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Theoretical Analysis of Maternal Health Seeking Behaviour in a Typical African Rural Community

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Abstract: **Universally, maternal healthcare system is an important segment of medical system in any society; this is as a result of the importance of mothers in the overall sustenance of human society. Despite the significance of maternal health care, however, there is an increasing gap between the developed countries and the developing countries in terms of levels of morbidity and mortality and mothers' survival at prenatal, delivery and postnatal periods. Across the globe, millions of women suffer from poor reproductive health and serious pregnancy related illnesses and disability and yearly the rate at which women die from complications of pregnancy and childbirth is alarming. Most of the deaths occur in Asia, but the risk of dying is highest in African countries. Patriarchal practices can be viewed as one of the leading reasons for the poor maternal health situation in Nigeria. Many have observed that traditional African culture has not been fair to women. Gender as entrenched in Cultural dictates, shapes behaviours; one's environment affects her reproductive attitudes, perceptions and motivations. The use and non-use of health services are determined by one's socio-cultural environment, which, in most cases, is shaped by its patriarchal structure. This paper attempts a theoretical analysis to explain maternal health-seeking behaviour in typical African rural community with the aim of closing the gap in knowledge and understanding of maternal health. As a means of methodology, related existing literatures were sourced to facilitate this review. The review shows that gender and patriarchy like the two sides of a coin, though different but inseparable to a large extent, determines the actions and inactions of women of child bearing age as regards their health seeking. Conclusively, the paper suggests that policy makers and maternal health advocates should embark on policies and advocacies that will enhance the new normal of discouraging the harmful traditional gender and patriarchal practices that could hinder healthy maternal health seeking.**

Keywords: **Behavioural Change, Rational Choice, Maternal-Health.**

I. INTRODUCTION

This paper involves some theoretical perspectives to examine maternal health behaviour and activities that shape such behaviour in order to understand the factors affecting access to and use of maternal health facilities. Based on this, the convergence of Model of Behavioural Change in Public Health, Rational Choice Theory and Location Theory presents an holistic analysis of access to and use of maternal health facilities.

II. MODEL OF BEHAVIOURAL CHANGE IN PUBLIC HEALTH.

The pattern of utilization of maternal health facilities is found to involve the interplay of several factors. According to Jegede (1998), patients are in dilemma of therapeutic choice because many factors account for their action and this is governed by health belief of the people. The health seeking behaviour has been explored from three perspectives, namely:

1. Those which utilize mainly psychological processes and variables to explain decisions;
2. Those which utilize individual demographic characters and health care delivery systems to explain decision; and
3. Those, which explain decisions as a result of social psychological processes (Igun, 1982).

Of those that predicate decisions mainly on individual psychological variables, the most well-known example is the Health Belief Model (HBM). This model was suggested by Rosentock (1966) and modified originally to explain preventive health behaviour, but it has since been applied to illness behaviour.

The model assumes that the beliefs and attitudes of people are crucial determinants of their health related actions. The model holds that, when cues to actions, such as assumptions are present, the variations in utilization behaviour can be accounted for by beliefs concerning four sets of variables. These are:

1. The individual's view of his own vulnerability to illness;

2. His belief about the severity of the illness- this may be defined in terms of physical harm or interference with social functioning;

3. The person's perception of the benefits associated with actions to reduce the level of severity or vulnerability; and

4. His evaluation of potential barriers associated with the proposed action (this may be physical, psychological or financial) (Jegede, 1998).

In other words, somebody should believe that he is not protected against attack. As a result, a mother must consider the benefits of preventing the disease. She must also take into consideration the cost or inconveniences involved in seeking modern health care services, for instance in most of the rural African communities where most woman are not financially self-reliance.

The model was then subsumed under two broad headings, that is:

1. Health seeking behaviour, and

2. Decision-making process.

For a person to remain healthy he/she must take positive decisions and act upon them. Decision-making, therefore, depends on three factors namely:

1. Human nature;

2. Culture; and

3. Nature and pattern of health related behaviours.

Most women in rural communities do not seek orthodox facilities base on the limited information they have as regards the essence of maternal health and lack of decision making power as informed by patriarchy and financial dependency. For a person to make health decisions he must first believe that he/she is susceptible to that particular disease and also that the degree of susceptibility may either be severe or mild. In his study, Rosenstock (1974) observed that susceptibility is at three levels which are:

(1) High susceptibility- a situation in which a person expresses a feeling that he is in real danger of contracting a disease;

(2) Medium susceptibility- a situation in which a person believes that even though he is immune to a disease, yet a particular moment, he is likely to be adversely tormented; and

(3) Low susceptibility- a situation in which an individual completely denies any possibility of his contracting a disease. In most traditional communities, most women do not attach much importance to prenatal and postnatal checkup at orthodox facilities, believing that pregnancy management is a natural thing. Marshall (1974) has, however, argued that although someone may feel highly susceptible, yet, the seeker's response potential is enormous. The individual may not probably take actions unless he believes that becoming ill would result in serious organic or social impairment. This is in line with the fact that most women especially in rural areas visits hospital only during complications that threatens to claim their lives.

