

<http://heanoti.com/index.php/hn>



## RESEARCH ARTICLE

URL of this article: <http://heanoti.com/index.php/hn/article/view/hn20201>

---

### Maternal Access to Health Services by Pregnant Mothers in Bacnotan, La Union, Philippines

---

Autatanko Titus<sup>1</sup> (CA)

<sup>1</sup>(CA) Department of Nursing, School of Health Sciences, St Paul University Philippines; autat1@gmail.com  
(Corresponding Author)

---

#### ABSTRACT

Understanding variables that influence accessibility and health-seeking patterns of pregnant mothers is necessary for possible intervention of behavioural change. The research was conducted in District 1 of LA Union, City of San Fernando, Philippines to ascertain accessibility and utilization of maternal health services by pregnant mothers in Philippines' weak maternal health services delivery. The major purpose of the study was to determine the maternal access/utilization of pregnant mothers in Bacnotan district hospital regarding facilitating/hindering factors in accessing pregnancy related services. Descriptive method of research with the questionnaire was the main data gathering tools employed. Weighted mean were utilized to treat the data. The analysis of the gathered data indicate that the some pregnant mothers do not availed services at their convenient time due to understaffing of the health facility, some could not receive support from their husbands and spouse/relatives, while Some of them encountered barriers along traditional beliefs held by them and their spouse/partners. Based on the findings, Insight into facilitators and barriers to accessing/utilization of health services in this population revealed tools for enhancing engagement in health promotion programs addressing healthy lifestyle and the need for the management to employ more staff, design modality for outreach advocacy to the community members regarding support to the mothers and address other health related issues including barrier along traditional beliefs.

**Key words:** Community, Maternal & Child Health, Nurses & Midwifery Services, Accessibility and utilization, Health care

---

#### INTRODUCTION

##### Background

Child bearing is one of the hazardous experiences that women engage in while bringing new life to this world. It is often associated with complications that may cause morbidities, disabilities, and mortalities. World Health Organization (WHO) estimated that more than half a million women lose their lives in the process of reproduction worldwide every year; of these deaths, about 99 percent are from developing countries<sup>(1)</sup>.

Maternal health is a major global development challenge in Africa, which accounts for about half of the world's maternal deaths, with little or no progress towards reduction of maternal mortality<sup>(2)</sup>. Factors associated with maternal mortality in sub-Saharan Africa (SSA) were related to prenatal care coverage and skilled attendance at delivery.

Maternal deaths are still a huge concern for the Philippines. By 2006, the maternal mortality rate decreased to a rate of 162 per 100,000 live births and currently, the MMR is 120 deaths per 100,000 live births—still nowhere near the target that the MDGs established<sup>(3)</sup>. The author further postulated that in the Philippines, approximately 4,100 to 4,900 women and girls die each year due to pregnancy-related complications. Each year, an additional 82,000 to 147, 000 Filipino women and girls suffer from disabilities caused by complications during pregnancy and childbirth. And that poor women and women in rural areas are at a disadvantage. Around 75 percent of the poorest quintile does not have a skilled birth attendant to help them through their pregnancy. Rural areas also have higher maternal mortality rates because many women in rural areas begin having children at a young age. Another problem that adds to the high maternal mortality rate in the Philippines as presented by the author is the low level of contraceptive use. The Philippines is 80 percent Catholic, so birth control pills, condoms and other forms are contraceptive use are considered to be similar to abortion. This has led to limited access to contraceptives, since contraceptives were previously not widely available at health care clinics<sup>(4)</sup>.

The poor urban mothers are also highly at risk of dying due to pregnancy and childbirth because of lack of access to quality health services. These are mothers, including teenagers as young as 13, who experience unplanned pregnancies, lack adequate prenatal care, give birth at home with no skilled birth professional in attendance and have no access to basic emergency obstetric and neonatal care, and have no postpartum care hence it remains a challenge for local government units to consistently put children and women on their agenda given the possible change in leadership every 3 years<sup>(5)</sup>.

Various factors as presented by *Ashrita (2015)* are responsible for the high rate of maternal mortality that the Philippines face. According to the IRIN, some of the main causes of maternal deaths are hemorrhages, sepsis, obstructed labor, hypertensive disorders during pregnancy and complications associated with unsafe abortions. Having a physician, nurse or midwife who has had formal training present during the birth can decrease the maternal mortality rate, but currently, these skilled birthing attendants supervise only 60 percent of births in the Philippines. Others rely on traditional birthing attendants who do not have formal training and therefore are often unable to deal with complications<sup>(3)</sup>.

