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Availability, Accessibility and Health-seeking Behaviour of Women of Childbearing Age

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Abstract

This paper, investigates the literature on availability, accessibility and health-seeking behaviour of women of childbearing age. Specifically, the paper examines the demographic and socio-economic factors. Knowledge, attitudes and practices, availability and accessibility in the utilisation and preferences in the utilisation of healthcare facilities among women of childbearing age. In spite of the extensive literature on this, an undertaking of these major issues are still very clear. Further research to improve our understanding of these issues are recommended, especially for women of childbearing age in the rural areas.

Keywords
Reproductive age women; Availability; accessibility and utilization; Knowledge, attitude and practice; Maternal healthcare services

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1. Introduction

Enhancing women's health and decreasing maternal death have been the fundamental worry of some worldwide summits and meetings. It started with the global conference on safe motherhood held in 1987 and proceeded through International Conference on Population and Development (ICPD) 1994 through ICPD+5 (five-year appraisal of the 1994 ICPD) and the Millennium Development Goals. The first conference ended with a resolution requiring a decrease in maternal deaths by half by the year 2000. The ICPD focused on lessening maternal death to one portion of the 1990 levels by 2000 and a further one-half decrease by 2015 (UNFPA, 2004). The millennium summit in 2000 required a 75 per cent lessening by 2015 in the maternal mortality proportion from the 1990 levels (UN, 2008). To date, these expectations are not met. The world is nowhere close to accomplishing this goal, and it is not by any means certain whether worldwide maternal mortality levels had dropped in the previous decade to any substantial level (Shiffman, 2003) especially given the discrepancy between availability and accessibility to maternal healthcare services.

The literature on the availability and accessibility to maternal healthcare services have focused on five sub-themes. These are (i) demographic and socio-economic factors in maternal health seeking behaviour (ii) knowledge, attitudes and practices of maternal healthcare among reproductive age women (iii) availability and accessibility in the utilisation of maternal health- care services (iv) preference in the utilization as it relates to maternal healthcare seeking behaviour, and (v) impact of geographical factors on maternal health-seeking behaviour. Each of these sub-themes is discussed in turn in the rest of this paper, while the summary and conclusion are provided in the last section.

2. Demographic and Socio-economic Factors in Maternal Health-seeking Behaviour

Scholars have posited that, among maternal attributes, the education of women maintains one of the strongest nexus with the utilization of maternal health care services (Sari, 2009). For instance, Sari claims that formal education of women in the state of Peru impacts the utilization of maternal

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healthcare services positively. Elo (1992), using both the cross-sectional and fixed effects model, controlling for service availability and the socio-economic status of the family unit, affirmed the significance of maternal education on the usage of both pre-birth care and delivery assistance. In the same vein, Raghupathy (1996) demonstrated that maternal education has a critical effect on the utilization of maternal healthcare services. This suggests that the chances of utilizing pre-birth care and formal delivery are substantially more prominent for women with primary education, when compared to the uneducated one in Thailand.

The literature has also indicated that mothers who have undergone the process of formal education have more significant consciousness of the presence of maternal health services and profited in utilizing such services. The implication of this is that educated mothers gain better knowledge and information on modern-day health treatments and have more noteworthy utilities to create an understanding surrounding certain diseases. As education empowers women, they have more prominent certainty and capacity in utilizing the present day healthcare services for themselves and their children (Caldwell, 1979; Schultz, 1984). To this end, education of women reflects a higher expectation for everyday life and access to monetary and different assets, since better educated women will probably prefer marrying wealthier men or have increased income themselves (Schultz, 1984). Be this as it may, some scholars have argued against the postulation that education alone should not be perceived as the sole *sine qua non* for determining maternal healthcare seeking behaviour. For instance, Kyomuhendo (2003) submits that regardless of an ideal and empowering policy environment with all inclusive essential education and the avoidance of the centralization of health services, there has not been an expansion in the use of emergency obstetric care by women in Uganda. This is on the ground that women's health care seeking-behaviour was not the consequence of individual preferences or decisions but rather conditioned by community poverty, norms and tradition. Put differently, women's health care-seeking behaviour is conditioned by certain factors that incapacitate women from seeking appropriate healthcare services with regard to their peculiarity.

