

Access to health services: analysing non-financial barriers in Ghana, Bangladesh, Vietnam and Rwanda using qualitative methods

A review of the literature



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EXECUTIVE SUMMARY

This study forms part of a larger project supported by a grant from the Rockefeller Foundation, 'Support to UNICEF for Universal Healthcare with Equity through health system reorientation and strengthening' (Grant no. 2012 THS 319). It seeks to synthesise existing knowledge on how equity can be operationalised as a central objective of Universal Health Coverage (UHC). It aims to embed into UNICEF's District Health Systems Strengthening (DHSS) systematic methods to identify, assess and address non-financial access barriers as part of the causal analysis of priority bottlenecks, in a way that yields actionable data for district managers. It develops the premise that to meaningfully engage with at-risk groups requires building the capacity of local administrations to use appropriate methods to assess and resolve local barriers that prevent reaching UHC.

Against this backdrop, the current study had four specific objectives: i) to conduct a literature review to identify and synthesise non-financial access barriers to maternal and child health services in Bangladesh, Vietnam, Ghana and Rwanda; ii) to review the qualitative methods used to identify and assess these barriers as distinct from financial barriers; iii) based upon the findings of the literature synthesis, to review the conceptual model of Frenz & Vega for assessing non-financial barriers to UHC at the sub-national level; and iv) to make recommendations on how qualitative tools and the updated model can contribute to the equity-focused diagnostic and monitoring components of UNICEF's DHSS approach to bring about tangible benefits for the population in terms of equity of access and quality of care.

In the study, equity was understood to be the just distribution of healthcare according to need, leading to equal utilisation for equal need across socioeconomic groups. Access was seen as a multidimensional process of interaction between the health system and individuals, households and communities, influenced by diverse factors and dependent on empowerment. Barriers were defined as the manifestation of a 'lack of fit' between a potential healthcare need and the actual service that is supposed to be addressing that need.

A structured literature review was conducted. This methodology is derived from that accepted for systematic reviews, using rigorous study selection and defined inclusion and exclusion criteria, but it does not seek to identify and incorporate every paper published. Rather, it focuses on the synthesis being comprehensive, i.e. the final corpus of literature included all themes that could have been identified. The search strategy was designed to identify qualitative studies published in English that addressed non-financial barriers to access for maternal and child health services in Bangladesh, Vietnam, Ghana and Rwanda. Two online databases, PubMed and ProQuest were used as the basic search engines. After a five-phase search and inclusion/exclusion strategy, 48 papers were included in the full review – 18 for Bangladesh, 19 for Ghana and 11 for Vietnam. No appropriate material was found for Rwanda, so the review focused on three countries.

Appraisal was undertaken in order to achieve an understanding of each study on its own terms, with the intention that any study in which the depth and breadth of the reported data were

insufficient to suggest that the findings were trustworthy would be excluded. A customised appraisal form was developed that gathered information across four domains: research and analytical question; research team and level of reflexivity; methodology and study design (including theoretical framework, participant selection, setting and data collection); and analysis and findings. No study was excluded due to assessment of conduct (validity and robustness), assessment of reporting (transparency) or assessment of content and utility of the findings.

The findings were analysed to produce a thematic synthesis. There are three main stages to thematic synthesis: preliminary coding of material into emerging trends; building descriptive thematic constructs; and developing analytical themes. It is an inductive approach that is data driven and generates themes that are empirically faithful to the cases or literature from which they were developed. Six analytical themes were identified that articulate non-financial barriers preventing access to maternal, neonatal and child health (MNCH) services in Bangladesh, Vietnam and Ghana: perception of the condition; home management and local treatment; the influence of family and community; lack of autonomy and agency to act; physical accessibility; and health facility and biomedical deterrents. The thematic analysis forms the substantive core of this report.

In line with this qualitative review, a second workstream of the project reviewed literature that used quantitative analysis to identify and assess non-financial barriers to access using household survey data [Thiede & Koltermann 2013]. One conclusion drawn was that because of the dominance of data sources representing the national level, with only limited sub-national disaggregation largely by geographic area and urban/rural residence, household surveys can only provide one side of the access paradigm. The analysis of household surveys provides important orientation as to the interrelationship of different access barriers, but the complex interactions between various predisposing, enabling and need factors at the local level, where services are supplied and accessed, are hardly reflected. Synthesising the results of the qualitative and quantitative workstreams allows for analysis that moves between the national, sub-national and local levels, and can be mutually enforcing. The discussion section presents a preliminary analysis of key findings from the two workstreams that highlight areas of particular interest: education; gender; decision-making and autonomy; use of maternal health services and location of delivery; use of child health services.