The Philippines has made significant improvement in the lives of children based on the progress made for Millennium Development Goal (MDG) 4 on reducing child mortality, under-5 mortality declined from 80 deaths in 1990 to 30 deaths per 1,000 live births in 2011. This is an indication that the country will more likely meet its 2015 MDG target of 27 deaths per 1,000 live births<sup>(4)</sup>.

The Department continues to implement and reinforce the three-pronged strategy of Women's Health and Safe Motherhood: deployment of skilled human resources for health, construction and development of health facilities to support the referral system for basic and comprehensive emergency obstetric care, and reproductive or family planning services<sup>(6)</sup>.

Metro Manila boasts of world-class modern facilities that mainly the wealthy and middle class families have easy access to for quality and affordable maternal and child health services. However, this is not always the case for poor families<sup>(5)</sup>. Similarly, the DOH's in Philippines purposeful implementation of a World-Bank-funded project within the context of the sectoral reform programme provides a good model of aid-effectiveness principles in practice. The experience of the country's maternal mortality reduction programme indicates the positive outcomes that can be achieved when local government leadership is coupled with investments (both domestic and foreign assistance) in multiple areas of the health system<sup>(7)</sup>. In as much as Philippines' government is intensifying efforts to for the improvement on utilization of health services for the improvement of maternal health in her 2016-2022 health policy, there are limited studies that identify factors affecting uptake of maternal health services, especially among vulnerable groups in La Union district. There is need for aggressive studies to address the components of maternal health care with the hope of resolving them all.

It is worthy to note that early and frequent antenatal care (ANC) attendance during pregnancy is important to identify and mitigate risk factors in pregnancy and to encourage women to have a skilled attendant at childbirth. Postnatal care improves the health of both the newborn and mother.

Health promotion practitioners struggle to develop strategies to encourage change in health-seeking behavior that are effective and sustainable in reducing risk factors for lifestyle diseases. A reason for the difficulty may be the mismatch between individuals' and programs' priorities. While health service providers emphasize the long-term benefits of behavior change, participants may be more focused on the present personal costs of such change. In view of this, exploration of the facilitators and barriers to health-seeking behavior of key populations may be useful in providing an essential information base for health promotion practitioners to address these personal costs. Tailoring health messages will likely facilitate uptake of planned interventions for the community<sup>(8)</sup>. As a result, skilled antenatal care and birth attendance has been advocated globally as the most crucial intervention to reduce maternal mortality. Poor usage of skilled attendance and maternal primary health care services results in high levels of maternal mortality in the developing countries.

Antenatal care and birth attendance has been advocated globally as the most crucial intervention to reduce maternal mortality. Poor usage of skilled attendance and maternal primary health care services results in high levels of maternal mortality in the developing countries. And various studies have been done around the world to identify factors that influence the choice of child-bearing women's health care. Some of the identified factors include cost of services; socio-demographic and educational level of the client; women's level of autonomy in making health care decisions; physical accessibility to health care services and the type of health services rendered, disease pattern and healthcare workers attitude. Maternal deaths could be prevented if women were able to access and utilize good quality services, especially when complications arise<sup>(9)</sup>.

Access to information about maternal services therefore should be available in the community to help women make choices about who to see and where to go, as well as decide the type of care they require. Information about family planning services can help reduce unwanted pregnancies and their adverse consequences. Access to health care particularly at the critical time of birth, can help ensure that childbirth is a joyful event. Access means that women can reach maternal health care easily and not be deterred by cost or poor treatment by staff and those women have been seen to travel long distances to access quality health care despite a ready availability of primary health care facilities around where they live, work and school.

However, lack of transport makes it difficult for pregnant women or women in labour to reach help quickly and that proximity as a very strong determinant of choice of health institution to the child bearing woman cannot be over emphasized; this implies that hospitals especially primary health centers, when sited 5 km from place of residence/work, is likely to receive high turnout of clients. Fees charged for health care often put women off having their babies in hospitals or even seeking help when complications arise. Many women also say they prefer

to rely on traditional birth attendants because health workers are rude and unsympathetic. In many cases, decisions about seeking care are made by mothers-in-law, husbands or other family members<sup>(9)</sup>.