Another perspective to this is that the degree of the husband's education reflects the tastes and preferences for healthcare services usage by women. The husband's state of mind towards modern- day healthcare services could impact the wife's choice. Caldwell (1986) has posited that men with higher educational background may assume a more essential part in childcare choices than men with less education. Shariff and Singh (2002) note that, in India, maternal education has a very significant effect on the likelihood of health care use. and the education of the man expands the likelihood of prenatal and postnatal care use by 10 percent and 8 per cent respectively and demonstrated that the likelihood of the utilisation of trained medical personnel at the period of delivery by 7 per cent.

The existing literature in developing climes has demonstrated the critical part of media platforms (radio, television and social media outlets) in disseminating information on health-related issues. Obermeyer (1993) in Morocco and Tunisia, asserts that sitting in front of the television week by week is related with a rise in the probability of both pre-natal care and hospital facility delivery. Three sources of information are normally utilized: radio, television, daily papers and magazines. The kind of exposure that women have through various media outlets, such as the radio, television and daily papers, fundamentally expands the usage rates for all services in India (Shariff and Singh, 2002). Available statistics indicated the existence of 5 per cent expansion in the likelihood of the utilisation of ante-natal care.

The autonomy that women enjoy in decision making has a major effect on maternal health-seeking behaviour. The ability of women to take decisions and exercise control over their health impacts their behavioural posture on health seeking and utilization of healthcare facilities. Sari (2009) puts it thus:

> Autonomy has been characterized as the ability to control one's personal environment through control over resources and information in order to care for a woman who often listens to the radio contrasted with a woman who does not settle on choices about one's own particular concerns or about close relatives. -p.25

Similarly, Bloom, Wypij and Grupta (2001) note that women's autonomy can be conceptualized as

their capacity to decide occasions in their lives, despite the fact that men and other women might be against their desires. The relationship between women's autonomy and the utilisation of health facilities cannot be severed. There are several dimensions of autonomy that can impact women's service use and choice. These include freedom of movement, basic leadership power and control over capital. Citing the experience of North Indian city, they argue that it has been demonstrated that women's autonomy, as measured by the degree of a women's freedom of movement, seems, by all accounts, to be a noteworthy determinant of maternal healthcare usage among the poor to middle class women.

Woldemicael (2007) examined distinctive dimensions of women's basic leadership self-rule and relationship to maternal and child healthcare use. Basically, most autonomy indicators are vital predictors of maternal health in spite of the fact that the quality and measurable importance change by healthcare usage outcome and country. At times significance is lost when socio-economic indicators are held steady. The leadership role of women in seeing family or relatives on utilization of antenatal care and child immunization is especially amazing. Again, the loss of centrality of different measurements of women's decision-making when socio-economic variables were controlled demonstrated that some health-seeking practices are more subject to socio-economic factors like education and employment. Most socio-economic indicators had solid impact on the two women's basic leadership independence and on use of maternal and child health services use. These findings propose that both women's self-sufficiency and socio-economic indicators ought to be analysed with a view to understanding the determinants of maternal and child care services usage.

The issue of women's dependence on men for monetary survival is undoubtedly a major barrier to women's control over their conceptive behaviour in Third World nations. Enhancing or encouraging the participation of women in the economic life of their family units and groups may be the way to their accomplishing a kind of 'authority' on their conceptive well-being. Access to employment opportunities has been identified as a crucial factor that increases women's economic or financial status and thus conceptive health status. This is so because it brings issues to light and gives new thoughts, behaviour and openings through connection with other individuals outside the home and group (Sharma, Sawangdee and Sirirassamee, 2007). Sharma *et al*. (2007), observed that employment may not really be related with more prominent subscription to certain maternal health services. The experience of Nepal points to the fact that non-working women might be in an ideal situation compared to working women. With regard to developing nations, women's work is to a great extent destitution-prompted and is probably going to negatively affect the use of maternal health services.

The husband's occupation can represent family wage or societal position; expanded wage positively affects utilisation of present day health services (Elo, 1992). Differential usage of health services by various women is a manifestation of the occupation of their husbands. Paul and Rumsey (2002), in their study on provincial Bangladesh, demonstrated that fathers employed in non-agricultural occupations picked trained personnel for delivery more frequently than fathers who were ranchers or individuals from other occupations. Chakraborty, Islam, Chowdhury and Bari (2002) in their study on Bangladesh, submit that women whose spouses work in business or services are destined to be the clients of expert healthcare services to treat their complications.

