
ANTE – Natal Health Care Seeking Behavior among the Rural Women in Tamil Nadu – A Study in Chidambaram Area Cuddalore District

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Abstract: Antenatal care is an important indicator in any health system. Through our study we intended to assess the perception of pregnant women regarding health seeking behaviour and awareness about complications during pregnancy. Thus totally 300 respondents within the age group of 15 to 45 were selected as sample. Though the schedules were administered to all the women (300) selected in the sample villages for this study, 40 women were identified as unmarried and 260 women were married. The data are collected from the respondents by employing a well-structured interview schedule. The data are collected from the respondents by employing a well-structured interview schedule. The researcher visited each household and collected relevant data from the members. The respondents extended full cooperation in the process of data collection. The collected data are classified and tabulated with the help of computer programming. The data interpretation is done with the help of percentage analysis. The association between the reproductive health problems at various levels reported by the mothers in the study area and their socio – economic and demographic background were established with the use of chi square test. The reproductive health problem reported by respondents in the study area was analyzed with the socio-economic and demographic characteristics of the women. Pregnancy induced hypertension swelling of feet, paleness/anemia, fetal movement, whit discharge, and Nausea/vomiting were the major problems reported by the women in the study area. To assess the reproductive health problems of the women in the ante-natal period 260 married women were taken in to the account for further analysis. Although few of the antenatal mothers in the study population were aware about some complications of pregnancy, but in general knowledge among most of the women was inadequate. There is a need for creating awareness among the antenatal mothers about common complications in pregnancy. On the other hand, the notion of routine care seeking during the antenatal period seems to be well rooted among the study population which is a very good sign. It is a good opportunity and is foundational to all other interventions relating to betterment of antenatal care in the community.

Keywords: Antenatal care, Reproductive health Problems, Socio economic back ground

1. INTRODUCTION

Reproductive morbidity, as indeed maternal morbidity in general, is an outcome not only of biological factors, but also of women's poverty and lack of control over resources. Antenatal care is an important indicator in any health system. Antenatal care is an important indicator globally and nationally to assess the health care of the country. According NFHS 4 (National Family Health Survey) only 43.8% of the women had full antenatal check-up in rural area of Tamilnadu. In low performing states ASHAS (Accredited Social Health Activists) in addition to ANMs (Auxiliary Nurse Midwife) were involved in ensuring optimal antenatal care. Pregnancy is still not considered as a high risk situation and the women presents infrequently to the health checkups. Awareness about complications of pregnancy was found to be associated with pregnancy care seeking. On the other hand health care delivery systems also fails to understand the local contextual belief as well in delivering quality service to the patients. In India, nationwide quantitative data are available in antenatal care.

Through our study we intended to assess the perception of pregnant women regarding health seeking behaviour and awareness about complications during pregnancy. Similarly malnutrition, infections, early and repeated

childbearing, and high fertility play an important role in poor maternal health conditions in India. Further, lack of access of health care, along with the poor quality of the delivery system and its responsiveness to women's needs exacerbate maternal morbidity. Hypertensive disorders of pregnancy, including toxemia or eclampsia are also a frequent cause of maternal health, especially among very young mothers and those pregnant for the first time. Evidence suggests that toxemia and eclampsia accounted for another 13 percent of all maternal deaths (Bhatia, 1993 and Kapil, 1990).

2. HEALTH CARESEEKING BEHAVIOR

Pregnancy related health care begins with antenatal care, which involves looking carefully at the pregnancy history and conducting of physical examination of women to check. Whether the pregnancy is progressing normally. A pregnant woman can receive ante-natal care services either by visiting a health center where such services are available or from health worker during their home visits and thereafter for post-partum check-up it any follow up for the same. The community need assessment approach envisages that all pregnant women must receive basic professional antenatal care. Quality of antenatal care can contribute significantly to the reduction of maternal morbidity and mortality among pregnant women, which include advice on diet, intake of tetanus toxoid injections and the provision for iron and folic acid tablets to reduce anemia. Improved nutritional status coupled with antenatal care can be of help to reduce the incidence of low birth weight babies and thus reduce pre-natal, neo-natal and infant mortality.