Mluleki et al. stated that many factors play a role in this inadequate use of maternal health care services such as: lack of information, cultural factors, and educational attainment of the women especially among those residing in rural areas. Accessibility of maternal health care facilities and general health facilities is important in ensuring that lives are saved through the provision of essential maternal (or medical) services<sup>(2)</sup>.

Lack of access to health care services for pregnancy and delivery are among the main reasons for high maternal and neonatal mortality rates worldwide<sup>(10),(11)</sup>. Maternal care services remain important indicators for monitoring the progress of maternal outcomes, including maternal mortality. Antenatal care, delivery at health facilities with skilled professionals, and postnatal care reinforce the timely management and treatment of complications to reduce maternal deaths. In spite of the importance of facility based delivery in preventing maternal death, a larger proportion of women give birth outside of health facilities without any skilled attendance<sup>(12),(13)</sup>. Antenatal care is one of the pillars of the Safe Motherhood Initiative, and helps provide interventions that are necessary for healthy pregnancy outcomes<sup>(14)</sup>. It is important to assess whether the utilization of these key services is equitable across countries, and by geographic and socioeconomic strata within them.

Significant progress has been made in maternal, newborn, and child health (MNCH) in recent decades<sup>(15)</sup>. Between 1990 and 2015, the global mortality rate for children under age five years dropped by 53 percent, from 90.6 deaths per 1,000 live births in 1990 to 42.5 in 2015<sup>(16)</sup>. Maternal mortality is also on the decline globally.

Result of findings in Odetola et al (2015) studies on Health care utilization among rural women of child-bearing age: a Nigerian experience indicate that it is quite true as peoples' decisions most of the time are influenced by their level of education as highly educated childbearing women for example will patronize the best health institution based on their informed minds and perhaps affordability of the service. This is also because the highly educated respondents are likely to earn more to afford even the service cost of the institutions of their choice<sup>(9)</sup>.

Perceived lack of consideration for cultural beliefs, traditions, and practices by health care professionals caused stress and was deemed a barrier to health service access. One of the respondents wrote the following under barrier to taking care of health in the host country: "cultural beliefs that Australians do not understand. For example, the Australian nurse did not understand that I do not want to shower 30 minutes after delivery because it will make me sick. Cultural meanings, attitudes, and beliefs impact behaviors. These cultural beliefs are hard to explain to health care professionals from different cultural orientations, language proficiencies, and authoritative status. Having a tolerant approach of the different cultural perspectives of illness causation may help to promote better patient-health provider relationship<sup>(8)</sup>.

The study investigated the predictors of utilization of maternal health services encompassing prenatal, intra-natal and post-delivery care. Therefore, the purpose of this study was to explore the association between selected socio-economic and demographic factors and the likelihood of utilizing moderate and desirable packages of MHS. This paper contributes towards enhanced understanding of factors that influence uptake of maternal health services in Bacnotan Hospital, District 1 La Union, Philippines based on a combined indicator of skilled attendance at delivery, antenatal care and post-natal care.

Achieving the MDG goal on maternal health requires providing high-quality pregnancy and delivery care, including essential obstetric care, focus antenatal care, and improving women's sexual and reproductive health<sup>(17)</sup>. The goal of prenatal care is to detect any potential complications of pregnancy early, to prevent them and to direct the women to appropriate specialist medical services. Maternal health is very important and health professionals must play effective roles to achieve the MDGs five (To improve maternal health of women both locally and internationally). Every woman has to visit the nearest facility for antenatal registration and to avail prenatal care services. This is the only way to guide her in pregnancy care to make her prepare for child birth. In view of this women should be guided on how to seek information on maternal health.

A review of the Millennium Development Goals suggests that limited progress is being made to reduce maternal mortality especially across developing countries including Nigeria<sup>(18)</sup>. However, interest abounds for community-based approaches to improving maternal health outcomes. One crucial lesson learnt from the Safe Motherhood Initiative is that community involvement is pivotal for sustained reduction of maternal mortality. This along with WHO recommendations on antenatal care should remain a strong weapon for the achievement of all the strategies and goals of reducing maternal and infant mortality globally.