Older and youthful women have diverse experiences and age impacts their behaviour on seeking healthcare. Raghupathy (1996) asserts that a higher number of younger women will more probably use present-day healthcare facilities than older women, since they probably have more exposure to knowledge of modern health, more access to education while older women have accumulated knowledge based on experience on maternal healthcare. In this manner, they are liable to have more certainty about pregnancy and labour or they might be less comfortable with current medication and more hesitant to exploit accessible services. As a result, they may give less significance to get institutional care. The experienced and abilities gained by more seasoned women ought to affect the utilisation of health services. Sharma et.al. (2007) in a study in Nepal, demonstrated that women more than 35 years were less inclined to use pre-natal care; however they were more prone to use

delivery and post-natal care. Paul and Rumsey's (2002) study in Bangladesh showed that the kind of professional attention women get at delivery did not vary essentially with the age of the mother. In Philippines, more educated mothers have a tendency of having less conventional visits both in urban and rural areas and to expand their private visits in urban regions (Wong, Popkin, Guilkey and Akin, 1987).

Place of residence has also been shown to be a vital indicator of the utilization of present-day healthcare resources for childbirth. Paul and Rumsey (2002) aver that a higher proportion of births in urban areas occur in modern healthcare facilities as against the rural areas. Obermeyer (1993) in Morocco claims that, residence is the most grounded indicator of utilization of maternal health services, with urban women a few times more inclined to utilize health services. In Philippines, urban and rural women contrasted altogether in the sorts of pre-natal medical care often used. For the urban women, the most commonly used type of care was modern public, while rural women often used traditional practitioners. Generally, about 38% of the rural and 59% of the urban women had modern pre-natal medical care. The place of residence of women is important when defining women's use of maternal healthcare (Wong et al; 1987). It can also be described through the availability of health facilities. It is very clear that generally, medical facilities are more readily accessible in urban than rural areas. Also, urban women tend to be more educated and, as such, have greater knowledge about the advantages of maternal healthcare.

Studies have revealed that there is a serious negative relationship between birth order and the use of healthcare services in modern times. There are, perhaps, three possible explanations for this. It has been demonstrated that women with first child pregnancy were more careful about subsequent pregnancies and, as a result, sought out trained medical professionals. It has also been confirmed that, as the number of children born increases, women may tend to believe that modern health- care is not necessary and tend to rely more on past experiences and knowledge. In the same vein, a higher birth order indicates a greater family size and, as such, lower resources (both time and money) available to seek formal healthcare. Celik and Hotchkiss (2000) found that Turkey women who were delivered of their first children were found to be more likely to use pre-natal care and professional assistance during delivery than women with more than two children.

Babalola (2014), in a multilevel analysis of observational data derived from mortality, morbidity and service utilization survey, investigated the compelling and propelling factors associated with utilization of maternal health services (MHS) in Haiti from 2007 to 2012. The results showed strongest adjusted predictors, which included child's birth rank, household poverty, and community media saturation. Significant clustering of use of MHS existed at the community level. Therefore, efforts to promote maternal healthcare services should identify and pay special attention to the needs of uneducated women, address the distance-decay phenomenon, and improve access for the poor. Community mobilization efforts designed to change norms hindering the use of MHS were also relevant.

Oyewale and Mavundla (2015) assessed the social and economic variables that contribute to exclusion of women from maternal health benefits in the capital city of Nigeria. They found that there were some variations in the utilization of maternal healthcare services, in the antenatal care, delivery care, postnatal care and contraceptive services among women with different socio-economic characteristics. The payment system for maternal healthcare services was regressive. There were inconsistencies in the predictive effect of the socio-economic characteristics of women (age, education, birth order, location of residence, income group and coverage by health insurance) on maternal healthcare service utilization when considered independently with the exception of birth order, which showed consistent effect. In other words, the socio-economic characteristics of women are predictive factors of utilisation of maternal healthcare services.

Similarly, Shah and Bélanger (2011), based on two waves of the National Family Health Surveys, investigated the effect of maternal characteristics on women's likelihood of using prenatal and delivery healthcare services among two groups of tribal women in 1998-99 and 2005–06, respectively. The results revealed that tribal women in the north-eastern states of India are more likely to utilize

maternal healthcare facilities compared to those in the central states of the country.

Abor and Nkrumah (2011) examined the socio-economic indicators of maternal healthcare utilisation and variation in the utilisation of maternal health services over time in the 21st century Ghanaian society. They discovered a low use of prenatal care and that delivery at a health facility and postnatal care resulted in reduction in the use of such services over time. Accesses to health facilities, household wealth, residence, ethnicity, geography, age, and education among other characteristics were identified as important socio-economic factors influencing utilization of maternal health services. Education, residence and accessibility to health facilities were important denominators to inter-period changes in the utilization of maternal health services. Moerover, Chubike and Constance (2013) found maternal age, parity and number of living children to have significant effect on maternal utilization of health services while maternal occupation and husband educational level do not have significant effect.

