Original Article:
Women Status and Access to Maternal Healthcare Services in Primary Healthcare Facilities of North Ukelle, Yala Local Government Area of Cross River State

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Abstract: Introduction: Access to skilled maternal health services has been recognized as a panacea to poor maternal health outcome. However, poor access to skilled maternal health services prevail and this is worrisome because of the corresponding poor maternal health outcomes. This study examined women's status and access to maternal health services in primary healthcare facilities of North Ukelle.

Methods: A cross sectional survey design was adopted for this study while a validated questionnaire with a reliability coefficient of 0.67 was administered to obtained data. A multistage sampling technique was used to select 390 women who had been pregnant within twenty four (24) months prior to the survey. Both descriptive and Chi square techniques were applied to analyze data using SPSS 21.0. Result: Findings from this study showed low access, as only 176(45.1%) accessed maternal care in the primary healthcare facilities. Decision for care was taken by husbands alone for 152(39%) respondents and the influence of low decision autonomy was conspicuous as husband's decision determined place of registration for maternal care in 254 (65.1%) respondents. Access to health facility based care increased with higher level of education. Interestingly, women involved in trading 72(18.5%) accessed care more than civil servants 43(11.0%). Chi square analysis showed no significant association between occupation and access. Conclusion: Based on these findings, flexible maternal care periods such as evenings and weekends should be adopted to accommodate working class women with tight time schedule.

Key Words: Women status, Decision autonomy, Access, Maternal health services.

Introduction:
The challenge of access to skilled maternal health services in low income countries has been a global concern among stakeholders in health. This is worrisome as low access is associated with corresponding poor maternal health outcomes. Many factors including the low socioeconomic status of women have been implicated in perpetuating poor access to maternal health services in healthcare facilities. Women's low status which manifest as lack of decision making autonomy, educational and occupational disadvantaged positions have been attributed to the culturally embedded patriarchal practices prevalent in Africa.[1,2] This trend often increase the diverse health challenges experienced by women of reproductive age as it limits their ability to access maternal healthcare services [1-4].

Barriers to accessing maternal health services affect the health status of women and contribute to the lingering high maternal mortality rate (MMR) prevailing in Africa [4,5]. Maternal mortality rate therefore may be viewed as the consequences of the poor status of women as it affects the degree of access to skilled maternal healthcare [6]. Access to maternal health services entails the ability of women to obtain prenatal, antenatal, facility-based delivery and postnatal services and has been seen as the panacea to poor maternal and child health outcomes prevailing in many developing countries [7,8]. Several studies [9-11] have implicated the low status of women as barrier to skilled maternal healthcare with resultant high maternal mortality rate. According to the World Health Organization (WHO) [12] 800 women die every day from preventable causes related to pregnancy and childbirth. In Nigeria, the 2013 Demographic and Health Survey (NDHS) reports that, Nigeria has a Maternal Mortality Rate (MMR) of 545/100,000 while [13,14] asserts that Nigerian women are 500 times more probable to lose their lives in childbirth when compared to most advanced...
nations of the world. Maternal mortality is therefore seen as a “social justice issue because women alone suffer from maternal deaths” and a large percentage of these deaths mostly occur among women of lower socioeconomic status [15-18]. In Africa, where patriarchal practices exist, decisions on where, when, and even whether a woman should have access to maternal healthcare is not within the purview of the woman but the husband. Women ability to take decisions on healthcare has been identified as a determinant to maternal healthcare access [19]. According to Woldemeskel, making autonomy refer to their ability to take and execute independent decisions on issues pertaining to personal matters even though husbands and others may be opposed to the decision”. The decision to access maternal healthcare is a complex process which has caused a lot of maternal death due to delay in taking decision to seek care [21,22]. Challenges in women health decision autonomy and control in developing countries have been reported in several studies [23, 24]. In one focused Group discussion (FGD), an FGD participant expressed “I believe one major reason why some women in this town do not go to deliver in the hospital is because they are powerless. … as women, we are expected to be submissive to our husbands. Because of this, most of us women depend on our husbands to make decisions for us. So if my husband makes a decision that I should not go to give birth at the hospital, I have to obey him” [24]. In Nigeria, evidence from the 2008 Demographic and Health Survey shows that, decision for women healthcare services was taken by husbands in 56% of women [25]. Ganle et al [24], report that the final decision on access to maternal care was taken by husbands in 49.2% of women, 16.2% by mother in-laws while only 2.7% of the women took the final decision themselves. Some studies have reported high level of powerlessness in healthcare decision making among women while most women who prefer to use modern maternal healthcare are incapacitated because the decision for care is dependent on the decision of significant others [26-28]. Conversely, [10] observed that participation or non-participation of women in their healthcare decisions had little or no effect on access to facility-based maternal care. Women educational status has been identified as a determinant of access to skilled maternal care [17,25]. Education equips women with information and cognitive skills to recognize unfavourable symptoms. It influences the health-seeking behavior through a number of pathways such as: higher level of health awareness and knowledge of available health services; some earning possibility to bear cost of maternal care and, ability to take healthcare decisions and negotiate care options [29]. Education generally enhances women’s social and economic status [30,31] and educated women are more able to overcome negative cultural norms, gain skills and confidence in bargaining for autonomy within the family and community [6,32]. According to Chimankar and Sahoo [32], the possibility of assisted skilled delivery is 5.3 times higher for women with higher education as against 1.7 times for those with secondary education. Adedokun and Uthman [33] also observed that about 62% of the women did not utilize health service during delivery and more than three-quarter of those with no education, never utilized the facility for delivery. There is a corresponding higher possibility of “attending at least 4 antenatal clinics with increasing educational level” [19]. On the contrary, [34] report that the level of education acquired by women was not a significant determinant of access to maternal healthcare services. Umar[6] further argued that, educated people tend to miss follow up visits because of their jobs, do not comply with full treatment regimen and are more likely to practice self-prescribed treatment. Occupational status of women is an important factor for improving women’s overall status in the society. This is because a woman’s occupation, employment or income status translate to their financial independence and ability to pay for maternal care [30,35]. Awusi, Anyanwu and Okeleke [36] report that 100% of women who were traders had higher use of maternal services than those who were farmers (48%) and full time house wives with no source of income (36%). Adebowale and Akinyemi [37] also observed that about 71.1% and 54.9% of women who earned 20,000 naira and at least 5,000 naira as average monthly income accessed skilled maternal services. Also, women who engaged in income generating occupations other than farming are more likely to seek maternal care early and attend three or more antenatal care visits [30]. In divergence from other studies, Adamu [38] asserts that non-working women are more likely to use skilled maternal health services than working class women because they have more time to attend clinics than working class women. Similarly, Nai-Peng [39] reported that the “odds of using a health facility for delivery were about the same for both working and non-working women in Tanzania and three South Asian countries.