Non-financial barriers constitute significant constraints to the equitable access of the full range of health services included under national UHC policies. However, barriers have different expressions and weight depending on context. In each country studied, there is virtually no data available to assess comprehensively the relative importance of various financial and non-financial barriers to access and utilisation. There is, therefore, a pressing need for further research on how specific barriers interrelate and what their role and contribution is to accessing healthcare across different at-risk groups.

This suggests that we need to take local contexts into account in the design of conceptual frameworks that guide analysis and shape policy at different administrative levels of a health

system. The model developed by Frenz and Vega [2010] is particularly useful in this respect. It aims to understand the access process and identify the sources of barriers and facilitators by taking account of supply and demand factors. In so doing, it identifies unmet need and proposes that the achievement of UHC with equity should be addressed from a population perspective with the goal of providing effective coverage to care for all, across socio-economic, socio-cultural and needs gradients. Health systems research has shown conclusively that the poorest and most vulnerable in society often shoulder the greatest burden of ill health, and that those individuals who are least likely to act (i.e., seek timely and appropriate care) are those who are least able to (due to limited access opportunities, lack of knowledge, lack of perceived value or acceptability, etc.) Systems that fail to ensure equitable provision and access to healthcare, especially for women and children, continue to deepen health disparities and hinder both national and international development.

Creating equitable access requires a wide range of evidence-based interventions to overcome (or at the least, to minimise the impact of) specific barriers, beyond increasing the availability of services by expanding healthcare facilities to underserved areas. With respect to the three countries included in this review, there is obvious scope for increasing the fit between the identified or potential health need and the actual service supposed to be addressing that need. As part of the wider project to support UHC with equity through health system reorientation and strengthening, this review should be used as a platform for developing a strong base of qualitative evidence.

In conclusion, three next steps are recommended.

1. Complete a more comprehensive synthesis of the findings from this and the quantitative review. This will further develop the 'mixed-methods' approach, and will allow for greater insight into non-financial access barriers in Bangladesh, Vietnam and Ghana.
2. Use the synthesised analysis as a guide for targeted research that explores specific barriers in specific contexts, or addresses knowledge gaps. The lack of data on non-financial access barriers for maternal and child health services in Rwanda (hence its non-inclusion in this review) signifies an obvious direction for future research.
3. Conduct a feasibility study to examine how an assessment of non-financial access barriers may be operationalised and incorporated into DHSS. This will include a critical appraisal of the qualitative methods that may be used, and the development of an analytical framework to assess both financial and non-financial barriers simultaneously, weighing their relative impact across different risk groups.

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INTRODUCTION

Background

Global efforts to attain the Millennium Development Goals (MDGs) suggest that using nationally aggregated data to develop effective and equitable policies aimed at achieving the MDGs or progressing towards Universal Health Coverage (UHC) have failed to identify, and subsequently address, substantive differences in patterns of coverage and access amongst at-risk sub-populations (such as women, children under five and neonates, or groups defined by residence, geographic area or livelihood). National strategies and policies based on such data often include a narrow set of assumptions on the composition of barriers preventing attainment of UHC. These largely focus on gaps in service provision, including insufficient facilities and staff, stock outs of essential commodities, lack of awareness or knowledge of available services [Bhutta et al. 2009], and financial barriers, such as direct and indirect user fees that prevent low-income families from accessing services [Marshall et al. 2010; Ridde 2011]. These are important components, but they do not account for the multitude of obstacles that may impede access, lead to inequitable access, and contribute to high levels of unmet need.

UNICEF is developing a feasible approach to assessing both financial and non-financial access barriers to health services included under national UHC policies, by incorporating qualitative and quantitative methods into their equity-based and results-focused approach to District Health System Strengthening (DHSS). Their DHSS approach seeks to support district health management teams in assessing, monitoring and implementing equity-focused health services for the most deprived children and their families, in order to achieve UHC and accelerate progress towards the MDGs.

The assessment of district performance starts with an analysis of health system bottlenecks that prevent universal coverage of high-impact maternal, neonatal and child health (MNCH) interventions. By using disaggregated data, patterns in bottlenecks can be compared for various at-risk populations within the district. District managers conduct a causal analysis of high-priority bottlenecks to identify root problems and develop contextually appropriate solutions. Currently, analyses of why the demand for services is lower than the supply available are often limited to an assessment of service-provision issues plus financial barriers. In policy terms, non-financial factors have received limited consideration [Ensor & Cooper 2004; O'Donnell 2007].