DLHS-RCH collected information from women on specific problems they may have had during their last pregnancy and whether they received any antenatal checkups. Women who did not receive antenatal check-ups were asked the reason for not receiving such care. Women who received antenatal check-ups were asked about the care provider, the timing of first antenatal check-ups, and the advice given. In addition, a question was asked from women whether they received tetanus toxoid injections and iron and iron folic acid tablets or syrup during the pregnancy. A pregnant woman can have an antenatal checkup by visiting a doctor or other health professionals in a medical facility, receiving a home visit from a health worker or both.

3. METHODS AND MATERIALS

The researcher has selected five villages in Chidambaram taluk in Cuddalore district Viz., Usapur Meethikudi, Sivapuri, Kattukudalur and Nandhimangalam. From each village 60 respondents were selected randomly as sample for this study. Thus totally 300 respondents within the age group of 15 to 45 were selected as sample. Though the schedules were administered to all the women (300) selected in the sample villages for this study, 40 women were identified as unmarried and 260 women were married. The data are collected from the respondents by employing a well-structured interview schedule. The researcher visited each household and collected relevant data from the members. The respondents extended full cooperation in the process of data collection. The collected data are classified and tabulated with the help of computer programming. The data interpretation is done with the help of percentage analysis. The association between the reproductive health problems at various levels reported by the mothers in the study area and their socio - economic and demographic background were established with the use of chi square test.

4. RESULTS AND DISCUSSION

The reproductive health problem reported by respondents in the study area was analyzed with the socio-economic and demographic characteristics of the women. Pregnancy induced hypertension swelling of feet, paleness/anemia, fetal movement, whit discharge, and Nausea/vomiting were the major problems reported by the women in the study area. To assess the reproductive health problems of the women in the ante-natal period, 260 married women were taken in to the account for further analysis. The following table discusses the percentage of women reported reproductive health problems and their socio-economic and demographic background. Religion caste, family type, educational status, percentage, age at marriage, age at menarche, age at first birth, children ever born, family size occupation household annual income and annual medical expenditure are the variables correlated with the women reported reproductive health problems during their pregnancy. The discussion reveals that, 260 married women, 97.3 per cent of them reported one or more reproductive health problems during their pregnancy. A higher

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percentage of Hindus, other castes, joint family system, primary education, age group (20-24) age at menarche above 16 years, age at marriage (18-20) years, age at first birth (23-24), occupation of agriculture, annual household income lower (< 10,000) and medical expenditure lower (< 500) women reported the reproductive health problems than the other group women reported the low percentage during their pregnancy.

Table -1: Distribution of Respondents by Reproductive Health Problems during pregnancy and their background Characteristics

Sub-Variables	Yes	No	Total	Chi-square	df	P value
Religion Hindu	245(96.84)	7(100)	252(96.9)	0.22	1	0.63
Christian	8 (3.16)	0(00)	8(3.08)			
Total	253(100)	7(100)	260(100)			
Caste SC/ST	51(20.16)	2(28.57)	53(20.38)	0.29	1	0.58
Others	202(79.84)	5(71.43)	207(79.6)			
Total	253(100)	7(100)	260(100)			
Family type Nuclear family	139(54.94)	3(42.86)	142(54.6)	0.40	1	0.52
Joint family	114(45.06)	4(57.14)	118(45.3)			
Total	253(100)	7(100)	260(100)			
Educational Status Illiterate	27(10.67)	1(14.29)	28(10.77)	4.07	6	6.66
Primary	68(26.88)	1(14.29)	69(26.54)			
Middle	49(19.37)	3(42.86)	52(20.00)			
High school	60(23.72)	1(14.29)	61(23.46)			
Hr. Secondary	17(6.72)	1(14.29)	18(06.92)			
Graduate	30(11.86)	0(00)	30(11.54)			
Professional	2(0.79)	0(00)	2(00.77)			
Total	253(100)	7(100)	260(100)			
Present Age ≤ 19	17(6.72)	1(14.29)	18(06.92)	2.26	4	0.68
20-24	78(30.83)	3(42.86)	81(31.15)			
25-29	63(24.90)	2(28.57)	65(25.00)			
30-34	45(17.79)	0(0)	45(17.31)			
Above 35	50(19.76)	1(14.29)	51(19.62)			
Total	253(100)	7(100)	260(100)			
Age at Menarche ≤12	14(5.53)	0(00)	14(5.38)	1.27	4	0.86
13	23(9.09)	0(00)	23(8.85)			
14	26(10.28)	1(14.29)	27(10.38)			
15	87(34.39)	3(42.86)	90(34.61)			
Above 16	103(40.71)	3(42.86)	106(40.77)			
Total	253(100)	7(100)	260(100)			
Age at marriage <18	38(15.02)	1(14.29)	39(15.00)	0.81	3	0.84
18-20	107(42.29)	3(42.86)	110(42.31)			
21-23	85(33.60)	3(42.86)	88(33.85)			
above 24	23(9.09)	0(0)	23(8.85)			
Total	253(100)	7(100)	260(100)			
Age at First Birth <20	32(12.65)	0(0)	32(12.31)	5.88	4	0.20
21-22	29(11.46)	1(14.29)	30(11.54)			
23-24	87(34.39)	3(42.86)	90(34.62)			
25-26	42(16.60)	1(14.29)	43(16.54)			
Above 27	63(24.90)	2(28.57)	65(25.00)			
Total	253(100)	7(100)	260(100)			
Children Ever born 1	60(23.72)	4(57.14)	64(24.62)	4.56	4	0.33
2	77(30.43)	1(14.29)	78(30.00)			
3	66(26.09)	1(14.29)	67(25.77)			
4	32(12.65)	1(14.29)	33(12.69)			
5 & above	18(7.11)	0(0)	18(6.92)			
Total	253(100)	7(100)	260(100)			