Statement of Problem

The availability of maternal health services in health facilities does not invariably imply access to these services by women of reproductive age. Much effort has been invested into making health services available at all levels of healthcare by the stakeholders, however, poor access to maternal health services still prevails in developing countries [19,22,40]. Availability and access to maternal healthcare services are important if positive maternal health outcomes are to be achieved. Globally, only 64% of women receive a maternal antenatal care four times throughout their pregnancy and only 50% of all births take place in a health facility in developing countries [41]. In Nigeria, [1,33,41] observed that majority (62%) of the women do not receive skilled care during delivery and 61% of pregnant women do not received skilled antenatal care. Cross River State maternal mortality rate is unacceptably high as the 2013 baseline survey reports a maternal mortality rate of 545/1000 live birth [42]. This is worrisome as low access to maternal health-care services still prevails maternal health outcome. A study in Akapbuyo in Cross river State [9] indicate that, “out of 130 women, 84.6% of all the births occurred outside the government health facility” while [43] also observed that out of 7,759 women only 46 percent (3569) attended four facility Antenatal care visits in cross River. These reports reveal the lingering challenges of access and therefore demand new action if positive maternal health outcomes are to be achieved. A variety of factors have been identified as contributing to the lingering challenge of poor access to skilled facility-based maternal care in government health facilities; one of the factors is the low socioeconomic status of women [9-11,17]. North Ukelle is a rural community in Northern senatorial district of Cross River State with primary healthcare centers and numerous health Posts in each of the political wards thus, reducing the challenge of distance and availability. Yet, a study in Northern Cross River [35] report that only 16.5% of women accessed government facilities for care indicating low access. This concern prompted this study which investigates women status and access to maternal healthcare services in the Primary healthcare centers of North Ukelle, Yala Local Government Area of Cross River State.