Investigating the effect of demographic and socio-economic factors on the utilization of maternal healthcare services using the 2006 Uganda Demographic Health Survey, Sabiti, Amoateng and Ngake (2014) concluded thus:

> …three indicators of maternal health care services were examined, namely visits to antenatal clinic, tetanus toxoid injection and place of delivery. It was found that urban women are more likely compared to their rural counterparts to use antenatal care services, receive tetanus toxoid injection and deliver babies in public health facilities. The same positive relationship was observed between a woman's educational background and visit to antenatal care clinic, place of delivery and tetanus toxoid injection.

Pandey and Karki (2014), showed that in central Nepal, although more than half of the women of childbearing age were not aware of the outcomes of lack of antenatal care, age, education, income, type of family had a strong relationship with the attendance at antenatal care service. In other words, socio-demographic, cultural, and service availability as well as accessibility influence the use of maternal health services.

Chomat, Solomons, Montenegro, Crowley and Bermudez (2014) revealed that, in Quetzaltenango, extreme poverty, poor education, and poor access to basic resources were prevalent among pregnant and breastfeeding women. Out of 100 women aged 14–41 years old, 33% did not use the formal healthcare for antenatal care, while the majority consulted traditional birth attendants. Only 13% delivered in hospitals. Lower socio-economic status and lack of fluency in Spanish, socio-economic disparities, ethnic and linguistic differences, and poor access to basic resources were found to be a barrier to access and utilization of health facilities.

Mluleki and Sathiya (2015), used qualitative methods to examine the socio-demographic determinants of maternal healthcare utilization in Mdantsane, a township in the Eastern Cape Province of South Africa. The results suggested that lack of awareness about the maternal health services offered within the public health system is an important determinant of the frequency in which maternal health services are used. The study concluded that most health professionals and patients (women) are not aware of the available maternal health services, and the lack of awareness leads to a minimal utilization of such services.

3. Knowledge, Attitudes and Practices of Maternal Healthcare Services among Reproductive-age Women

Knowledge, attitudes and practices of maternal healthcare services among reproductive age women have been well documented in the literature (Prabir, Debasis and Debidas 2011; Ajediran, Augustine, Jonathan and Hughton 2013; Adeusi, Adekeye and Ebere 2014). These authors argue that socio-economic factors significantly influence antenatal coverage, knowledge, attitude and practices. Given this, they note that initiatives should be taken at government and non-government levels to increase knowledge, attitude and practices for the improvement of antenatal and delivery practices to develop a sound health for future generations. Also, there is urgent necessity to provide women with the appropriate health education to enable them to make informed decisions concerning their health and that of their children.

Health and nutrition knowledge attitudes and practices of pregnant women attending and those not attending antenatal care (ANC) clinics in Western Kenya were studied by Perumal, Cole, Ouedraogo, Kirimi, Cornelia, Low, Levin, Kiria, Kurji and Oyunga (2013). The results showed that

nutrition knowledge, attitudes, and dietary diversity score (DDS) were not significantly different between ANC clinic attending and non-attending women. Among women who attended ANC clinics, 82.6% received malaria and or anthelmintic treatment, compared to 29.6% of ANC clinic non-attendees. Higher number of ANC clinic visits and higher maternal education level were significantly positively associated with maternal health knowledge. Substantial opportunities exist for antenatal Knowledge Attitude and Practice (KAP) improvement among women in Western Kenya, some of which could occur with greater ANC attendance. Further research is needed to understand multi-level factors that may affect maternal knowledge and practices.

Olugbenga-Bello, Asekun, Adewole, Adeomi and Olarewaju (2013), examined men's perception, attitude and involvement in maternal care using a cross sectional descriptive survey in Osun State, Nigeria. Level of awareness of men about maternal health was found to be high, whereas their involvement in giving care was poor and only about half of them had good attitude towards maternal healthcare. Education and awareness programmes should, therefore, be carried out by governmental agencies and non-governmental organizations to address involvement of men in maternal healthcare. The attitude and socio-cultural practices during pregnancy among women in Akinyele Local Government Area of Oyo State was examined by Ezeama and Ezeamah (2014). The study revealed that the more educated the pregnant women were, the more they registered and attended the ANC. As such, regular health education of pregnant women on how to minimize unhealthy cultural practices was recommended

Kululanga, Sunday, Chirwa, Malata and Maluwa (2012) examined the factors militating against husbands' participation in maternal healthcare in a rural setting in Malawi. They reported thus:

> The sex role norms and health system issues were the two main barriers to husband involvement in maternal health care. Therefore, it was suggested that maternal health care services that are essential should be de-feminized in order to create the foundations for a more equal access by both women and men.- p.145.