Family Size ¹		103(40.71)	3(42.86)	06(40.77)	0.19	2	0.99
2		103(40.71)	3(42.86)	106(40.77)			
Above 3		47(18.58)	1(14.29)	48(18.46)			
Total		253(100)	7(100)	260(100)			
Occupation Agriculture		95(37.55)	2(28.57)	97(37.31)	2.05	3	0.56
Coolies/wages		85(33.60)	4(57.14)	89(34.23)			
Business/ Trade		27(10.67)	0(00)	27(10.38)			
Employed		46(18.18)	1(14.29)	47(18.08)			
Total		253(100)	7(100)	260(100)			
Household income ≤10,000		98(38.74)	2(28.57)	100(38.46)	4.59	6	0.59
10,001-20,000		88(34.78)	5(71.43)	93(35.77)			
20,001-30,000		21(8.30)	0(00)	21(8.08)			
30,001-40,000		10(3.95)	0(00)	10(3.85)			
40,001-50,000		8(3.16)	0(00)	8(3.08)			
50,001-60,000		8(3.16)	0(00)	8(3.08)			
Above 60,000		20(7.91)	0(00)	20(7.69)			
Total		253(100)	7(100)	260(100)			
Medical expenditure ≤500		109(43.08)	4(57.14)	113 (43.46)	3.32	5	0.65
501-1000		69(27.27)	1(14.29)	70 (26.92)			
1001-1500		24(9.49)	1(14.29)	25(9.62)			
1501-2000		16(6.32)	1(14.29)	11(6.54)			
2001-2500		11(4.35)	0. (0)	24(4.23)			
Above 2501		24(9.49)	0. (0)	24 (9.23)			
Total		253(100)	7(100)	260(100)			

While cross classifying the women reported reproductive health problems with their background characteristics it was found that there is no significant selection between the variables and women with reproductive health problems.

5. PLACE OF HEALTH CARE TREATMENT FOR HEALTH PROBLEMS AFTER MARRIAGE

The following table analyses the place of treatment for their reproductive health problems before marriage with their socio economic and demographic characteristics. Place of treatment sought by the women in rural areas is an important indicator of their treatment seeking behavior as well as the reproductive health status of the women. In the following analysis the place of treatment for the health problems of 260 married women in the study area have been analyzed with their socio economic and demographic Characteristics. The analysis shows that majority of the women (64.2%) sought health care for their health problems from Private health facility. Only 29.23% of the women sought health care from government health facilities such as Government hospitals and Primary Health Centers. A considerable proportion of women sought traditional medicines also. While the socio economic and demographic characteristics of the respondents sought health care for their health problems before marriage correlated with the place of health care treatment. Out of 253 SC/ST women, more than 52 percent of them sought health care from the Government health facilities such as Government hospitals and Primary health Centers in the study area. Whereas the family type is concerned, there is no significant relation between the Family type and the place of health care treatment.