Antenatal care is a critical opportunity for health providers to deliver care, support and information to pregnant women. This includes promoting a healthy lifestyle, good nutrition; detecting and preventing diseases; providing family planning counselling and supporting women who may be experiencing intimate partner violence.

### **Explanatory Variables**

In this study, Andersen's behavioral model of health service use was adapted to examine the relationship between individual-level socioeconomic and demographic factors and the utilization of a specific package of maternal health services. According to Gideon et al (2015) in Andersen's behavioral model, healthcare utilization is a function of three major elements: predisposing factors (socio-demographic factors), enabling factors (e.g.

income and health insurance) and healthcare needs such as functional disability and chronic illnesses. The predisposing factors in the model were: education level attainment, marital status Occupation/Employment and number of children ever born. Wealth indicator was also considered an enabling factor<sup>(19)</sup>.

### Statement of The Problem

Several strategies have been on ground to reduce maternal morbidity/mortality rate globally including Ante-natal Clinic (ANC), Maternal and Child Health (MCH), Primary health care (PHC), Focused antenatal care (FAC), Millennium Development Goals (MDGs) among other. The challenge of reducing maternal mortality remains a major problem inspite of improves in medical services, technology and aggressive training of health personnel by most countries in the world. Several studies suggest that limited progress is being made to reduce maternal mortality especially across developing countries. Antenatal care therefore is considered a key entry point for pregnant women to receive a broad range of health promotion and disease preventive services. The knowledge road to health has many pitfalls and women in less developed countries particularly those who are poor, illiterate and unemployed, face crucial tradeoffs when they attempt to fulfill their biological, social, physiological and other needs.

### METHODS

The researcher utilized quantitative-descriptive survey with questionnaire for the study. Articles for the review was drawn from peer-reviewed journals, conference papers, health professional studies, research by recognized independent institutions, and narrative review of various topics which describes the status quo. This was used in the study to find out the level of access/utilization of respondent on maternal health services in the health facilities among the patients.

This study was conducted at health institution in District Hospital Bacnotan. The study population included women of child-bearing aged between 18 and 50 years attending the antenatal clinics in OPD for antenatal check-up/treatment in the health institution under study. Total of 102 respondents were selected and given questionnaire to fill for the study.

Ethical approval to conduct the study was obtained from the Saint Louis University Baguio, Philippines and Bacnotan District Hospital ethical committee. The participants' informed consent was sought with an assurance of their confidentiality and anonymity. The questionnaire was administered by the researcher to individual participants of the selected group and retrieved on the spot. Filling in of the questionnaire took between 20 and-30 minutes and the data collection procedure lasted for four weeks.

A well-structured weighted questionnaire of 56 items involving open- and close-ended questions was used to interview the targeted population group. The first part of the questionnaire focused on the profile of the respondents which included age, sex, and occupation while the second part focused on the level on maternal health access/utilization of services available etc.

The face and content validity of the questionnaire were ensured while a test-retest method was adopted to determine the reliability of the instrument within a two- week interval. The reliability was determined by comparing the two results after administration with a Chrobach's Co-efficient of 0.67.

A permission letter was obtained from the dean of graduate school Saint Louis University Baguio; forward it to the health institution where the study was conducted for approval before floating the questionnaire to the patients during their daily hospital attendance. The researcher introduced himself to the respondents to gain their trust, rapport, and cooperation before the distribution of the questionnaire. A verbal consent for participation was obtained from the participants to ensure voluntariness and respect of their autonomy and the right to withdraw anytime during the process of data collection was stressed to the participants. The researcher explains the purpose, objectives, processes, benefits and other important information needed by the participants regarding the study. To safeguard the privacy of the respondents, the researcher explains to the mothers that information collected will be treated with anonymity and confidentiality. The questionnaire was given to all those who were willing to volunteer in the established inclusion criteria.

Descriptive statistics primarily with closed-ended frequency questionnaire was employed for qualitative method in interpreting the responses. The qualitative data was embedded in the discussion of the quantitative data, highlighting to persuade the implementation of the stated laws which will help to establish an in-depth strategy to stimulate the policy maker' effort towards policy amendment to better improve maternal health access/utilization for overall quality services to the beneficiary's (patients/citizens) of Philippines. Weighted mean was used for the computation to determine the extent of access/utilization of health services by the pregnant mothers while Pearson's Correlation coefficient was employed for the demography status in the study.