Barry, Frew, Mohammed, Desta, Tadesse, Akilu, Biadgo, Buffington and Sibley (2014) assessed the impact of community maternal and newborn healthcare on type of birth attendant and completeness of maternal and newborn care received during birth and the early postnatal period in rural communities in Ethiopia. They observed that:

> …the Maternal and Newborn Health in Ethiopia Partnership (MNHEP) family meetings complemented routine antenatal care by engaging women and family caregivers in self-care and health care seeking, resulting in greater completeness of care and more highly skilled birth care.-p.44

Ojong, Uga and Chiotu (2015), investigated pregnant women's knowledge and attitude towards focused antenatal care using a descriptive design. Although knowledge towards focused antenatal care was high and attitude was favourable intensive awareness creation on focused antenatal care for pregnant women was recommended. Furthermore, Yar'zever and Said (2013) assessed the knowledge of the utilisation of maternal healthcare services using cross-sectional descriptive study. Knowledge of maternal health facilities and services generally showed that urban and rural reproductive women had extremely sound knowledge of maternal health services and programmes provided by the government, with 99.0% of urban and 82.4% of rural women. Overall, only 63.4% urban and 51.4% rural women utilize health facilities and their programmes. Knowledge of maternal health facilities was higher among those with formal education, high income and younger respondents. Oyewale and Mavundla (2015) cited the work of Butawa, Tukur, Idris, Adiri and Taylor (2010) in Kaduna, Nigeria, who examined the knowledge and perceptions of maternal health. They argued that:

> The number of schooling years completed by women influenced their perception and utilization of health care services.-p.2.

4. Availability and Accessibility in the Utilisation of Maternal Healthcare Services

Assessing the usage of maternal healthcare involvement in developing climes, Lale and Rosalind (2007) observe that there are variations in the scope, strength and implications of evidence. There are some lines of divergence which are caused by factors associated with healthcare users (for example age, education, medical insurance, clinical risk factors) or to supply of healthcare (for instance clinic availability, and distance to facility), or by an interaction between such factors (for

example perceived quality of care). The line of divergence is usually framed by contextual issues having links to funding and organization of healthcare or social and cultural dynamics. The evaluation of the context-specific causes of varying use of maternal healthcare, if safe motherhood is to become a reality in developing countries must be attempted.

Nnebue, Ehenebe, Nwabueze, Obi and Ubajaka and IIika (2014) examined constraints to utilisation of maternal health services at the primary healthcare sector. Bad state of roads, lack of transportation and high transportation cost were some of the difficulties experienced before utilizing the facilities. The difficulties experienced at the facilities were inadequate medical equipment, lack of transportation and unavailability of drugs. Apart from antenatal care, other maternal health services were underutilized. The authors note that funding, good access roads, affordable transportation and appropriately integrated services would boost utilization.

Factors related to maternal healthcare services, such as income status, knowledge on danger signs during pregnancy, husband's education and place of delivery were the determinants. Antenatal care (ANC), income status, family size, the women`s time taken to health facility, husband's attendance at ANC with spouse and who decides place of delivery were factors for delivery service utilisation. Postnatal care was associated with place of delivery, knowledge on complicated related pregnancy, from where information is received and knowledge on postnatal care. The proportion of ANC, delivery service, and postnatal care in Northern Ethiopia was, however, fair. Women's own monthly income, husbands' educational status, place of delivery and their knowledge on danger sign that could occur during pregnancy could influence ANC utilisation. The husband's educational status might have an impact on women's decision to deliver at health institution and accompanying of women to ANC by their husbands and their awareness of postnatal care services could influence postnatal care utilisation (Asfawosen, Mussie, Huruy and Wondeweson, 2014). To Okeshola and Sadiq (2013), certain contributing factors are associated with home delivery. For instance, access to the socio-demographic characteristics of women who give birth at home is of major consideration. Effective interventions to promote maternal health service utilisation should target the underlying individual, household, community and policy-level factors.

