McMullan C (2005): Healing in places of decline: (re)imagining everyday landscapes in Hamilton, Ontario. *Health and Place* 11, 299–312.
- [39]. Wilson K, Elliott S, Law M, Eyles J, Jerrett M, Keller-Olaman S, (2004): Linking perceptions of neighbourhood to health in Hamilton, Canada, *Journal of Epidemiology and Community Health* 58, 192–8.

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