Table 1. Tool for treatment of data

Mean	Description
2.35-3	Always available
1.68-2.34	Sometimes available
1-1.67	Not available

Note: Range of Scale =  $\frac{\text{Highest Score}-\text{Lowest Score}}{\text{Number of categories}} = \frac{3-1}{3} = 0.67$

Table 2. Pearson’s correlation coefficient

Pearson’s Correlation	Description
1.00	Perfect
0.91-0.99	Very High
0.71-0.90	High
0.51-0.70	Moderate
0.31-0.50	Low
0.01-0.30	Negligible

## RESULTS

### Prenatal services provided

Based on the result of the findings, it can be noted from the table that there are three indicators on the provision of prenatal services to pregnant mothers. Psychological support and Counselling on Nutrition during pregnancy (e.g. Adequate and rich nutritional diet), has the highest indicator with 3.00, administration of: Tetanus-toxoid and other drugs 2.86, and information about maternal and new-born health needs have the lowest with 2.83.

Table 3. Summary of prenatal services available/provided to mothers in the health facility

Health Services Available and provided	AWM	DE
Psychological support and Counselling on Nutrition during pregnancy (Adequate and rich nutritional diet)	3.00	AA
Administration of: - Tetanus-toxoid immunization and other drugs	2.86	AA
Information about maternal and new-born health needs	2.83	AA
Grand total	2.89	AA

Note: AWM=Average Weighted Mean, DE=Descriptive Equivalent, AA=Always Accessed NA=Not Available

### Provision of Intra-natal/Labor/Delivery services

Table 4. Summary of provision of intra-natal services/facilitating & hindering factors

Intra-natal/Labor/Delivery service	AWM	DE
Information on intra-natal/Labor	2.91	AA
Provision of postnatal services	2.89	AA
Personal factors facilitating/Hindering access to health services	1.45	NA
Health personnel Factors	1.28	NA
Logistics factors	1.28	NA
Grand total	1.96	NA

Note: AWM=Average Weighted Mean, DE=Descriptive Equivalent, AA=Always Accessed NA=Not Available

Table 5. Summary of provision of postnatal services

Postnatal services	AWM	DE
Care of mother and the newborn after delivery in the hospital	2.90	AA
Health teaching about secondary haemorrhage 6 hours after delivery to the end of the 6, anaemia, Nutrition, and postnatal exercise, nurture and how raise the child etc.	2.86	AA
Information on exclusive breastfeeding and counselling about family planning	2.85	AA
Grand Total of weighted mean	2.86	AA

Note: AWM=Average Weighted Mean, DE=Descriptive Equivalent, AA=Always Accessed NA=Not Available

### Personal factors/reasons facilitating/hindering mothers to access of health services

The summary of the findings on table 6 indicate that all the factors under facilitate/hindered the smooth provision of health services to pregnant mothers.

Table 6. Factors facilitating/hindering access to health services (personal reason, health personnel, and logistics)

Factors facilitating/Hindering access to health service	AWM	DE
Personal factors/reasons	1.63	NA
Health personnel Factors	1.28	NA
Logistics factors	1.12	NA

Note: AWM=Average Weighted Mean, DE=Descriptive Equivalent, AA=Always Accessed NA=Not Available

Table 7. Summary of level of access/utilization of health services by the pregnant mothers according to profile, services and factors, and factors

Indicators	Services	P- values	Degree of relationship	Remarks
Educational Level	Prenatal, Intranatal & Postnatal	0.130113	Positive Negligible Correlation	Not Significant
Marital Status	Prenatal, Intranatal & Postnatal	0.098873	Positive Negligible Correlation	Not Significant
Work/Occupation	Prenatal, Intranatal & Postnatal	0.011628	Positive Negligible Correlation	Not Significant
Parity/No of Children	Prenatal, Intranatal & Postnatal	0.167015	Positive Negligible Correlation	Not significant
Services	Prenatal, Intranatal & Postnatal	-0.03423	Negative Negligible Correlation	Not significant