Problem statement

Service provision, financial factors and managerial issues contributing to bottlenecks are being systematically explored within the approach to DHSS supported by UNICEF. What is needed, however, is an enhanced and rigorous method for assessing non-financial access barriers that contribute to bottlenecks. Non-financial barriers represent a significant constraint to the equitable access of health services included under national UHC policies. A strong body of research has explored non-financial factors on the supply-side and there are pervasive

examples across the continuum of care that highlight major discrepancies between the coverage that should be attained for a given intervention and the actual demand for, and utilisation of, that intervention [O'Connell 2012; Estacio et al. 2012; Ebenstein 2010]. Evidence suggests that non-financial barriers account for a significant proportion of the gap, or 'lack of fit', between service provision, service access, and service utilisation amongst various at-risk sub-populations in low- and middle-income countries.

Overall aim

This study forms part of a larger project supported by a grant from the Rockefeller Foundation, 'Support to UNICEF for Universal Healthcare with Equity through health system reorientation and strengthening' (Grant no. 2012 THS 319). It seeks to synthesise existing knowledge on how equity can be operationalised as a central objective of UHC. It aims to embed into UNICEF's DHSS approach, systematic methods to identify, assess and address non-financial access barriers as part of the causal analysis of priority bottlenecks, in a way that yields actionable data for district managers. It develops the premise that to meaningfully engage with at-risk groups requires building the capacity of local administrations to use appropriate methods to assess and resolve local barriers that prevent at-risk groups from reaching UHC.

Against this backdrop, particular focus is given to key UNICEF interventions for maternal newborn and child health (MNCH) in Bangladesh, Vietnam, Ghana and Rwanda (see Appendix 1). These countries were selected for several reasons. They had been included in an earlier UNICEF-Rockefeller Foundation project to assess national health insurance in Africa and Asia (O'Connell 2012). Each was seen to have sufficient data sets including nationally standardised health and expenditure surveys and literature on health service access. Rwanda had less available data than the other three countries, but was included in the original remit given the country's important standing in global research on UHC and its strong political commitment to achieving UHC goals. In each country, UNICEF has an established country office and supports the use of the Multi Indicator Cluster Survey (MICS), Demographic and Health surveys and various standardised household expenditure surveys, which provide key sources of data for the overall project. The Rockefeller Foundation also has a presence in each country and all four are included in their Transforming Health Systems (THS) initiative. This is a five-year project that seeks to advance national progress towards UHC through an equity-focused approach to strengthening national and sub-national health systems. THS is aligned with the December 2012 declaration on UHC by the UN General Assembly, and is a core priority for the Foundation.

Specific objectives

This study (Workstream 1 of the larger project) had four specific objectives:

1. Conduct a literature review to identify and synthesise non-financial access barriers to MNCH services in Bangladesh, Vietnam, Ghana and Rwanda.
2. Review the qualitative methods used to identify and assess these barriers, as distinct from financial barriers.

3. Based upon the findings of the literature synthesis, review the conceptual model of Frenz and Vega [2010] for assessing non-financial barriers to UHC at the sub-national level.
4. Make recommendations on how qualitative tools and the updated model can contribute to the equity-focused diagnostic and monitoring components of UNICEF's DHSS approach to bring about tangible benefits for the population in terms of equity of access and quality of care.

This study is closely related to Workstream 2 of the larger project, the review of non-financial access barriers reported in quantitative literature analysing household survey data [Thiede & Koltermann 2013]. Objectives 3 and 4 drew on the preliminary review of findings from the two workstreams.

Report structure

Following this introduction, the report has six subsequent sections: an outline of the study's conceptual framework; a detailed methodology (including the search strategy used to identify literature for the review, the appraisal of papers included, and the analytical methods used for the thematic synthesis of findings); a tabular presentation of findings; the substantive thematic synthesis organised around six themes (perception of the condition, home management and local treatment, influence of family and community, lack of agency and the ability to act, physical accessibility, health facility and biomedical deterrents); discussion; and conclusion and recommendations. Prior to its finalisation, a working draft of the report was shared with UNICEF and colleagues for comment, and amendments were incorporated as appropriate.

CONCEPTUAL FRAMEWORK

Achieving UHC implies a reorientation of services and structures within existing health systems. In line with this reorientation, attaining equity in the financing and delivery of services is an important goal [Frenz and Vega 2010]. Equal access to health services for people whose healthcare needs are similar is regarded as an established principle of health equity [Oliver & Mossialos 2004]. Beyond this, however, the health equity debate is yet to present a single operational definition of 'access' to health services, although there is general understanding that any conceptualisation needs to consider the multiple dimensions of access that move beyond narrow economic or financial components.