Table 2: Distribution of Respondents by Place of Health Care treatment for the Health Problems after marriage and their Background Characteristics

Sub-Variables	Govt.Hospital	Private Hospital	PHC/ Sub Centre	Traditional Method	Total	Chi-square	df	P value
Religion Hindu	42(97.67)	161(96.4)	33 (100)	7 (70)	245(96.84)			
Christian	1 (2.33)	6(3.59)	0 (0)	3 (30)	8(3.16)			
Total	43 (100)	167 (100)	33 (100)	10 (100)	253(100)			
Caste SC/ST	17(39.53)	20 (11.98)	11(33.33)	3 (30)	51(20.16)			
Others	26(60.47)	147(88.0)	22(66.67)	7 (70)	202(79.84)			

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Total	43 (100)	167 (100)	33 (100)	10 (100)	253 (100)			
Family type								
Nuclear	35(81.40)	84 (50.30)	15(45.45)	5 (50)	139 (5.94)	15.20	3	0.002
Joint	8 (18.60)	83 (49.70)	18(54.55)	5 (50)	114(96.61)			
Total	43 (100)	167 (100)	33 (100)	10 (100)	253 (100)			
Education								
Illiterate	2 (4.65)	17 (10.18)	7 (21.21)	1 (10)	27 (10.67)	19.38	18	0.369
Primary	12(27.91)	40 (23.95)	12(36.36)	4(40)	68 (26.88)			
Middle	12(27.91)	30 (17.96)	7(21.21)	0 (00)	49 (19.37)			
High School	7 (16.28)	43 (25.75)	5 (15.15)	5 (50)	60(23.72)			
Hr. Secondary	3 (6.98)	13 (7.78)	1(3.03)	0 (00)	17(6.72)			
Graduate	6 (13.95)	23 (13.77)	1(3.03)	0 (00)	30(11.86)			
Professional	1 (2.33)	1 (0.60)	0(0.00)	0 (00)	2(0.79)			
Total	43 (100)	167 (100)	33 (100)	10 (100)	253 (100)			
Present Age								
<19	1 (2.33)	12 (7.19)	3 (9.09)	1 (10)	17(6.72)	16.61	12	0.165
20-24	7 (16.28)	61 (36.53)	7 (21.21)	3 (30)	78 (30.83)			
25-29	13(30.23)	37 (22.16)	9 (27.27)	4 (40)	63 (24.90)			
30-34	8 (18.60)	28 (16.77)	8(24.24)	1 (10)	45 (17.79)			
Above 35	14(32.56)	29 (17.37)	6(18.18)	1(10)	50 (19.76)			
Total	43 (100)	167 (100)	33 (100)	10 (100)	253 (100)			
Age at menarche								
<12	2(4.65)	10(5.99)	2(6.06)	0 (00)	14(5.53)	8.59	12	0.73
13	2 (4.65)	14 (8.38)	4 (12.12)	3 (30)	23(0.09)			
14	4 (9.30)	17 (10.17)	3(9.09)	2 (20)	26 (10.28)			
15	15(34.88)	54 (32.34)	14(42.42)	4 (40)	87 (34.39)			
Above 16	20(46.51)	72 (43.11)	10(30.30)	1 (10)	103(40.71)			
Total	43 (100)	167 (100)	33 (100)	10 (100)	253 (100)			
Age at marriage								
<18	6 (13.95)	27 (16.17)	3 (9.09)	2 (20)	38(15.02)	9.77	9	0.36
18-20	20(46.51)	72 (43.11)	14(42.42)	1 (10)	107(42.29)			
21-23	15(34.88)	54 (32.34)	12(36.36)	4 (40)	85(33.60)			
24+	2 (4.65)	14 (8.38)	4 (12.12)	3 (30)	23(9.09)			
Total	43 (100)	167 (100)	33 (100)	10 (100)	253 (100)			
Age at First Birth								
≤20	5(11.63)	2(12.57)	4(12.12)	2 (20)	32 (12.65)	11.12	12	0.51
21-22	5 (11.63)	18 (10.78)	3(9.09)	3 (30)	29(11.46)			
23-24	14 (32.51)	55 (32.93)	15(45.45)	3 (30)	87 (34.39)			
25-26	8 (18.60)	26 (15.57)	6 (18.18)	2 (20)	42(16.60)			
26+	11 (25.58)	47 (28.14)	5 (15.15)	0 (00)	63 (24.90)			
Total	43 (100)	167 (100)	33 (100)	10 (100)	253 (100)			
Children Ever born								
1	5 (11.63)	46 (27.54)	5 (15.15)	4 (40)	60 (23.72)	34.74	12	0.001 (S)
2	6 (13.95)	55 (32.93)	15(45.45)	1 (10)	77 (30.43)			
3	17(39.53)	43 (25.75)	3 (9.09)	3(30)	66 (26.09)			
4	11(25.58)	14 (8.38)	6 (18.18)	1 (10)	32 (12.65)			
4+	4 (9.30)	9 (5.39)	4(16.16)	1 (10)	18(7.11)			
Total	43 (100)	167 (100)	33 (100)	10 (100)	253 (100)			
Family Size								
1	8 (81.40)	75 (50.30)	18 (54.55)	2 (20)	103 (40.71)	25.37	12	0.01
2	20 (46.51)	71 (42.51)	6 (18.18)	6 (60)	103 (40.71)			
3& Above	15 (34.88)	21 (12.57)	9 (27.27)	2 (20)	47 (18.58)			
Total	43 (100)	167 (100)	33 (100)	10 (100)	253 (100)			
Occupation								
Agriculture	7 (16.28)	73 (43.71)	11 (33.33)	4 (40)	95 (37.55)	26.98	9	0.01
Coolies/wages	23 (53.49)	43 (25.75)	14 (42.2)	5 (50)	85 (33.60)			
Business/Trade	1(2.33)	20 (11.98)	5 (15.15)	1 (10)	27 (10.67)			
Employed	12(27.91)	31 (18.56)	3(9.09)	0 (00)	46(18.18)			
Total	43(100)	167(100)	33(100)	10 (100)	253(100)			
Income								
≤10,000	16(37.21)	64 (38.32)	14(42.42)	4 (40)	98(38.74)	13.83	18	.740
10,001-20,000	15(34.88)	54 (32.34)	14 (42.42)	5 (50)	88(34.78)			
20,001-30,000	5(11.63)	12 (7.19)	3(9.09)	1 (10)	21(8.30)			

