

## The Phenomenon called ‘Access to Maternal Health Care’

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**Abstract:** *Access to health care carries a basic definition of seeking and receiving care through different means and processes and governed by a variety of factors. Across years, there have been various models and frameworks explaining the inter linkages between these means, processes and factors to understand access in its complete view. This study attempts at reviewing existing models and frameworks and build a comprehensive view of the phenomenon. The created framework consists of four basic components: predisposing/enabling factors at the individual/household/community level; predisposing factors at the health systems level; perceptions of the individual/family/community about the illness/condition and the benefits/barriers about the treatment; and the action taken to engage with that illness/condition. The study concludes defining access as not just the utilization of services at the physical and financial face value but a complex interplay of health seeking behavior of individuals, various components of public and private health systems, and the consequent action taken by the individuals to improve their health condition.*

**Key Words:** access to health care; utilization of health services; maternal health care

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### Introduction

A variety of definitions are available to explain what access to health care means. To some it refers to entry into or use of health care system while to others it characterizes factors influencing entry or use (Penchansky and Thomas, 1981). Frenk defines access to health care as the process of seeking and receiving care (Hall et al. 2008) Institute of Medicine (IOM), (1993) defines access to health care as the timely use of personal health services to achieve the best possible health outcomes. The online dictionary of medical conditions terminology defines it as the degree to which individuals are inhibited or facilitated in their ability to gain entry to, and to receive care and services from the health care system. Factors influencing this ability include geographic, architectural, transportational, and financial considerations, among others. Thus access to health care can be defined as the ability to make use of the available health care services which in turn is a function of numerous underlying factors.

The decision of accessing care and where to access it begins long before arriving at a health facility. It is governed by variety of factors and a complex of choices to be made. Many a times, services are available but are

not availed. The access to services is not just dependent on physical and financial accessibility but underlying social factors, demographic factors, psychological factors, knowledge of different kind of providers, the services they provide, how and where to utilize these services and cultural alignments with such treatments.

There are various frameworks and models available which explain the dynamics of health care access and utilization beginning from Health Seeking Behaviour models, frameworks governing utilization and access of health care services, frameworks defining factors that may affect delays in accessing care, frameworks explaining determinants of health system and so on. The following literature dwells in understanding these different kinds of frameworks and how they govern an individual's access to health care.

**Health Belief Model:** This model explains three set of factors that may potentially influence the health seeking behaviour by an individual, i.e. individual perceptions, modifying factors and likelihood of action. Individual perceptions about his or her susceptibility towards the disease and seriousness of the disease would decide care

seeking. Modifying factors may include demographic, socioeconomic and psychological characteristics acting as facilitators or barriers towards care seeking. They may also include cues generated by external stimuli like campaigns, advices, etc. Likelihood of action is the sum of the perceived benefits and barriers in care seeking. Thus, this model conceptualizes the health care seeking based on perceived susceptibilities, barriers and benefits. However, this model doesn't take into account the community and health system characteristics shaping the health care seeking of an individual (Stephenson and Tsui, 2002).

**Kroeger's Framework:** This conceptual framework proposed that determinants governing utilization of services can be grouped under three categories. First include predisposing factors like age, sex, household composition and size, ethnic group affiliation and education. Second include illness characteristics, expected benefits from treatment and beliefs about disease causation. Third include health care system characteristics including cost and quality of care (Elo, 1992).

**WHO Framework:** WHO developed a framework in 1991 for the use of maternal health care. This model talks about the predisposing factors towards care seeking. These include socioeconomic status, cultural environment, demographic factors, and status of women. These factors acts through women's knowledge and available information, her cognitive dispositions, perceptions of appropriate and inappropriate health care behaviours and issues related to health services like access, quality, costs, availability of health worker, etc. (Griffiths and Stephenson 2001).

**Thaddeus and Maine's Framework:** The three delays model was developed in 1994. It proposes the factors that affect delays in accessing medical care at the onset of an obstetric complication. They suggest that socioeconomic and cultural factors; accessibility of facilities and quality or perceived quality of care provided by the facility affects the utilization and outcome. These factors have an effect on the three phases of delay in seeking care: actual decision to seek care, identifying and reaching the facility and receiving adequate and appropriate treatment at the health facility. (Griffiths and Stephenson 2001).