Similarly, in their investigation of the level of awareness and barriers to utilisation of maternal healthcare services among reproductive age women (15 to 45 years) in Bayelsa State, Onasoga, Osaji, Alade and Egbuniwe (2014), reported that:

> The majority of the respondents [182 (94.8%)] were aware of maternal health services but only a small number [8 (5.2%)] actually knew the main services rendered at maternal health care services. The major variables associated with barriers to utilisation of maternal health services among respondents were poor knowledge of the existing services, previous bad obstetric history, and attitude of the health care providers, availability, accessibility and husband's acceptance of the maternal healthcare services. Government should therefore fund maternal health services in order to make it affordable, acceptable and available to women. Also nurses should encourage women of reproductive age to utilize maternal health by providing a welcoming and supportive attitude at all contacts.-p.10

Ugal, Ushie, Ushie and Ingwu (2012), in a study on maternal healthcare in Cross River State, Nigeria revealed that maternal health facilities are available in the state but that most of them did not satisfy the international standards for both basic essential obstetrics care and comprehensive essential obstetrics care. Besides, certain constraints impeded the utilisation of health facilities. These according to them were health cost, culture and decision-making issues. There was a significant association between utilisation of maternal health facilities and the success rate of maternal health and live birth outcomes. The upgrading of maternal health facilities in all areas is relevant to improving maternal health outcomes.

Worku, Yalew and Afework (2013) evaluated the factors responsible for the effective utilisation of skilled maternal care in the North-western part of Ethiopia. They assessed the consequence of individual, communal, and health facility characteristics in the utilisation of antenatal, delivery, and postnatal care by a skilled provider. They found that:

> …about 32.3%, 13.8% and 6.3% of the women had the opportunity to get skilled providers for their antenatal, delivery and postnatal care respectively. A noteworthy heterogeneity was observed among groups for each indicator of skilled maternal care utilisation. At the individual level, variables related to awareness and perceptions were found to be much more relevant for skilled maternal service utilisation. Preference for skilled providers and previous experience of antenatal care were consistently strong predictors of all indicators of skilled maternal health care utilisations. Birth order, maternal education, and awareness about health facilities to involve skilled professionals were unswervingly strong predictors of skilled antenatal and delivery care use. Mutual factors were relevant for both delivery and postnatal care, while the features of a health facility were more pertinent for use of skilled delivery care than other maternity services. Factors operating at individual level play a significant role in determining utilisation of skilled maternal health services. Involvements to make better community consciousness and perception about skilled providers and their care, ensuring the seamless performance of health care facilities have been well thought-out crucial to improve skilled maternal services and such interventions should target underprivileged .-p.1

In South Africa there are disparities with regard to access to and use of maternal health services. Silal, Penn-Kekana, Harris, Birch and Mclntyre (2012) examined the phenomenon of affordability, availability and acceptability obstructions to obstetric care from the viewpoints of women who had in recent times used or attempted to use these services. It was observed that affordability, availability and acceptability impeded access to obstetric services. They concluded that:

> …rural women encountered the utmost obstacles, including extended travel times, highest costs connected with delivery, and lowest ranks of service acceptability, comparative to urban residents. Negative provider-patient exchanges, including staff inattentiveness, turning away women in early-labour, shouting at patients, and insensitivity towards those who had experienced stillbirths, also inhibited access and compromised quality of care. To change towards realizing its MDGs, developing countries cannot just focus on growing levels of obstetric coverage, but must scientifically examine the access restraints facing women during pregnancy and delivery. Additional expectations ought to be met to respond to these "patient-oriented" barriers by refining how and where services are provided, mostly in rural areas and for poor women, as well as changing the attitudes and actions of health care providers.- p.1

With respect to India, Bredesen (2013) posits that the ability of women to utilize healthcare services in rural communities is directly linked with low access to healthcare resources and inadequate educational resources, distance, cost of transportation, cultural, religious, and family factors. He adds that, when women's perspectives are properly construed and understood, there will be a kind of reduction in the barriers to health care during pregnancy and childbirth.