## DISCUSSION

### Prenatal services provided

The results also indicate that the pregnant mothers are not starved of health services whenever they visit the health facility with any health problem(s) in addition to the normal prenatal appointment. However, their problem is long waiting hours before they are attended to. The findings is in consonant with Zohra et al (2016) in Adam et al (2005) who states that significant progress has been made in maternal, newborn, and child health (MNCH) in recent decades and that Maternal mortality is also on the decline globally<sup>(15)</sup>. Furthermore, the findings are in consonant with Lubbock (2008) who posits that health facility-based care increased women's sense of security and safety, which contributed to their perception of the value of institutional care and encouraged further utilization of services<sup>(20)</sup>. And that women's perception that facility-based care provides a safe environment for receiving care evolved from the quality of care they received and their delivery outcomes with previous pregnancies. This is indicative that the health personnel are living up to the expectation in terms of provision of health care in study. There is need for the health professionals to further intensify efforts to for the improvement on utilization of health services for the improvement of maternal health to Philippines' citizens.

### Provision of Intra-natal/Labor/Delivery services

As gleaned from the table 4, the indicators show that the services are always available. The highest weighted mean was gained from Information on intra-natal/Labor 2.91. Findings on this support Mluleki et al (2014) in Ngomane (2010) who opined that accessibility of maternal health care facilities and general health facilities is important in ensuring that lives are saved through the provision of essential maternal (or medical) services<sup>(2)</sup>. This result agreed with Alvarez et al (2009), & Birmeta et al (2013) who according to them, lack of access to health care services for pregnancy and delivery are among the main reasons for high maternal and neonatal mortality rates worldwide. Maternal care services remain important indicators for monitoring the progress of maternal outcomes, including maternal mortality<sup>(10),(11)</sup>.

All the indicators in the summary of provision of postnatal services on table 5 have encouraging results because all the services were availed by the pregnant mothers. The findings is in congruent with Mluleki et al (2014) where they stated that accessibility of maternal health care facilities and general health facilities is important in ensuring that lives are saved through the provision of essential maternal (or medical) services<sup>(2)</sup>. The first six weeks following the baby's birth (postnatal period) is a very important time not only for the baby but also for the wellbeing of the mother. As a new mother, she will be faced with numerous physical, emotional and social challenges. While there are some common postpartum body changes and symptoms, what she experiences will be unique and will not be the same as other women.

Since the goal is to provide the woman with access to effective, practical and supportive postnatal care that is essential for her current and future health and wellbeing, while her focus will be on her beautiful little baby the midwives should look after her and the baby. Additionally, the role of the midwife during the postnatal period is to provide support, advice and care at a level determined in partnership with the patient. She can be a great source of information and support for the woman during her postnatal visits. As such, she should ensure the health and wellbeing of both the woman and her baby after birth and assist her with breastfeeding and to help increase her confidence in her mothering skills.

### Personal factors/reasons facilitating/hindering mothers to access of health services

Some of the factors that facilitate/hindered the smooth provision of health services to pregnant mothers along personal factors includes; some women's intentions to seek delivery care may be thwarted by their failure to access or pay for emergency transportation or their inability to travel due to extremely rapid labour, lack of assistance or support from the spouse, effects of single parental syndrome etc. Other expenses related to seeking care are Cost of food/feeding during confinement and the likes. However, these barriers do not completely explain the discrepancy between the use of prenatal services and the use of delivery services. Traditional belief and some socio-cultural factors may explain this disconnect between women's utilization of prenatal and delivery services.

Respondents under the cultural factors that serves as a barrier in the, main study shows that; because of cultural belief such as Namalingo, Mystical and supernatural causes, and massaged with coconut oil with the aim

of restoration of their health, expelling blood clots from the uterus (womb) into a normal position, and promoting lactation, will prefer home delivery. The findings corroborates the study of Maneze et al (2015) who reviewed that Cultural meanings, attitudes, and beliefs impact behaviors. These cultural beliefs are hard to explain to health care professionals from different cultural orientations, language proficiencies, and authoritative status. Having a tolerant approach of the different cultural perspectives of illness causation may help to promote better patient-health provider relationship<sup>(8)</sup>.

Under health personnel factor, time spent/waiting time in the clinic to avail services (spare time of patient do not match operating hours of facilities) is a common factor both in developed and underdeveloped countries but mostly observed in developing countries. Another common feature is poor attitude of health personnel towards patients. Negative attitudes can significantly affect the therapeutic nurse-patient relationship, by negatively influencing the provision of care to patients hence there is need to inform the health professional to change their attitude towards patients who come to the hospitals for treatment of every ailments.