**Cleason et al. Pathways Framework:** The Pathways framework shows that the maternal health outcomes are affected by a variety of factors at different levels of the health system through direct and indirect pathways. The factors are grouped under three categories:

household/community characteristics comprising of household behaviours and risk factors, household resources and community factors; health system and other sectors characteristics comprising of health service supply, other parts of health system, and supply related factors; government policies and program factors comprising of health reforms and action in other sectors (World Bank n.d.).

**Anderson et al. Framework:** It is one of the best known frameworks for studying access. It is a behavioural model that identifies three kinds of individual determinants of utilization: predisposing, enabling and need. Predisposing factors include socio-demographic factors (e.g., race, gender, educational attainment, occupation) that measure individual biological and social structural traits. Individual health beliefs and attitudes are also part of these factors. Enabling characteristics facilitate an individual's use of health care services and include financial resources. Finally, need refers to whether individuals perceive that they need care, whether they think this care is of value, and the degree to which a health care professional believes an individual needs care. The model has expanded to include variables that describe the health care delivery system (e.g., policies, resources, and organization supply), external environmental factors (e.g., economic climate, relative wealth, politics, and violence) and community-level enabling characteristics (e.g., availability of physicians within the community) (Hall et al. 2008).

As we look at the various models and frameworks, we gather that 'access' is not a simple phenomenon; instead it is underlined by various other issues, problems and factors. In order to understand the access of health care we need to build a comprehensive conceptual framework drawing out from different components of already existing one suiting to the contextual need of stakeholders.

### **Conceptual Framework for 'Access of maternal health care providers'**

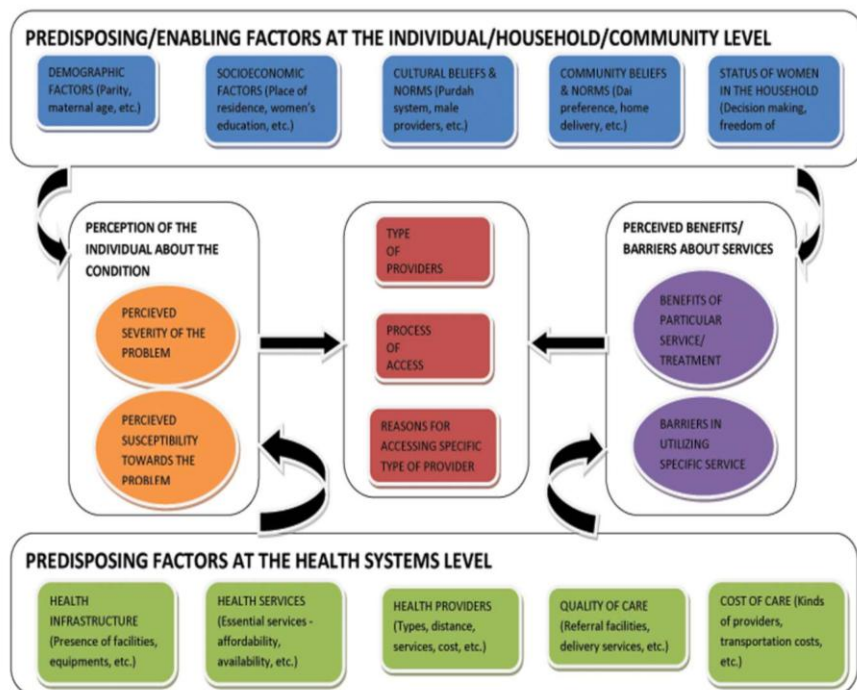
The following conceptual framework draws from the existing models and frameworks and tries to explain the driving factors behind accessing a particular kind of health care. The framework consists of four components: predisposing/enabling factors at the individual/household/community level; predisposing factors at the health systems level; perceptions of the individual/family/community about the illness/condition and the benefits/barriers about the treatment; and the action taken to engage with that illness/condition. As we explain the different components of this framework, we

will see that the predisposing factors at the individual/household/community level and predisposing factors at the health systems level, helps in the formulation of perceptions about illness/conditions. These perceptions would in turn motivate the individual to judge the benefits of a particular kind of health care and barriers accessing it. A judgment about the benefits and barriers would either push or prevent the individual/family to take an action to choose different facilities that are available in the markets for their specific illness/problem.