Corroborating Bredesen's argument, Babalola and Fatusi (2009), assert that individual, household, community and state-level factors are the crucial element that influence maternal health in different parts of south-western Nigeria. They indicated that:

> …almost three-fifths (60.3%) of the mothers used antenatal services at least once during their most recent pregnancy, while 43.5% had skilled attendants at delivery and 41.2% received postnatal care. There are cohesions and differences in the predictors of the three indicators of maternal health service utilisation. Education is the only individual-level variable that is steadily a substantial predictor of service utilisation, while socio-economic level is a consistent significant predictor at the household level. At the community level, urban residence and community media saturation are dependably strong predictors. In disparity, some factors are significant in predicting one or more of the indicators of use but not for all. These varying predictors include specific discrete level variables (the woman's age at the birth of the last child, ethnicity, the notion of ideal family size, and approval of family planning), a community-level variable (prevalence of the small family norm in the community), and a state-level variable.- p.1

Adopting a similar methodological approach Envuladu *et al.* (2013) found that the cost of hospital bill (93.6%), unexpected labour (75%), unfriendly attitude of health care workers (61.4%), distance to health care centres (36.4%), and failure to book for ANC (10.7%) were some of the factors that determine the choice of a place of delivery among pregnant women in Jos Plateau, central Nigeria. They submit that in order to reduce child

morbidity and mortality rates and refine maternal health, important consideration must be given to factors like female education and empowerment, attitude of health care workers and distance of health facilities to the people in most communities. These, according to them, will enhance the attainment of millennium development goals.

Yiran, Teye and Yiran (2014), using mixed methods, examined accessibility of maternal healthcare by migrant female headporters in Accra, Ghana. The findings revealed that factors affecting accessibility of maternal health services are geographical accessibility, financial accessibility, acceptability, constant shortage of medicines in the hospitals and many others. It was therefore suggested that government should increase the number of health facilities as well as strengthen the National Health Insurance Scheme so as to increase access to healthcare by this vulnerable and poor group of people.

Bhattacherjee, Datta, Bikash and Chakraborty (2013), assessed the status of maternal healthcare services and associated factors among recently delivered women in India. They assessed the extent of utilising maternal healthcare services including antenatal care during pregnancy, providing of safe delivery and postnatal care after delivery. The important factors associated with low utilisation of services were belonging to Islam, scheduled tribe, lower socio-economic status, and lower literacy level of both the husband and the wife. The major barrier towards utilisation of these services was ignorance closely followed by distance to the healthcare centre. The study provided new insights for policy makers to mobilise funds for achieving the best possible quality of maternal and child health services.

Lubbock and Stephenson (2008) have also established the fact that procrastination in seeking maternal healthcare amid pregnancy is affected by poor access to care and economic barriers as well as individual and community knowledge and reception of maternal health services. The support given by men to their wives during pregnancy, earlier maternal healthcare experiences, and the level of communication with other women and health workers affect women's decisions to seek maternal healthcare services. Available evidence indicates that in order to improve maternal health outcomes in developing nations, interventions must be applied at a hierarchy of levels: individual, household, and community.

According to Akpenpuun (2013), some socio-cultural factors impact the utilisation of maternal and child healthcare services in some local government areas of Benue State in North-central Nigeria. The level of education of mothers' patriarchal family system, cultural beliefs and economic status of the family are the salient features whose influence on the level of utilisation of maternal and child healthcare services cannot be ignored. In their analysis on the rate of utilisation of maternal health services in the Indian city of Nepal, Baral, Lyons, Skinner and Van (2012), confirmed that educated and enlightened women, who live in urban areas and central and western regions of Nepal and who are in comfortable households, are more likely to use maternal health services than others. Also, women who have more than three living children are less likely to use maternal health services than others in the same city.

Azuh, Fayomi and Ajayi (2015), argue that the husband's perception of pregnancy complications, age at marriage, family type, treatment place decision among other factors are the essential determinants of the utilisation of healthcare services by mothers. Singh *et al,* (2014) equally affirms that there is a considerable amount of variation in use of maternity care as a result of factors like educational attainment, household wealth, religion, parity and place of residence. They noted that the encouragement of the use of family planning, female education and higher age at marriage, training susceptible groups, involving media and grassroots-level workers and collaboration between community leaders and healthcare system are important strategies for improving the usage of maternity services among urban adolescents.

Some scholars have also noted that the availability and accessibility in the utilisation of maternal healthcare services determines the extent to which maternal health services are utilized (see Ganle *et al*., 2014; Wilnda, Oyerinde, Putoto, Lochoro, Dall, Manenti, Segafredo, Atzori, Criel, Panza and Quaglin, 2015). Findings from these scholars indicated that policy interventions should centre on age differentials in use of maternal and child health services. The implication of this submission is that women with higher parities and those in rural areas with poor income are more

susceptible to the problem of poor maternal healthcare utilization. It has also been shown from findings that there is need to increase the availability and accessibility of skilled birth care, address the low utilisation of maternity services and improve the quality of care rendered.