30,001-40,000	1(2.33)	8 (4.79)	1(3.03)	0 (00)	10(3.95)			
40,001-50,000	1(2.33)	6 (3.59)	1(3.03)	0 (00)	8(3.16)			
50,001-60,000	1(2.33)	7(4.19)	0(0.0)	0 (00)	8(3.16)			
Above 60,001	4(9.30)	16 (9.58)	0(0.0)	0 (00)	20(7.91)			
Total	43(100)	167(100)	33(100)	10 (100)	253(100)			
Medicalexpenditure ≤500	16(37.21)	71 (42.51)	17(51.52)	5 (50)	109(43.08)	16.85	15	0.32
501-1000	12(27.91)	42 (25.15)	11(33.33)	4 (40)	69(27.27)			
1001-1500	7(16.28)	14 (8.38)	2(6.06)	1 (10)	24(9.49)			
1501-2000	1(2.33)	13 (7.78)	2(6.06)	0 (00)	16(6.32)			
2001-2500	4(9.30)	6 (3.59)	1(3.03)	0 (00)	11(4.35)			
Above 2501	3(6.98)	21 (12.57)	0(00.0)	0 (00)	24(9.49)			
Total	43(100)	167(100)	33(100)	10 (100)	253(100)			

Surprisingly, the women sought health care treatment for their health problems from private health facilities were higher than the women sought health care treatment irrespective of their educational status. Present age of the women is also an important variable to be taken into consideration while assessing the reproductive health status and treatment seeking behavior. In the study area, higher percentage of women in the higher age groups sought health care from Government health facilities. Women with younger ages prefer Private health facility for their health problems. Hence, there is an urgent need to create an awareness among young women about health services rendered by the government health facilities at free and low cost and the quality of health care services of the government health care facilities have to be improved so as to enable the young rural women to make use of the health care services. The age at menarche of the respondents in the study area has also been cross classified with the place of treatment sought by them. The analysis shows that, there is no significant association between the age at menarche of the respondents and the place of health care treatment. The same trend can also be inferred while analyzing the age at marriage with the place of health care treatment of the women in the sample area. The percentage of women sought health care treatment from Private health care facility has increased with their age at first birth. Hence, it can be inferred that a positive association is exist between the ages at first birth and the percentage of women sought health care treatment in private health facility.