However, ability to take action depends on several factors regardless of the level of susceptibility, and these factors have been identified and categorized as:

1. Personal dispositional factors such as age, sex and marital status; and

2. Personal enabling factors such as income, place of residence, transportation, occupation, education, and insurance scheme

In most rural communities of Africa, access and use of maternal health facilities will be affected by demographic and socio-economic status of the women. These factors propel them to act in a given way based on their beliefs in their vulnerability to the risk of non-compliance. Associated with this belief is the knowledge and acknowledgement of the level of severity of the ill health and other "costs" involve use or non-use of maternal health facilities. Therefore, according to Feyisetan, Asa and Ebigbola (1997:22).

The extent of which modern methods are adopted may still depend on the people's conception of the causes of ill-health and on their level of conception about the efficacy of such methods

In traditional Yoruba land in Nigeria for instance, illness is conceived as either natural, supernatural while death is a result of preternatural or supernatural manipulations. Women are expected to do their best to their survival while spiritual consultations are made as supplements to the natural course of health seeking (nutrition, sanitation, and medication). This is the more reason why some women in Sub-Sahara Africa even among the literate, do visit traditional practitioners as either alternative or a compliment to the orthodox facilities. In most cases, when for instance, women experience persistence miscarriage, recourse is made to traditional herbal or supernatural consultation (to either appease the god or unravel which taboo was broken or sacrifice to materialize the demonic effect (Odebiyi, 1977, 1989). With the modern social structure in the forms of public health care, literacy, city formation and infrastructure, the influence of supernatural or preternatural belief is being eroded, since secular knowledge is entrenched over spiritual or mystical knowledge.

Belief is part of the whole social structure and it changes as part of changes in the social system. Being subject to change itself, health-seeking behaviour is also bound to change. Since this paper also examine why users may use maternal health facilities in certain situations and why they may not use it in some other situations there is need to understand human behaviour.

III. RATIONAL CHOICE THEORY

The basic principles of rational choice theory are derived from neoclassical economics as well as utilitarianism and game theory; Levi *et al* (1990) The focus in rational choice theory is on actors. Actors are seen as being purposive, or as having intentionality that is, actors have ends or goals towards which their actions are aimed. Actors are also seen as having preferences or values, utilities. Rational choice theory is unconcerned with what these preferences, or their sources, are. Of importance is the fact that action is undertaken to achieve objectives that are consistent with an actor's preference hierarchy. Although rational choice theory starts with actor's purposes or intentions, it also take into consideration at least two major constraints on action. The first is the scarcity of resources. Actors have different resources as well as differential access to other resources. This is in line with the fact that maternal health facilities are not within the reach of the poor people, majority of whom encounter health problems in their day - to- day subsistence activities have little or no access to health care and where they have at all they do not have enough resources (money) for procurement due to high cost for those with lots of resources, the achievement of ends may be relatively easy. However for those with few, if any, resources, the attainment of ends may be difficult or impossible.

Related to scarcity of resources is the idea of opportunity costs, or 'those costs associated with foregoing (sic) the next most attractive course of action" (Friedman and Hechter, 1988:202). In pursuing a given end, actors must keep an eye on the costs of foregoing their next most attractive action. An actor may choose not to pursue the most highly valued end if her resources are negligible, if as a result the chances of achieving that end are slim, and if in striving to achieve that end she jeopardizes her chances of achieving her next most valued end. Actors are seen as trying to maximize their benefits, and that goal may involve assessing the relationship between the chances of achieving a primary end and what that achievement dies for chances for attaining the second most-valuable objective. (Ritzer, 1996).

A second source of constraints on individual action is social institutions. As Friedman and Hechter put it:

An individual will typically. "Find his or her actions checked from birth to death by familial and school rules; laws and ordinances, firm policies; churches, synagogues and mosque; and hospitals and general factors. By restricting the feasible sets of course of action available to individuals, enforceable rules of the game-including norms, laws agendas, and voting rules in systematically affect social outcomes". (Friedman and Hechter, 1998, *p23*)

These institutional constraints provide both positive and negative sanctions that serve to encourage certain actions and to discourage others. In many parts of the world, women's decision-making power is extremely limited; particularly in matters of reproduction and sexuality, mothers-in-law, husbands or their family member often makes decisions regarding maternal care. Also, to a large extent religion does play a vital role in making decision about potential health, for instance among the Jehovah 's Witness sect within Christianity, blood transfusion is against their religious beliefs.