In his key work on health service coverage and its evaluation, Tanahashi promoted a comprehensive view of coverage that included the ability of a health service to interact with its target population [Tanahashi 1978]. This has become a centrepiece of the conceptualisation of equity and access in the context of UHC, and was integrated into the framework of UHC with equity developed by Frenz and Vega [2010]. Tanahashi's model distinguishes service capacity or potential coverage from service output or actual coverage, and their relationship is defined by service utilisation. Further, the model assumes five successive stages towards a 'desired health intervention' that also defines the measurements of coverage: the availability of resources; accessibility of coverage; acceptability of coverage; contact coverage (people who

have ‘contacted’ the services as a proportion of the target population); and effectiveness of coverage. Tanahashi’s work remains at the forefront of the analysis of equity and health service coverage, although the default order in which he regards the various stages may be unnecessarily limiting. That said, the model is especially useful for an equity analysis because it facilitates the identification of groups with various patterns of unmet needs.

There is widespread agreement within health systems research that the dimensions of access comprise affordability, availability and acceptability of services, even if these dimensions cannot always be clearly defined (compare, for example, the use of the three terms by McIntyre et al. [2009] with the five components – approachability, acceptability, availability, affordability and appropriateness – forwarded by Levesque et al [2013]). As labels, they may be assigned to different components at different times, but ultimately they represent a set of complex factors that describe the relationship of the health system to its target population(s), and that determine access to effective healthcare.

Access is a complex phenomenon and equitable access can only be achieved if all the dimensions of access are addressed. This means taking into account the healthcare system, and collective and individual perspectives. It is helpful, therefore, to distinguish access from utilisation, and acknowledge that the latter is not necessarily a good proxy for measurement of the former. McIntyre and Thiede have argued that access should be regarded as the state of empowerment of individuals to use health services following their own informed decision, and stress the relational nature of the dimensions of access [McIntyre et al. 2009; Thiede 2005; Thiede et al. 2007].

Access as a concept of ‘bi-directional interaction’ [Thiede et al. 2007] becomes important with regard to the interpretation of barriers. In this study, we define a barrier as the manifestation of a ‘lack of fit’ between a potential healthcare need and the service that is supposed to be addressing that need. As such, a barrier is not absolute or static, but is dynamic and can manifest in multiple ways. Barriers are located at the interface between the health delivery system and its target population, and can occur at any (or multiple) points along the pathway of seeking and receiving effective care. The relative significance of an access barrier therefore depends on the interaction (or degree of fit) between the healthcare system and individual, household or community. Removing the barriers, or devising a system which functions within parameters that mitigate the barriers, is a policy challenge and a precondition of achieving UHC with equity.

This study builds on the conceptual model devised by Frenz and Vega [2010]. Following a review of extensive theoretical literature and evidence generated through health systems research on equity of access as it relates to UHC, they integrated common elements from diverse disciplinary perspectives to set forth an analytical framework to assess equity of access in UHC policies. It draws on the premise that equity of access is the result of the interaction between supply and demand issues at various levels and that equity demands particular concern for groups with greater needs. In recognising that a population sub-group’s resources and capabilities are characterised by the interdependence of human, social and financial

capital, it highlights the determinants of unmet need in a health system's context. Frenz and Vega [2010] stress the complexity of access and model it as a multi-staged process in which individuals recognise the need for healthcare, find available and acceptable services, make contact and ultimately receive an appropriate intervention. As they conclude, this is a 'path along which many obstacles may occur' [Frenz and Vega 2010].

Given the interrelationship of access dimensions, it is difficult to analyse financial and non-financial barriers to health service access in complete separation. With this caveat in mind, however, and because of the emphasis on financial barriers in previous research, this study focuses on the identification and assessment of non-financial barriers reported in qualitative literature documenting access to MNCH interventions in Bangladesh, Vietnam, Ghana and Rwanda.

METHODOLOGY

Given the nature of qualitative research there is ongoing debate about how feasible or acceptable it is to conduct a synthesis of qualitative evidence, as it may de-contextualise findings that are specific to a particular place, time and group of participants [Sandelowski et al. 1997; Sandelowski & Barroso 2007; Campbell et al. 2003]. Despite such concerns, the approach can yield rich, compelling and useful results that go beyond a summary of the primary studies, particularly when dealing with questions relevant to patient experience of illness and healthcare. The synthesis of qualitative literature has made valuable contributions to the development of policy and practice. As Walsh and Downe conclude, 'in response to the postmodernist critique that synthesis is reductionist, it may be helpful to view the process as opening up spaces for new insights and understandings to emerge... an appreciation that synthesis is an ever-expanding, boundary-breaking exercise. This focus then respects the multi-layered contexts that can be peeled back to reveal generative processes of phenomena not glimpsed in standalone studies' [Walsh & Downe 2005].