The place of residence indicates the geographical proximity to the services. A study done by Bulatao and Ross (2002) in 49 developing countries indicates that 68% of urban women had adequate access to maternal services compared to 39% of their rural counterparts. Similarly, 81% of urban women had access to a 24-hour district hospital and antenatal care compared to 58% of rural women.

Another indicator is the economic status of the individual which would define the ability to pay and hence make a choice between public and private services. Maternal education may be interlinked with many other determinants. With education, women realize the benefits of health services, also they have more autonomy in taking decisions and there is an increased knowledge about health care services.

A study done by Vora et al. (2009) based on National Family Health Survey (NFHS) 3, data shows that 18% of the illiterate mothers had institutional deliveries compared to 86% of those who had 12 or more years of education. Similarly, 13% of women of low economic status had institutional deliveries compared to 84% of women of high wealth quintile. Also, only 19% of the mothers of lowest wealth quintile received post natal care compared to 79% of the mothers of highest wealth quintile.



**Predisposing/enabling factors at the individual/household/community level:** These include demographic factors, socioeconomic factors, cultural beliefs and norms, community beliefs and norms and status of women in the household.

Demographic factors could be parity, maternal age, women's employment outside home and husband's level of education. Socioeconomic factors may include place of residence, household living conditions, household income, woman's education, woman's occupational status, etc.

Age is often presented as a proxy indicator for the accumulated experience, including in the use of health services. Older women are seen to be more confident and influential in household decision-making than younger women. Age is highly correlated with parity, and, in some settings, with educational level. It is also associated with marital status, socioeconomic status and decision-making power (Gabrysch and Campbell, 2009).

Cultural norms like the purdah system at times prevent women in seeking treatment outside their homes. As seen in our country, the health system is largely governed by male providers that complicate the situation and women are left nowhere to go to. Vissandjee et al. (1997) cited in Ensor and Cooper (2004) suggests that distance is a much greater barrier to women than men in India. One of the probable reasons behind this is the cultural unacceptability for women to leave their homes for longer periods.

Women who deliver at home, view childbirth as a normal phenomenon and would seek medical care only in case of a problem. They prefer deliveries by dais because they associate safety and comfort with them; also they feel safe and reassured delivering at home.

Community beliefs and norms play a major role in shaping up the care seeking by individuals. Many individuals do place importance on how community



view their actions especially around childbearing. A high number of home deliveries in India owes to the traditional beliefs around childbirth and misconceptions and fears about the practices in the medical institutions. For example, medical services are viewed only for curative purposes and not for preventive measures. A study by Griffith and Stephenson (2001) found that women in Mumbai slums used antenatal care only when they had any problems during their pregnancies.

Another issue that is important to consider is that decisions around care seeking are done mostly by men or the mothers-in-law in the household. A study by Piet-Pelon et al. (1999) cited in Ensor and Cooper (2004) suggests that in most of the South Asian societies, it is the mother-in-law who takes decisions around child birth, pregnancy especially in cases of early marriage. The decision about the place of delivery and who is going to conduct the delivery is largely dependent on the beliefs of the mother-in-law. Also, women's autonomy is not only dependent on her education but employment status, involvement in intra household decision making, communication with spouses and other family members. The autonomy of women also plays a role in freedom of movement and decision making power in accessing a particular kind of service (Bhatia and Cleland 1995).

***Predisposing factors at the health systems level:*** These include health infrastructure and services, health providers, quality of care and costs involved in seeking care.

In developing countries, even though the woman might have an appropriate place of delivery, there are number of factors which can interfere with it. First, the delivery should be assisted by trained personnel who are able to recognize complication and refer the case when required. Second, referral facilities should be well equipped to deal with emergency cases. Also, an effective transport system is required to get the women to an appropriate place.