5. Preference in the Utilisation of Maternal Healthcare Facilities

Preference in the utilisation of maternal healthcare are facilities has attracted the attention of several researchers. Cheptum (2014) and others, working on barriers to access and utilization of maternal and infant health services in Migori Kenya, stated that, although there are some barriers to access to and utilisation of maternal and infant health services, gradual access and utilisation of these service requires concerted efforts by the community and the government in policy making.

Interrogating the problems of utilising maternal healthcare services in Nigeria, Ajaegbu (2013) found that three-quarters of women testified that they had at minimum one problem in accessing healthcare in some parts of the Nigerian polity given that 56% of the women were of the opinion that getting money for treatment was a grave impediment militating against easy access to healthcare services. Apparently, inadequate fund for treatment constitutes a serious impediment to easy access to maternal healthcare services in Nigeria. Other problems such as transportation and distance to hospitals pose great challenge to accessing maternal health care services in rural areas of Nigeria. Considering the problems of accessibility to maternal healthcare services in Uttarakhand, Chimankar and Sahoo (2011) submit:

> …the educational level of women, birth order and wealth index are significant predictors in explaining ante-natal and delivery care. Adjusting the effect of other variables, the predictive power of women's educational level, wealth index have been definitely associated with antenatal care and also delivery care.- p.209

Kou, Poon,Tse, Mak and Leung (2015) found that knowledge and future preference of Chinese women in the utilisation of a public hospital in Hong Kong to other maternal healthcare facilities was based on perception and level of education. More information should be provided by health care professionals in order to facilitate an informed choice by patients.

6. Effects of Geographical Factors on Maternal Health-seeking Behaviour

The literature suggests that distance and other geographical factors are often regarded as major intervening traits for access to medical care and resultant health outcomes (see Peters, Anu, Gerry, Damain, William and Rahman, 2008; Cromley and Cromley, 2009). Studies in developing nations have revealed that the deplorable condition of many roads and poor communication network, particularly in the poor, remote and adverse physiography constrain access to healthcare and results in poor health outcomes (see Baker and Will, 2000; Rahman and Devid, 2000; Gupta, Pascal, Khassoum and Mario, 2003, Peters *et al*., 2008).

Some scholars have faulted the theory of geographical determinism when considering the issue of accessibility to maternal healthcare services in some climes. Scholars who subscribe to this strand of thought argue that the role of geographical accessibility differ with regard to the perceived health needs, where the population that has a higher perceived need for services gets less swayed by geographical inaccessibility (see Arcury *et al*., 2005, Furuta and Salway, 2006). For instance, studies on India and other developing nations (Arcury, Wilbeth, John, Jill and Jamie, 2005; Furuta and Salway, 2006) suggest the fact that for child birth and maternal health needs in particular, the role of geographical accessibility gets overshadowed by the tradition linked to it. Okafor (1982), found in the study of spatial location and utilisation of health facilities in defunct Bendel State, Nigeria, that utilisation of health facilities is closely bound to their location, since distant location implies a higher delivery price of health services. Stock (1983) found that the effects of distance decay on utilisation levels varied according to type of facility, social and demographic variables and illness. Although, the per capita consumption of healthcare decreased exponentially, concentric bound villages showed great disparities in utilisation rates, which were only partly attributed to distance. In the same vein, Buor (2004) is of the opinion that the fundamental issues impacting health services are: distance, education, income, service costs, insurance status, residential status and

attitude of medical staff. Poverty, literacy, poor physical access, poor access of insurance, place of residence and attitude of medical staff are the forces that influence access to health services in many parts of sub-Saharan Africa.

7. Summary and Conclusion

The paper examines the availability, accessibility and health-seeking behaviour of women of childbearing age. Specifically, an examination of the literature on the subject of discussion is done. Critically examined are the socio-economic factors in maternal health-seeking behaviour. Knowledge, attitudes and practices of maternal healthcare services among reproductive-age women are also reviewed. Availability and accessibility in the utilisation of maternal health- care services is equally examined not leaving out preference in the utilisation of maternal health care facilities. The effects of geographical factors on maternal health-seeking behaviour.

Evidently, the literature is rich on availability, accessibility and health-seeking behaviour of women of childbearing age, it is however not clear which of these factors are more significant in the determination of availability, accessibility and health seeking behaviour among women of childbearing age especially in rural areas.

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