Numerous strategies for the review and synthesis of qualitative literature have been developed including: meta-ethnography [Noblit & Hare 1988; Britten et al. 2002; Atkins et al. 2008]; thematic synthesis [Thomas & Harden 2008; Harden et al. 2004; Harden et al. 2006; Thomas et al. 2003]; grounded theory [Glaser & Strauss 1967; Strauss & Corbin 1998; Eaves 2001; Kearney 1988]; meta-study [Paterson et al. 2001]; textural narrative summary [Abott 1990]; qualitative comparative analysis [Ragin 1987]; and critical interpretive synthesis [Dixon-Woods et al. 2006]. Several formative papers address the different components of these approaches, highlighting their strengths and weaknesses and exploring procedural, conceptual and epistemological issues [Dixon-Woods et al. 2005; Barnett-Page & Thomas 2009; Lucas et al, 2007; Walsh & Downe 2005].

Some authors have suggested that studies using different qualitative methods should not be synthesised [Estabrooks et al. 1994; Jensen & Allen 1996], whereas others argue that the combination of different types of qualitative studies contributes to the depth and breadth of

the analysis and counterbalances the limitations of individual methods [Paterson et al. 2001]. Similarly, how to assess the quality of studies, what criteria may constitute quality, and whether or not to exclude studies from a review based upon an appraisal of quality is also debated [Carroll et al. 2012; Dixon-Woods et al. 2004; Popay et al. 1998]. A number of authors argue that 'weak' papers should be excluded [Campbell et al. 2003], whereas others suggest that the formal appraisal of quality may not be necessary and that excluding papers on quality alone risks discounting important studies for the sake of 'surface mistakes' [Jensen & Allen 1996; Sandelowski et al. 1997; Garcia et al. 2002]. There is little evidence on how the quality of reporting reflects the robustness, trustworthiness and transferability of the findings of qualitative studies [Dixon-Woods et al. 2007].

In reporting our review process below, we follow the five domains outlined in the ENTREQ guidelines for 'enhancing transparency in reporting the synthesis of qualitative research': research question; synthesis methodology; literature search and selection; appraisal; and synthesis of findings [Tong et al. 2012].

Research question

The primary research question for the review and synthesis asked 'What are the non-financial barriers to access for MNCH services in Bangladesh, Vietnam, Ghana and Rwanda?'

Synthesis methodology

Building on the platform of meta-ethnography, this review uses thematic synthesis [Thomas & Harden 2008]. Thematic synthesis developed from a need to conduct reviews that addressed questions relating to intervention need, appropriateness, acceptability and effectiveness, without compromising the key principles developed in systematic reviews [Barnett-Page & Thomas 2009]. It is derived from thematic analysis, a method frequently used to analyse data in primary qualitative research that involves the identification of prominent or recurrent trends and their organisation into structured themes [Guest et al. 2012; Bryman 2008; Ritchie & Lewis 2008]. There are three main stages to thematic synthesis: preliminary coding of material into emerging trends; building descriptive thematic constructs; and developing analytical themes. It is an inductive approach that is data driven and generates themes that are empirically faithful to the cases or literature from which they were developed. Direct findings are not necessarily generalisable, but theoretical insights or hypotheses arising from the synthesis of the included studies should be transferrable to other similar settings and contexts.

Literature search and selection

The search strategy was designed to identify studies that addressed non-financial barriers to access for MNCH services in Bangladesh, Vietnam, Ghana and Rwanda. We searched for studies that included qualitative data derived from a range of methodologies including in-depth interviews, focus group discussions, survey-based studies with open-ended responses and mixed-methods.

All electronic searches used keywords covering the main search domains, and a refined search string per country (see Appendix 2) was used as the basic search tool for two online databases, PubMed and ProQuest (incorporating the International Bibliography of the Social Sciences; Applied Social Sciences Index and Abstracts; EconLit; and Sociological Abstracts). The initial search included three parameters: the date of publication was 1st January 2000 to 31st December 2012; the language was restricted to English (search terms in both UK and US English were used); the publication type in PubMed was 'journal article' and in ProQuest was 'peer reviewed scholarly journal'.

When searching for studies to include in a statistical meta-analysis, the aim is to locate every relevant study since failure to do so may undermine the statistical models that underpin the analysis, thereby biasing the results. In meta-ethnography or thematic synthesis, however, it is not necessary to locate all available studies, but to search iteratively. As Dixon-Woods et al. [2006] conclude, 'rather than aiming for ... identification and inclusion of all relevant literature, as would be required under conventional systematic review methodology, we saw the purpose of the searching phase as identifying potentially relevant papers to provide a sampling framework'. As 'saturation of findings' is used as a marker of sample size in primary qualitative research, so 'conceptual saturation' can be used in thematic synthesis, because the purpose is interpretative explanation rather than prediction. Thematic synthesis focuses on the development of concepts and theory, rather than a meticulous summary of all data.