Women who choose to deliver in hospitals or more so in private institutions look for quality of services especially when cost is associated with it. A woman's previous exposure to health services also plays an important role in her care seeking. Also, a positive experience with the health system increases her chances of making further usage of the health care services.

The important choice between private and public services or institutional versus home delivery is dependent on various factors like place of residence, education, parity, and risk factors associated with

pregnancy. It is also important to look into the matter as to why people have to make these choices. It is well established that in the public sector, discrimination is done against the poor and the oppressed, poor quality of medicines are disseminated, lack of medicines, overcrowding and long wait, nepotism, bribery, rude behaviour of the staff are common features. The image of the field workers is not very good who is viewed as very distant, meant for a particular class and for those who can pay. She doesn't visit the poor for antenatal care and is available only when called for and paid for.

Delays in seeking care are at time overshadowed by health service delays that occur once the woman makes contact with the services. The number of referrals that a woman has to take before reaching the appropriate facility, whether the facility is well equipped to deal with the emergency and a stepwise hierarchical system leads to unnecessary delays and misreferrals.

Knowledge is not the only barrier when it comes to accessing services but rugged terrain, unpaved roads, no communication facilities, lack of transport, poor infrastructure between pregnant women in rural areas and good quality health care. Location, distance and costs involved in services affect health care utilization. Ensor (1996) cited in Ensor and Cooper (2004) did a study in Vietnam and found that distance is a principal determinant of how long patients delay before seeking care. Similarly a study done in Zimbabwe showed that 50% of maternal deaths caused due to haemorrhage could be attributed to lack of emergency transport.

It is well known that utilization of health services depend upon the availability, cost and quality of services. But, this doesn't mean that where all these characteristics are present, the utilization of services would be high. Under the same conditions, some women may use the services more than others.

***Perceptions of the individual/family/community about the illness/condition and the benefits/barriers about the treatment:*** These include the perceived susceptibility towards an illness or problem, perceived severity of the illness/problem, and perceived benefits of a particular kind of treatment or service and the barriers in utilizing this service.

Health service utilization by women is dependent on their hierarchy of needs, and as a result preventive services, are given the lowermost priority.

Using health care can also be a time consuming activity. Both the patients and relatives may have to invest long periods of their productive work hours to receive

treatment. This can have financial impact on individuals especially if the care seeking is at a time where the work is at its peak periods, for example, harvest time.

However, if we look at the opportunity costs, it may vary among different individuals. For example, people may overlook distance costs if they are searching for a suitable provider. A study done in Nepal suggests that the economic status of the family is low, educational level of woman and the sex of the head of the household doesn't make any difference to the place of delivery. (Matsumura and Gubhaju, 2001) However, education emerges as a dominant factor in determining the utilization of health services even if they are available.

Socioeconomic factors have no role to play when the women feel that the benefits of the services are outweighing the cost and the services are closer to their homes. This plays a very important role in the utilization of private services. A study done by Pathak et al. (2010) suggests that the use of pre natal care skilled birth attendants (SBA) remains low irrespective of place or state of residence. Though Government of India is making immense efforts but the poor don't use SBAs, and choose private providers. Such a situation may have arisen due to lack of public facilities, poor quality of care at public facilities, and need for emergency treatment. Also, women make rational decision in utilizing SBAs compared to pre natal care owing to the risky nature of childbirth as they have limited budgets to spend.

A study done across several countries suggests that women are more likely to choose to deliver at a facility instead of home if they are having a first birth; have had more ANC visits; live in urban areas, have greater wealth, and higher education; and do not report distance to a health facility as a barrier to health care (Pomeroy et al. 2010).

**Action taken to engage with that illness/condition:**

These would include the women's or family's access to a specific type of provider that the women accesses for particular kind of services or treatment.

Hence, we learn that access is not just the utilization of services at the physical and financial face value but a complex interplay of health seeking behavior of individuals, various components of public and private health systems, and the consequent action taken by the individuals to improve their health condition.

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