Objectives

Specifically, the study aims to:

i. Assess level of access to maternal health services in primary healthcare facilities

ii. Determine the influence of women decision-making autonomy on access to maternal health services

iii. Examine the relationship between women educational status and access to maternal health services

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iii. Examine the relationship between women educational status and access to maternal health services
iv. Investigate the influence of occupational status on access to maternal health services

**Hypothesis**

Women occupational status has no significant association with access to maternal health services in the Primary health care facilities of North Ukelle

**Materials and Methods**

The study adopted a cross sectional survey design aimed at describing the influence of women status on access to maternal health services in Primary Health Care facilities of North Ukelle, Yala Local Government Area, Cross River State. North Ukelle is a rural community in Yala Local Government with four political wards and four corresponding Primary healthcare centers with numerous health posts. The study population consisted of women of reproductive age (15-49 years) residents in North Ukelle who had been pregnant within twenty-four (24) months prior to the survey.

The sample size for this study was determined using the Taro Yamane formula based on the population of women in Yala LGA as documented in the 2006 Population and housing Census which was 106,141 [44]. The sample size for the study therefore was 398 women of reproductive age. A multistage sampling procedure was adopted to select a sample of 398 women of reproductive age. An initial division of the study area was done using the four political wards as clusters. Out of the four clusters, two clusters were randomly selected which were; Wanihem and Wanikade wards. From each of the two clusters, 199 households were selected through the systematic random sampling of every 2nd household. In the event that none of the women in the selected household met the inclusion criteria, the next household is skipped and the one following is selected.

The instrument for data collection was a validated questionnaire with a reliability co-efficient of 0.67 which had section A and B. Data was collected on a face to face basis with the help of two indigenous and trained research assistants to aid interpretation where necessary. Women in the selected houses that met the inclusion criteria and who gave verbal approval were given the questionnaire to fill independently. However, those who were unable to fill were assisted by the research assistants.

Data collection covered a period of three weeks with on-the-spot retrieval. Eight (8) questionnaires were invalid while three hundred and ninety (390) were filled correctly. Data obtained was processed using Social Package for the Social Sciences (SPSS) version 21.0. Both descriptive and Chi square technique were used to analyze data.

**Ethical consideration**

A written application for permission to carry out the study was submitted through the Primary Healthcare Department to the State Research and Ethics Committee. Permission was given which was submitted to the village heads. The purpose of the research was explained and verbal consent obtained before administration of instrument. Confidentiality was maintained.

**Results**

Table 1 shows the socio demographic data of respondents. Majority of the respondents (52/39.0%) were within the age range of 25-34 years while 125(32.0%) where within 15-24 years; 121(31.0%) had three (3) children while 149(38.2%) had four (4) children and above. Educational status of respondents revealed that majority of the respondents (109/27.9%) had primary education followed by those who never attended school with 104(26.6%) which shows a high level of illiteracy among women. Only 92(23.1%) had attained secondary education. For occupational status, majority 168(43.1%) were traders, only 92(23.6%) were civil servants while 130(33.3%) were farmers. This result shows that petty trading was a major source of income for women in North Ukelle.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 – 24 years</td>
<td>125</td>
<td>32.0%</td>
</tr>
<tr>
<td>25 – 34 years</td>
<td>152</td>
<td>39.0%</td>
</tr>
<tr>
<td>35 – 44 years</td>
<td>90</td>
<td>23.0%</td>
</tr>
<tr>
<td>45 years and above</td>
<td>23</td>
<td>6.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>390</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>251</td>
<td>64.3%</td>
</tr>
<tr>
<td>Not married</td>
<td>139</td>
<td>35.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>390</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>44</td>
<td>11.3%</td>
</tr>
<tr>
<td>2</td>
<td>76</td>
<td>19.5%</td>
</tr>
<tr>
<td>3</td>
<td>121</td>
<td>31.0%</td>
</tr>
<tr>
<td>4 and above</td>
<td>149</td>
<td>38.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>390</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Educational qualification</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tertiary</td>
<td>82</td>
<td>21.0%</td>
</tr>
<tr>
<td>Secondary school</td>
<td>95</td>
<td>24.4%</td>
</tr>
<tr>
<td>Primary school</td>
<td>109</td>
<td>27.9%</td>
</tr>
<tr>
<td>Never attended school</td>
<td>104</td>
<td>26.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>390</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trading</td>
<td>168</td>
<td>43.1%</td>
</tr>
<tr>
<td>Civil servant</td>
<td>92</td>
<td>23.6%</td>
</tr>
<tr>
<td>Farming</td>
<td>130</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>390</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christianity</td>
<td>325</td>
<td>83.3%</td>
</tr>
<tr>
<td>Islam</td>
<td>5</td>
<td>1.3%</td>
</tr>
<tr>
<td>Traditional religion</td>
<td>60</td>
<td>15.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>390</td>
<td>100%</td>
</tr>
</tbody>
</table>

Figure 1 below shows the level of access to maternal health services in the Primary health care facility. Results shows that, out of 390 respondents, only 176(45.1%) respondents used the primary health care facilities, 78(20.0%) accessed care in private clinics 46(11.8%) patronized traditional birth attendants while 90(23.1%) did not access any form of care. The result reveals low access to skilled care in the Primary healthcare facilities.