In developing our methodology, we therefore devised a 'structured' literature review. The form is derived from that accepted for systematic reviews, using rigorous study selection and defined inclusion and exclusion criteria, but it does not seek to identify and incorporate every paper published. Rather, it focuses on the synthesis being comprehensive, i.e. the final corpus of literature included presents all themes that could have been identified.

We used a five-phase search and inclusion/exclusion strategy.

Phase 1

Phase 1	No. of articles		
	PubMed	ProQuest	Combined*
Bangladesh	1330	691	1646
Vietnam	777	295	922
Ghana	761	268	881
Rwanda	165	61	194
			Total 3643

*duplicates removed

Results from the initial searches in PubMed and ProQuest were combined and duplicates were removed, resulting in 3,643 articles.

Phase 2

Phase 2	No. of articles
Bangladesh	92
Vietnam	51
Ghana	103
Rwanda	16
	Total 262

Two researchers independently analysed each paper by title and abstract (JB analysed all the papers, MP analysed the Vietnam papers, and LE the Bangladesh, Ghana and Rwanda papers). Duplicate articles were removed. Both researchers attributed a score to each paper: 2 for definite inclusion; 1 for potential inclusion; 0 for definite exclusion. The scores per article were added together and articles totalling 4, 3 and 2 points were included in the next round of review.

During this phase 3,381 articles were excluded because they failed to satisfy the initial selection criteria.

Articles were removed for one or more of the following reasons: they were not in English; they did not focus on one or more of the four target countries; they were obviously clinical or purely quantitative in scope (i.e. not qualitative or mixed methods); or they were not on topic. This phase resulted in 262 articles.

Phase 3

Phase 3	No. of articles
Bangladesh	22
Vietnam	21
Ghana	36
Rwanda	1
	Total 80

The full texts of the remaining 262 articles were reviewed for inclusion by the two researchers (JB analysed all the papers, LE analysed Vietnam and Ghana papers, and AS Bangladesh and Rwanda papers).

Any inconsistencies were discussed and resolved, and inclusion agreed through consensus. A further 174 papers were removed after the text had been reviewed. Articles

were removed because they were off topic (103 articles), quantitative (60 articles) or methodologically not appropriate (e.g. systematic reviews, commentary pieces – 11 articles). In addition, 8 articles were discounted because the full texts could not be accessed, despite attempts to contact the primary author. The remaining 80 articles were carried forward for detailed review.

Phase 4

Phase 4	No. of articles
Bangladesh	18
Vietnam	11
Ghana	19
Rwanda	0
	Total 48

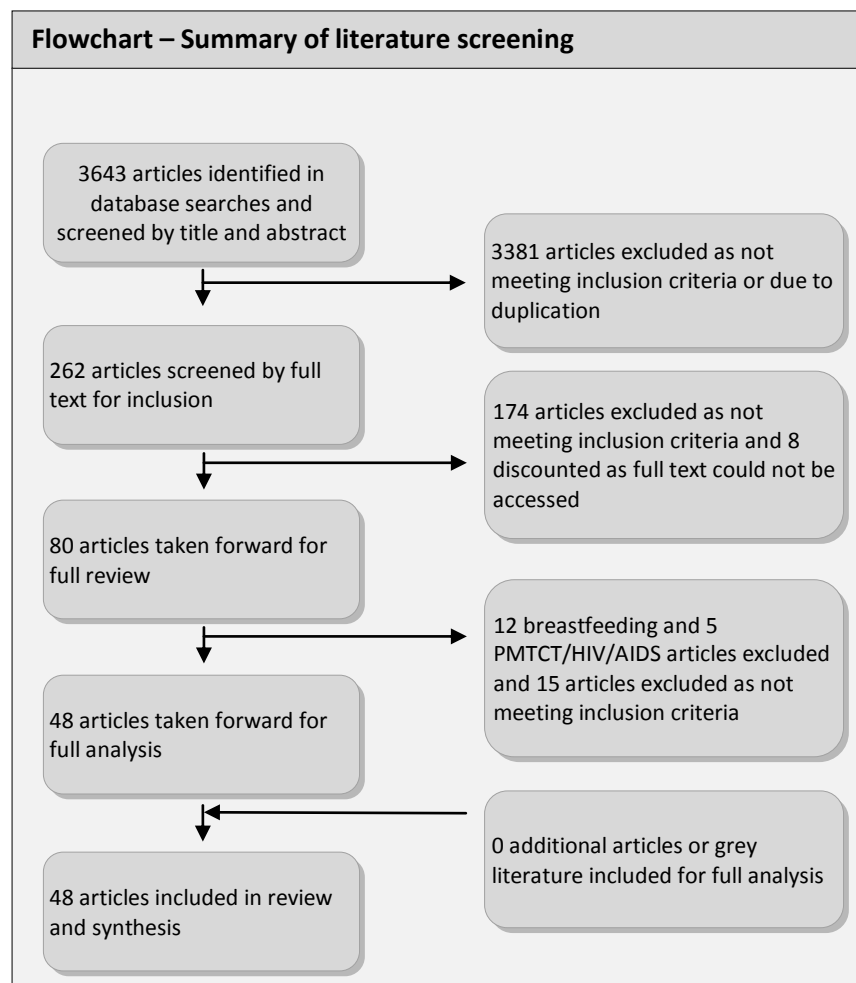
The full text of the remaining 80 articles was read in detail by the lead researcher in preparation for full data extraction. During this process, it was decided to narrow the focus of the review to specific MNCH services in line with UNICEF key interventions (see Appendix 1).