The findings support previous studies which indicated that health-care professionals in general hold a negative view of patients (Happell & Taylor, 2001; Howard & Chung, 2000), which can contribute to suboptimal care (van Boekel et al., 2013). Furthermore, there is evidence to suggest that nurses have a more negative attitude than other health-care professionals (Howard & Chung). Per Buguzi (2016), long waiting time and queues in public referrer hospitals have often been blamed on the shortage of health workers and inadequate hospital infrastructures. Long queues at the hospitals are tiring. But with the introduction of technology system, hospitals are now coming up with a lasting solution. This will go a long way to resolving Limiting opening hours by the health facility and availing of services at the convenient time for the patients.

Indicator shows 1.8 under health personnel factor which was attributed to long time waiting by the respondent. This result agreed with Rosenthal (2014) in her statement that Americans look down on national health system like Canada's and Britain's because of their notorious waiting list and there is also an emerging evidence that lengthy waits to get a doctor's appointment have become a norm in many parts of America Medicare particularly for general doctors but also for specialist. Similarly, Merritt Hawkins, a physician staffing firm found long wait in 2014 when it polled five types of doctors' office about several types of nonemergency appointments including heart checked up, visits for knee pain, and routine gynaecology exams etc.

Logistical barriers, which are a product of the political and economic environment, are easier to surmount than the intergenerational cultural influences in this region. Among them are that; women's utilization of services is affected by the varying degree to which they receive information about health care through formal and informal sources, including other women in the community, health workers, and partners, distance to health facility/Long travel distance or rugged terrain or topography that makes it difficult for mothers to access health services is another factor, and none availability of transportation in terms of emergency. Furthermore, the level of encouragement and promotion of healthy maternal health care-seeking behaviours provided by those information resources influences a woman's ability to overcome the cultural barriers to seeking care.

However, these barriers do not completely explain the discrepancy between the use of prenatal services and the use of delivery services. Traditional belief and some socio-cultural factors may explain this disconnect between women's utilization of prenatal and delivery services.

Result of findings in table 7 support Odetola et al (2015) whose studies on health care utilization among rural women of child-bearing age: a Nigerian experience indicate that it is quite true as peoples' decisions most of the time are influenced by their level of education as highly educated childbearing women for example will patronize the best health institution based on their informed minds and perhaps affordability of the service<sup>(9)</sup>. This is also because the highly educated respondents are likely to earn more to afford even the service cost of the institutions of their choice.

In summary, there is no significant relationship between the Level of access/utilization of health services by the pregnant mothers according to the Profile of services along educational attainment, marital status, and Parity/No of children/Kids, Occupation/Employment/working class pregnant mothers neither is there any according to profile on facilitating/hindering factors among the pregnant mothers/women attending Bacnotan district hospital for their antennal care. This shows that the under mentioned variables do not constitute much problem with accessibility of health services by the population under study hence are negligible.

## CONCLUSION

The study aimed at investigating factors that are associated with access/utilization of maternal health services in Bacnotan district hospital, District 1 LA Union, Philippines. First, the researcher noted that utilization of ideal maternal health services varies greatly by demographic and socioeconomic characteristics. The findings show that higher levels of education, in Bacnotan district 1, Personal factors/reasons, Health personnel factors, logistics and richer wealth status, are associated with increased utilization of desirable maternal health services package.

Therefore, to promote ideal maternal health services utilization, there is need to formulate policies and design programs, that will target women with low education, within and outside Bacnotan district and of poor

wealth status. Special attention should also be paid to women in the lower income categories, those with no education and those not working especially the single mom. Given the complex and varied settings within which the maternal health programs are offered in Bacnotan and Philippines in general, it is important to view any interventions within their demographic, socio-economic, political and geographic settings. The nature and scope of the population groups that are most affected by poor maternal health service delivery needs to be understood. Any future studies must therefore address aspects of health systems and the quality of care.

Based on the findings, the following conclusions were drawn; the inflow of patients into the hospital is high; while some pregnant mothers access/utilized the health services in the facility especially along prenatal services, some could not availed services at their convenient time due to understaffing of the health facility especially Nurses, Doctors and guidance and counsellors. Also some pregnant mothers could not receive support from their husbands and spouse/relatives. In addition, barriers were encountered along traditional beliefs held by some pregnant mothers and their spouse/partners. Finally, the physical infrastructures of the health institution require expansion.