Among the women sought health care treatment in private health facility, the women with the lesser number of children ever born were higher in proportion than women with higher number of ever born children. The percentage of women seeking health care treatment from private health facility is decreasing with the increased in the family size. Hence, an indirect association is being exists between the family size and the number of women sought health care treatment in private health facilities is the major reason for the decrease in the treatment seekers from the private health facilities. Hence, stringent efforts should be taken to streamline the fees collected by the private health facilities and reformative measures should also be accelerated to enrich the quality as well as quantity of the health care services rendered by the government health facilities. The higher percentage of Hindu women, other case women sought treatment in private health facility than government health facilities for their reproductive health problems. Nearly half of the women were in age at marriage (18-20) sought health care treatment from private health facility than the other age at marriage group women. Nearly 50 percent of women engaged in agricultural occupation and one fourth of women engaged in coolies/ daily wages sought private health facilities than the government health facilities for their health problems. Nearly 50 percentage of women from the families of lower medical expenditure groups sought medical treatments from the private health facility than the other medical expenditure group families. Similarly the higher percentage of women in the families spending more money for their medical expenditure sought health care from private health care facilities higher the money spend on medical expenses higher the percentage of women sought medical care from private health facility.

6. REASONS FOR NOT RECEIVING ANTE-NATAL CHECK-UP

Various studies found that the main reason women attended antenatal and postnatal care services was to ensure the safe health of both mother and infant. Financial difficulty emerged as the major issue among women who did not fulfill the minimum requirements of four antenatal care services. This was related to their perception about the antenatal care, cost of health services, transportation costs, lack of knowledge etc. In remote areas, the limited

availability of health services was also a problem, especially if the village midwife frequently travelled out of the village. The distances from health facilities, in addition to poor road conditions were major concerns, particularly for those living in remote areas. Lack of community awareness about the importance of these services was also found, as some community members perceived health services to be necessary only if obstetric complications occurred. The services of traditional birth attendants for antenatal, delivery, and postnatal care were widely used, and their roles in maternal and child care were considered vital by some community members. Health programs aimed at increasing community awareness about the importance of antenatal and postnatal services should be considered. Strengthening community-based participatory programs to actively engage in overcoming constraints will be beneficial.

Table-3: Distribution of respondents by reasons for not receiving antenatal check up

Sub-Variables	Felt unnecessary	Financial cost	Lack of knowledge	Total
Religion Hindu	1 (100)	2(66.67)	4 (66.67)	7 (70)
Christian	0(00)	1(33.33)	2 (33.33)	3 (30)
Total	1 (100)	3(100)	6 (100)	10 (100)
Caste SC/ST	0(00)	1(33.33)	3 (50)	4(40)
Others	1(100)	2 (66.67)	3 (50)	6 (60)
Total	1 (100)	3(100)	6 (100)	10 (100)
Family type Nuclear family	0(00)	1(33.33)	3 (50)	4 (40)
Joint family	1 (100)	2(66.67)	3 (50)	6 (60)
Total	1 (100)	3(100)	6 (100)	10 (100)
Education Illiterate	1 (100)	2 (66.67)	3(50)	6 (60)
Primary	0 (00)	1 (33.33)	3(50)	4 (40)
Middle	0 (00)	0 (00)	0 (00)	0 (00)
High school	0 (00)	0 (00)	0 (00)	0 (00)
Hr. Secondary	0 (00)	0 (00)	0 (00)	0 (00)
Graduate	0 (00)	0 (00)	0 (00)	0 (00)
Professional	0 (00)	0 (00)	0 (00)	0 (00)
Total	1 (100)	3(100)	6 (100)	10 (100)
Present Age ≤ 19	1 (100)	1 (33.33)	3 (50)	5 (50)
20-24	0 (00)	1 (33.33)	2 (33.33)	3 (30)
25-29	0 (00)	1 (33.33)	1 (16.67)	2 (20)
30-34	0 (00)	0 (00)	0 (00)	0 (00)
Above 35	0 (00)	0 (00)	0 (00)	0 (00)
Total	1 (100)	3(100)	6 (100)	10 (100)
Age at marriage Below<18	1 (100)	2 (66.67)	3 (50)	6 (60)
18-20	0 (00)	1 (33.33)	3 (50)	4(40)
21-23	0(00)	0 (00)	0(00)	0(00)
Above 24	0(00)	0(00)	0(00)	0(00)
Total	1 (100)	3(100)	6 (100)	10 (100)
Age at First Birth ≤20	1 (100)	1 (33.33)	3 (50)	5 (50)
21-22	0 (00)	2 (66.67)	2 (33.33)	4(40)
23-24	0(00)	0(00)	1 (16.67)	1(10)
Above 27	0(00)	0 (00)	0(00)	0(00)
Total	1 (100)	3(100)	6 (100)	10 (100)
Children ever born 1	0 (00)	1 (33.33)	2 (33.33)	3 (30)
2	0 (00)	0(00)	2 (33.33)	2(20)
3	0(00)	1(33.33)	1 (16.67)	2(20)
4	1(100)	1(33.33)	1 (16.67)	3(30)
5 & Above	0(00)	0(00)	0(00)	0(00)
Total	1 (100)	3(100)	6 (100)	10 (100)
Family size 1	1 (100)	2 (66.67)	3 (50)	6 (60)
2	0 (00)	1 (33.33)	3 (50)	4 (40)