Articles relating to breastfeeding, infant nutrition and complementary feeding were excluded, as these focused on

health practices rather than access to health services. Similarly, articles on the prevention of mother-to-child transmission (PMTCT) and HIV/AIDS testing and counselling were excluded, as these rarely focused on access to services, but on the services offered and experienced.

Consequently 12 articles on breastfeeding, and 5 articles on PMTCT and HIV/AIDS testing and counselling were removed. A further 15 papers were discounted at this stage because, upon a more in-depth reading, they were found to be off topic or predominantly quantitative. Finally, 48 papers were included in full analysis.

Phase 5



The bibliographies of all included articles were searched for additional references, including those that might act as ‘negative’ cases (cases that presented contrary views) thereby ensuring maximum variability in the literature. Generic web searches were also performed, but neither yielded studies that had not previously been considered. UNICEF country offices were contacted and a number of universities and schools of public health in each country, but again, these sources did not yield significant new material. Given the lack of articles for Rwanda, particular attention was given to purposively identifying relevant literature. A small selection of grey literature

was identified during this phase, but due to limitations in time and human resources, it was decided to focus the structured review entirely on scholarly articles published in peer-reviewed journals. No new literature was added at this stage and the synthesis therefore focuses upon barriers to access for MNCH in Bangladesh, Ghana and Vietnam only.

For a summary of the study selection and screening methods, see flowchart.

Appraisal

A customised appraisal form was developed (see Appendix 3) drawing upon several previously published tools for qualitative research and equity (Tong et al. 2007; Welch et al 2012; Ekman 2004). Information was gathered across four domains: research and analytical question; research team and level of reflexivity; methodology and study design (including theoretical framework, participant selection, setting and data collection); and analysis and findings. Table 1, presented in the Findings section below, summarises the methodological appraisal per paper (and should be related to the full appraisal form in Appendix 3)

Appraisal was undertaken in order to achieve an understanding of each study on its own terms, including potential bias [Sandelowski 2007], with the intention that any study in which the depth and breadth of the reported data were insufficient to suggest that the findings were trustworthy, would be excluded [Lloyd Jones 2004]. No study was excluded due to assessment of conduct (validity and robustness), assessment of reporting (transparency) or assessment of content and utility of the findings [Tong et al. 2007].

The methodological details of each study were central to the second component of this project, the review of qualitative methods used to identify, assess and measure non-financial barriers to maternal, newborn and child health services.

Data extraction and synthesis of findings

Line-by-line coding was applied to each paper included in the review. As each subsequent paper was coded, the emerging trends were grouped together, clustering like with like and creating new codes when required.

The second phase of synthesis was to analyse the grouped trends and build thematic constructs per country. In this way comparisons were made within and across studies (similar to 'reciprocal translation' in meta-ethnography). During this phase of coding, materials were distinguished according to Schutz's notion of first-, second- and third-order constructs [Schutz 1962; Dixon-Woods 2006; Atkins 2008]. First-order constructs reflect participant views or beliefs; 'the everyday understandings of ordinary people' (often presented in the results section of an article and based on narrative recounting or direct quotation). Second-order constructs are researchers' interpretations of participant understanding, the construct of the social sciences (usually found in the discussion and/or conclusion of an article). Third-order constructs build on the constituent explanations and interpretations to develop new insights, consistent with the original results, but extending beyond them (similar to 'line of argument synthesis' in meta-ethnography).

In the final stage of analysis, the thematic constructs per country were synthesised into analytic themes articulating the overarching barriers to access for MNCH services. Each analytic theme contained various sub-themes, under which in-country specifics were clustered for comparison and contrast (similar to hierarchical tree structure).

JB undertook the coding and organisation of themes by hand, and no software programme was used. AS then analysed all the papers deductively, going back through the material and labelling each identified thematic construct as it appeared. Any inconsistencies or areas for further analysis were highlighted and discussed by the research team, until all the material was resolved into appropriate themes. Table 2, presented in the Findings section below, summaries the contextual data and barriers identified per paper.