From the findings and conclusions, the following recommendations were drawn:

1. The proposed measures such as urgent need for employment of Nurses/Midwives, medical Doctors, and guidance and counsellor to handle those patients with superstitious beliefs in the community. The management should also make arrangement to expend the physical infrastructures of the health institution was suggested and presented to the hospital management for consideration
2. A parallel study in the region should be conducted on the maternal access/utilization of health services by the pregnant mothers.

### REFERENCES

1. WHO. Maternal Mortality in 2015: Estimates Developed by WHO, UNICEF, UNFPA and The World Bank. Geneva: WHO; 2007.
2. Mluleki T, Appunni SS. Determinants of Access to and Use of Maternal Health Care Services in The Eastern Cape, South Africa: A Quantitative and Qualitative Investigation; 2014.
3. Ashrita Rau. Maternal Mortality in the Philippines; 2015.
4. <https://borgenproject.org/maternal-mortality-philippines/>
5. Oñate K. The Challenges of Maternal Health in PH. 2015.
6. [http://www.doh.gov.ph/sites/default/files/publications/DOH\\_Annual\\_Report\\_2015\\_07132016.compressed.pdf](http://www.doh.gov.ph/sites/default/files/publications/DOH_Annual_Report_2015_07132016.compressed.pdf)
7. Huntington D, Banzon E, Recidoro ZD. A Systems Approach to Improving Maternal Health in The Philippines; 2011.
8. Maneze D, DiGiacomo M, Salamonson Y, Descallar J, Davidson PM. Facilitators and Barriers to Health-Seeking Behaviours among Filipino Migrants: Inductive Analysis to Inform Health Promotion; BioMed Research International. 2015;(2015):9.
9. Odetola TD. Health Care Utilization Among Rural Women of Child-bearing Age: A Nigerian Experience; Pan Afr Med J. 2015;20:151.
10. Alvarez JL, Gil R, Hernandez V, Gil A. Factors Associated with Maternal Mortality in Sub-Saharan Africa: An Ecological Study. BMC Public Health. 2009;9:462.
11. Birmeta K, Dibaba Y, Woldeyohannes D. Determinants of Maternal Health Care Utilization in Holeta Town, Central Ethiopia. BMC Health Services Research. 2013;13:256.
12. Tey NP, Lai SL. Correlates of and Barriers to The Utilization of Health Services for Delivery in South Asia and Sub-Saharan Africa. TheScientificWorldJournal. 2013;423403.
13. Hajizadeh M, Alam N, Nandi A. Social Inequalities in The Utilization of Maternal Care in Bangladesh: Have They Widened or Narrowed in Recent Years? International Journal for Equity in Health. 2014; 13(1):120.
14. Zere E, Kirigia JM, Duale S, Akazili J. Inequities in Maternal and Child Health Outcomes and Interventions in Ghana. BMC Public Health. 2012;12:252.
15. Zohra SL, Kumar R, Bhutta ZA. Community-Based Care to Improve Maternal, Newborn, and Child Health; Reproductive, Maternal, Newborn, and Child Health: Disease Control Priorities; 2016.
16. Ahmed S, Li Q, Liu L, Tsui AO. Maternal Deaths Averted by Contraceptive Use: An Analysis of 172 Countries. Lancet. 2012;380(9837):111–25.
17. WHO. Millennium Development Goal 5: Making Pregnancy Safer [Internet]. 2011 (cited 2011 Sep 17). Available from: [http://www.who.int/pmnch/media/press\\_materials/fs/fs\\_mdg5\\_Maternal\\_mortality/en/index.html](http://www.who.int/pmnch/media/press_materials/fs/fs_mdg5_Maternal_mortality/en/index.html).
18. WHO. The Safe Motherhood Initiative and beyond. Bull World Health Organ [Internet]. 2007 [cited 2013 March 4]. Available from: <http://www.who.int/bulletin/volumes/85/10/07-045963/en/>
19. Gideon R, Stephen O, Wandera T, Jhamba EA, Kiconco A. Determinants of Maternal Health Services Utilization in Uganda, 2015.
20. Lindsey AL, Stephenson RB. Utilization of Maternal Health Care Services in The Department of Matagalpa, Nicaragua. Rev Panam Salud Publica. 2008;24(2).