Friedman and Hechter enumerate two other ideas that they see as basic to rational choice theory. The first is an aggregation mechanism, or the process by which the separate individual actions are combined to produce the social outcomes. (Friedman and Hechter, 1988). The second is the growing sense of the importance of information in making rational choices. At one time, it was assumed that actors had perfect, or at least sufficient, information to make purposive choices among the alternative courses of action open to them. However, there is a growing recognition that the quantity or quality of available information is highly variable and that variability has a profound effect on actors' choices.

Suffice to say therefore that health education aims at informing people of the facts, create an avenue for making informed decisions and choices. Literacy is a function of accessibility to health information. Access to information relating to maternal health facilities will to a large extent influence the rate at which women will seek maternal health care. In choosing between alternative actions, a person will choose that one for which, as perceived by him at the time, the value, 'V', of the result, multiplied by the probability, 'P',of getting the result, is the greater, (Homan, 1974).

Basically, people examine and make calculations about the various alternative actions open to them. They compare the amount of rewards associated with each course of action. They also calculate the likelihood that they will actually receive the rewards. Highly valued rewards will be devalued if the actors think it is unlikely that they will obtain them, for instance, many women, especially in the village will prefer to use maternal health facilities but due to lack of access in terms of distance and cost among other constraints then they settle with the alternative available. On the other hand, lesser-valued rewards will be enhanced if they are seen as highly attainable. Thus, there is an interaction between the value of the reward and the likelihood of attainment. The most desirable rewards are those that are both very valuable and highly attainable. The least desirable rewards are those that are not very valuable and are unlikely to be attained (Ritzer, 1996).

Homans relates the rationality proposition to the success, stimulus, and value propositions. The rationality proposition maintains that whether or not people will perform an action depends on their perceptions of the probability of success. But what determines this perception? Homans argues that perceptions of whether chances of success are high or less are shaped by past successes and the similarity of the present situation to past successful situations, (Homans, 1974). Suffice to say therefore, a woman will seek health services based on her historical antecedents, for instance a woman who had safe delivery in a TBA at her first pregnancy have a high tendency of continuous utilization of the services as against modern health

In order to make rational decisions four stages must be fulfilled:

1. They must be exposed and have access to modern health care service;
2. They must evaluate the messages received from awareness programmes;
3. They must take definite decisions about whether they will use the modern health care services or not taking into consideration the advantages and disadvantages as well as the potential barriers of using it, and;
4. They must act upon the decision they have taken.

Rationality means that mothers accept both the end and the means, that is, they accept use of maternal health facilities as the best optimal therapeutic choice for preventing maternal ill-health. With this belief, they choose to use maternal health facilities. But non-rational women of reproductive age only accepted the goal of preventing themselves against ill-health and unsafe delivery but were skeptical about using maternal health facilities as the only appropriate therapeutic measure of achieving the goal (Jegede 1998).

A rational action involves a utilitarian consideration between competing alternatives for specific ends. This emphasizes the choice between means and ends, that is, a woman may accept and use maternal health facilities, and another may only accept that it is good but may not believe that it can solve her problem. This brings to focus the pathways to achieving the goal of good health.

According to Zola (1964), some people whose condition demanded a rationally positive action refused to take such action even when their lives were seriously in danger. He concluded that there is something about these people or in their background which has disturbed their rationality, otherwise they would actually seek aid. Blackwell (1963) and Green et al (1974) revealed that people delay seeking cure because of conflict between a strong feeling of susceptibility to disease and of a feeling that there are no efficacious methods of preventing or controlling the disease.in addition to Blackwell position, some people delay or even refuse cure due to stigmatization or labeling. Suffice to say therefore that many women may not utilize maternal health facilities due to inadequate drugs and personnel amongst other barriers.

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Location Theory

In classical location theory, the spatial pattern of economic activities is explained mainly in terms of transfer costs, which include both freight charges (transport costs) and the costs of insurance on materials and goods on route and losses incurred by deterioration of, or damage to material in route. Hoover (1948) remarked that the expense and inconvenience of shipping finished products to distant customers and procuring materials from distance sources include producers to locate near their markets or their sources of raw materials; in other words, industrialists tend to locate where aggregate transfer costs are at a minimum (Estall and Buchaman, 1968).

The notion of transfer costs has strong implications for the location of public facilities. Public facilities such as maternal health facilities have important characteristics, two of which are relevant to access and use of maternal health facilities. First, the services they produce are mostly for women of reproductive age, which serve as significant final consumer. Second, maternal health services generally require personal contact between the facility providers and the users.

Owing largely to these two characteristics, maternal health facilities generally ought to be located primarily with an eye to distribution, and thus oriented toward the users' accessibility depending on the transport situation and the locations that are more likely to minimize travel costs for those at strategic points in the transportation network. With regard to most maternal health facilities, transport costs assume greater importance than transfer costs partly because distribution in this case involves mainly the movement of users to points where facilities are supplied/available.