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Petty trading</td>
<td>272</td>
<td>69.0%</td>
</tr>
<tr>
<td>Agriculture</td>
<td>96</td>
<td>24.7%</td>
</tr>
<tr>
<td>Farming</td>
<td>12</td>
<td>3.1%</td>
</tr>
<tr>
<td>Wage labor</td>
<td>13</td>
<td>3.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>390</td>
<td>100%</td>
</tr>
</tbody>
</table>

Figure 2 below shows result for the number of times women visited the Primary healthcare facility for antenatal care before delivery. Data shows that out of the 176(45.1%) respondents...
who accessed care in the primary health facility, majority 80(45.5%) had three visits while only 18(10.2%) visited the health facility four times before delivery. This shows that most respondents did not meet the four required number of antenatal visits recommended.

Figure 2: Number of antenatal visits to the Primary healthcare facility

Figure 3 shows respondents level of decision autonomy on access to maternal healthcare services. Out of 390 respondents, responses from 152(39%) women shows that only their husbands decided on where and when to access maternal healthcare while 70(18%) of women took maternal healthcare decisions alone. About 90(23%) of respondents indicate that mother in-law and others took decision on maternity care. This indicates low decision making autonomy among North Ukelle women even in issues that concern their health.

Table 2 shows responses on the influence of decision making autonomy on access to maternal healthcare in the primary healthcare facilities. Out of 390 respondents, 254(65.1%) responses shows husband decision determined where they registered for maternal care while husband decision also affected when they registered for care 220(56.4%). Majority 234(60%) were not even consulted for their opinion on where to seek care while 212(54.4%) agreed that husband or family refusal to give consent can deprive women of accessing skilled care in the health center during delivery. However, low decision autonomy did not affect revisits. This may be attributed to the low financial cost involved in revisits if the clients has no complaint.

The influence of women educational status and access to maternal health services in Primary healthcare facilities as displayed in Table 3 revealed that 56(14.4%) out of 82 respondents with tertiary education used the Primary healthcare facilities. Although the population of women with Primary level of education and never attended school was higher, their level of access to skilled maternal services was lower with 42 (10.7%) and 31(7.9%) respectively. The result shows that higher level of education is associated with a corresponding increase in access to maternal care in the Primary healthcare facilities.

Table 4 below displays result on occupational status and access to maternal healthcare services. Out of 168(43.1%) respondents who were traders, 72(18.5%) patroonized the health facility for maternal healthcare, 61(15.6%) respondents from the 130 (33.3%) women who were farmers used the facility while only 43(11.0%) out of 92(23.6%) who were working class accessed care in the health facility. Interestingly, findings from this study show that traders and farmers accessed maternal care in the health facilities more than civil servants or women with formal jobs.

Table 5: Chi-square analysis of occupational status and Access to maternal health services

The Chi-square analysis of the relationship between women occupation and access to maternal health services showed that the calculated (x2) value of 0.6 was observed lesser than the critical value of 5.99 at 0.05 level of significance. The null hypothesis was therefore accepted which implies that women’s occupational status does not significantly influence access to maternal health services in the Primary Healthcare facilities.

**Discussion**

Access to skilled maternal health services have been a challenge in Nigeria [9,19,22] despite the importance of accessibility to maternal health outcomes. The findings from this study as shown in figure 1 revealed that out of 390 respondents only 176 (45.1%) of the respondents accessed maternal health services in the Primary health care facilities. This result corroborates the findings by Ugal [34] that only 16.5% of women accessed care in government facilities while 80.3% patronized traditional birth attendants. This result also agree with the study by Oyewale and Mavundla [1] who reveal that 61% of women did not received skilled antenatal care (ANC) while only 38% of women received skilled delivery care. The observed trend in this study may be related to the prevailing patriarchal norms in Ukelle where the husband must give consent for care before women can access care. Again, preference for alternative healthcare pathways such as private clinics and traditional birth attendants as shown in this study may be attributed to flexible terms of payment and time of consultation by these alternative channels. Private clinics accept payment of maternal care cost by instalment while traditional birth attendants accept payment by instalments and alternative forms of payments such as working in the provider’s farm as monetary equivalent for cost of care. The study also observed that only 18(10.2%) visited the health facility four times and above. Majority had three visits which is less than the recommended number of visits for Focused antenatal care by WHO. This result agrees with the report of [35,43] in Cross River where only 46% of the study population visited the health facilities four times for antenatal care. This may not be unconnected to women inability to obtain permission from husband or mother in-law or lack of time-off from work, business or farm. The challenge of obtaining permission for maternal care have also been identified by [4,40]. This observed trend poses a challenge as less than four antenatal visits are not adequate to achieve positive maternal health outcomes as conditions that complicate pregnancy and labour cannot be detected with fewer visits.