Above 3	0 (00)	0 (00)	0 (00)	0 (00)
Total	1 (100)	3(100)	6 (100)	10 (100)
Age at Menarche ≤12	0 (00)	1 (33.33)	3 (50)	4 (40)
13	1 (00)	1 (33.33)	2(33.33)	4(40)
14	0(00)	1 (33.33)	1 (16.67)	2(20)
15	0(00)	0(00)	0(00)	0(00)
Above 16	0(00)	0(00)	0(00)	0(00)
Total	1 (100)	3 (100)	6 (100)	10 (100)
Occupation Agriculture	0 (00)	1 (33.33)	3 (50)	4 (40)
Coolies/wages	1 (100)	2 (66.67)	3 (50)	6 (60)
Business/Trade	0 (00)	0 (00)	0 (00)	0 (00)
Employed	0 (00)	0 (00)	0 (00)	0 (00)
Total	1 (100)	3(100)	6 (100)	10 (100)
Household income ≤10,000	1 (100)	2 (66.67)	3 (50)	6 (60)
10,001-20,000	1 (00)	1 (33.33)	2 (33.33)	3 (30)
20,001-30,000	0 (00)	0 (00)	1 (16.67)	1 (10)
30,001-40,000	0 (00)	0 (00)	0 (00)	0 (00)
40,001-50,000	0 (00)	0 (00)	0 (00)	0 (00)
50,001-60,000	0 (00)	0 (00)	0 (00)	0 (00)
Above 60,000	0 (00)	0 (00)	0 (00)	0 (00)
Total	1 (100)	3(100)	6 (100)	10 (100)
Medical Expenses ≤500	1 (100)	2 (66.67)	3 (50)	6 (60)
501-1000	0 (00)	1 (33.33)	3 (50)	4 (40)
1001-1500	0 (00)	0 (00)	0 (00)	0 (00)
1501-2000	0 (00)	0 (00)	0 (00)	0 (00)
2001-2500	0 (00)	0 (00)	0 (00)	0 (00)
Above 2500	0 (00)	0 (00)	0 (00)	0 (00)
Total	1 (100)	3(100)	6 (100)	10 (100)

This above table also shows that the percent distribution of women did not receive any ante-natal check-ups in a health facility by the main reason for not receiving checkups by selected background characteristics. For almost more than half of the women reported by lack of knowledge and 30 per cent of women were also reported by financial cost. The majority of Hindus, other caste, joint families' illiterates, respondents married below the age of 18, respondents who had their first birth in the ages between 21 and 22 years, coolies/wages, lower income group families and medical expenses women were reported by financial cost and lack of knowledge.

7. POLICY SUGGESTIONS

The higher cost for medical treatment in private health facilities is the major reason for the decrease in the treatment seekers from the private health facilities. It is important that public health strategies take into account the availability, affordability and accessibility of health services. Poverty alleviation strategies will help financially deprived communities to use antenatal and postnatal health services. This study also demonstrated the importance of health promotion programs for increasing community awareness about the necessity of antenatal and postnatal services. Strategies that address problems related to the limited availability of health services should be a priority. This includes efforts to retain village midwives in isolated areas, as well as the use of a team of providers, such as a midwife and midwife assistants, to increase the coverage of their services. The involvement of traditional birth attendants might be an alternative solution for providing basic antenatal and postnatal services under the supervision of health professionals. Hence, stringent efforts should be taken to streamline the fees collected by the private health facilities and reformative measures should also be accelerated to enrich the quality as well as quantity of the health care services rendered by the government health facilities. Local community members should also be involved to encourage pregnant women.

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