It is possible to distill from the foregoing an important location objective for maternal health facilities. In the location of maternal health facilities, a primary objective is the maximization of social utility or the minimization of social costs for a given population (the users). At the same time all users should have access to facilities. The smaller the aggregate travel costs, the more efficient the set of facility locations and the more accessible the facilities to the user population.

Non-monetary criteria are very important in the location of maternal health facilities. The relevant variables in this regard refer to social or human entities to which it is difficult, if not impossible, to assign monetary values (Erinosho, 1982). It is not possible for instance, to know how much monetary benefit results from suitable access to maternal health facilities.

However, one thing is obvious, inefficiently located health facilities lead to more costly services and consequently the public ends up receiving less for its tax payments. (Erinosho,1982). Efficient locations are necessary if societal resources are not to be unduly wasted in overcoming distance unnecessarily. An efficient set of locations of maternal health facilities can reduce maternal morbidity and mortality, save human effort and monetary resources that can be devoted to many other things (Abler *et.al* 1977).

IV. CONCEPTUAL FRAMEWORK

In order to clearly highlight the links between socio-economic and cultural variables and access and use of maternal health facilities, an integration of model of behavioural change in public health, rational choice theory and location theory is shown in fig. 1. It highlights and also activates factors affecting access and use of maternal health facilities.

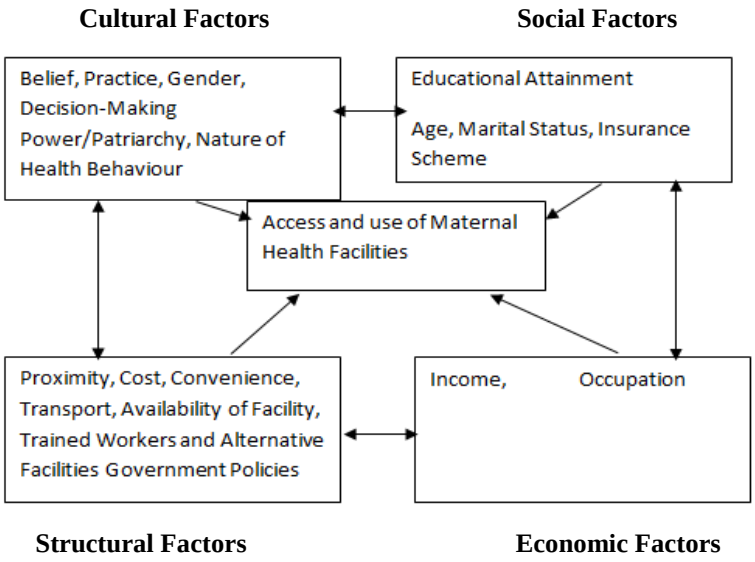

Figure 1

As the dependent variable, access and use of maternal health facilities are influenced by the independent variables embedded in the socio-economic and cultural life of the people (Dada, 2019).

The economic status of women in terms of her occupation and her income is a paramount factor in the equation of access and use of maternal health facilities. Similarly the social factors such as educational attainment, marital status, age at marriage and insurance scheme also determine whether a woman will seek health facility or not and the type of facility she visit.

Moreover, the framework indicates that cultural factor such as beliefs; attitudes and practice, gender issue in terms of decision-making power and patriarchy are proximate determinants of access and use of maternal health facilities. To a large extent men's involvement in reproductive health decisions impinges forcefully on use of maternal health facilities.

In addition other factors affecting access and use of maternal health facilities include cost, proximity, availability of the facility, government policies, convenience, availability of skilled workers and alternative facilities amongst others.

V. CONCLUSION

The combination of model of behavioural change in public health, rational choice theory and location theory to explain factors affecting access and use of maternal health facilities in rural communities of Sub-Saharan Africa was useful for comprehensive and holistic analysis which the paper seeks to establish.

VI. RECOMMENDATIONS

The recommendations can be classified into three broad categories, which include: education and sensitization; public and private sector intervention, and academic contributions.

1) Governments, donors and international agencies can take steps to increase women's decision-making power within the family and community, particularly by investing in the education of women and girls, raise awareness of the critical importance of women's health to children and families and the need for women to have the power to make decisions about their own health and reduce women's disproportionate poverty, lack of economic power and lack of education, all of which constrain their ability to seek and receive maternal health care throughout the cycle of pregnancy and birth.

2) Introduction of community-financing schemes and making sure that public funds are used to finance transportation and care for the poor.

3) The paper also recommends that sustained research on reproductive health should be encouraged in order to proffer lasting solution to many health problems which serves as a cog in the wheel of development of the developing nations.

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