Women healthcare decision autonomy as observed in this study is low as only 70(18%) of respondents agreed to taking independent decision on maternal care access while for 152(39%) respondents, maternal care decision was taken by husbands which corroborate the findings by [25,26]. This finding is similar to the report by [24,26,28] that, most women would prefer to use modern maternal healthcare but are incapacitated because the decision for care is dependent on the decision of husband and significant others. Lack of decision autonomy on access as observed in this study may be attributed to the prevailing patriarchal norms of submissiveness to husbands [24] which is a highly valued virtue in the Nigerian society. This, and the popular dictum of “he who pays the piper dictates the tune” further increase women powerlessness to decide when and where to seek maternal care. This result highlights the need for financial empowerment and the child girl education. When women are able to pay for the maternal care cost, they confidently negotiate care options and seek care when and where necessary. Delay in accessing maternal care is attributed to husband consent which has denied most women of assisted delivery with consequent poor maternal health outcomes. Conversely, findings from this study deviates from the report by [10] who observed that women decision autonomy and participation in taking decisions concerning their health have no significant influence on access to maternal care services. Women educational status was observed as the strong determinant of access as 56(14.4%) of women with tertiary education accessed care in the healthcare facilities. Finding shows that access increased with higher level of education. This result agrees with the findings of [19,32] that higher educational status has a strong positive effect on the possibility of using maternal health services with a “corresponding higher possibility of “attending at least 4 antenatal clinics [19].

Increase access to skilled maternal healthcare services by women with secondary and tertiary education is related to enhanced knowledge on the implications of not accessing skilled care services. Information gained through classroom exposure, media and books enhance women ability to recognize abnormal signs and symptoms during pregnancy. Education also builds women self-esteem and gives them the confidence to discuss maternal care options with spouse and interact confidently with the healthcare providers. Women with no form of education may feel inferior and, the fear of being treated with disdain by the providers scare them from the health facility. The positive influence of educational status observed in this study disagree with the findings of some studies [6,33] who report that level of education has no significant influence on the use of skilled maternal health services. Responses in this study and the chi square analysis on women occupation and access to maternal health services showed no significant influence of occupation on access to maternal healthcare. Interestingly, traders and farmers accessed maternal healthcare more than civil servants. This finding is similar to the assertion by Adamu [38], Nai-peng and Snow-Li [39] while, it contradict the findings of [36,37]. Adebowale and Akinyemi [36] report that women with jobs and who earned at least 20,000...as average monthly income accessed skilled maternal services. The observed trend in this study suggest that the influence of educational variable must have played a role as some of the traders and farmers may be educated but with no formal jobs. Due to the prevailing unemployment, some literate women may venture into trading so as to earn income which may have influenced their health seeking behaviour. Again, time constraint experienced by working class women or civil servants may have influenced the trend observed in this study. Traders and farmers do not need formal permission to be off-work to access care while women on formal jobs may be constrained through bureaucratic processes to be permitted as clinic days are on work days. This may discourage them from patronizing the government facilities which has strict time regimen for maternal care clinics with providers while they may patronize other pathways with flexible and open consultation time that fit their schedule.

**Conclusion**

Women’s access to maternal health services in the Primary healthcare centers is a challenge in North Ukelle as revealed in this study. Poor access of skilled maternal care was identified as low decision making autonomy and low educational status of North Ukelle women. Interestingly, occupational status had no significant influence on access. The palpable powerlessness and low educational status translating to low access to care could be address through implementing free education for the girl child at the primary and secondary level particularly in rural communities. Education reduces the patriarchial ties of powerlessness in decision making and lack of information because it empowers the girl child with information, high self-esteem and confidence to negotiate maternal care options with spouse and significant others. Strategies to increase women financial independence through loans for small scale businesses at the grassroots (rural

**References**

communities) should be implemented. To accommodate the civil servants and women who have less free periods, flexible schedule for maternal care services (evenings and weekends) should be adopted by healthcare providers serving in rural communities. It is also important that free maternal health service programmes should be implemented in earnest, void of informal cost so as to eliminate barrier of service cost.

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