The synthesis of barriers to access and the analysis of methods, provide robust evidence about how non-financial access barriers can be identified and assessed at sub-national levels using qualitative methodologies.

Limitations

Several authors have commented on difficulties associated with locating qualitative studies, mainly because of the poor indexing of qualitative research [Atkins 2008; Barroso et al. 2003]. We attempted to mitigate this limitation by supplementing the database searches with citation searching in retrieved papers, generic web searches, consulting experts and locating grey literature. Although this process did not yield any new or significant material, it is possible that relevant articles may still have been inadvertently omitted. The initial search parameters, particularly restricting the language to English, may have also prevented the identification of relevant papers. This is likely to have contributed to the lack of papers for Rwanda, as a proportion of the literature is published in French. Importantly, however, because of the methods employed (structured literature review and thematic synthesis), the synthesis of findings is comprehensive for Bangladesh, Ghana and Vietnam, even if not all available papers were included.

When attempting to incorporate Schutz's [1962] three orders of construct into the initial coding of trends, several issues were encountered. As Atkins et al [2008] also found, accessing first-order constructs for synthesis can be problematic, since the extracts of primary data included in the papers are already selections made by the author from their full dataset, and therefore may not reflect the totality of participant experiences. Second-order interpretations can offer more insight through their explanation of observed phenomena, but this level of analysis was found to be minimal, particularly in qualitative papers that were highly descriptive. In several papers, it was difficult to distinguish first- and second-order constructs, and to gauge the reflexivity of the author (to what extent their presence in the field, background and/or theoretical position influenced the action, their interpretation and subsequent reporting). Similarly, in mixed-methods papers, it was not always clear if findings and conclusions were drawn from the qualitative or quantitative component of the studies being reported. Our methodology allowed us to incorporate information from different study types, so it was possible to use a variety of qualitative data in the synthesis. Distinguishing between Schutz's three orders of construct was an additional layer of analysis. It was not crucial to the synthesis itself, and therefore the limitations described did not have a great impact upon the results of our review.

Retaining the context of the research is an important aspect of synthesising qualitative literature. In our review, we were aware of the obvious contextual differences between Bangladesh, Ghana and Vietnam, but also the contextual differences found within each country. Including characteristics of the study population (e.g. their socio-economic status, ethnicity, religion, geographic location, etc.) were important facets of the review, and were particularly relevant in the later stages of the project when results were combined with that of Workstream 2 that focused on the quantitative identification and assessment of barriers [Thiede & Koltermann 2013]. Unfortunately, not every paper adequately reported the context of the qualitative research, or the impact of the context on findings. When possible, we systematically recorded the various contextual factors, and highlighted the remaining gaps in reporting.

THEMATIC SYNTHESIS

Through thematic synthesis of the literature reviewed, six analytical themes were identified that articulate non-financial barriers preventing access to MNCH services in Bangladesh, Vietnam and Ghana: perception of the condition; home management and local treatment; the influence of family and community; lack of autonomy and agency to act; physical accessibility; and health facility and biomedical deterrents. Table 2 above, highlights contextual data and barriers identified per paper reviewed.

Perception of the condition (including local aetiology)

How a condition is perceived, or illness interpreted, can be highly influential in terms of if, when and where care is sought. Symptoms need to be recognised, considered problematic and to warrant treatment, only then will the mechanics of care-seeking start. If symptoms are not recognised, or if they are recognised but not considered problematic, or if treatment is regarded as inappropriate or not necessary, then care-seeking will not commence.

The perception of a condition may include inherent and prescriptive care-seeking or non-care-seeking. Several studies described illnesses that respondents labelled as unsuitable for medical intervention, or 'not-for-hospital'. In rural Ghana, for example, *asram* and *puni* were regarded as a range of traditional illnesses that affected infants but had no clear biomedical equivalents [Hill et al. 2003].¹ Both were commonly found across Ghana, and were universal amongst indigenous groups [Okyere et al. 2010]. The conditions were considered untreatable by biomedicine, and their diagnosis has been interpreted as a significant barrier to appropriate care-seeking [Okyere et al. 2010]. Instead, a culturally-prescribed course of action was adopted, but as Hill et al. [2003] point out, this was only problematic if the children labelled with these illnesses were 'actually severely ill'. Whilst Bazzano et al. [2008a] found that some respondents were open to the possibility of treating *asram* at a health facility, they concluded that categorising an illness as 'not for hospital' may serve, in some cases, as 'a means of assuaging emotional concerns on the part of the family who cannot afford to pursue, or do not trust, medical treatment'. They reported instances of patients being advised by nursing staff to 'leave the health facility and go home for traditional medicine'; although health providers claimed such advice would never be given.

In their investigation of the circumstances of child death in Dhaka slums, Caldwell et al. [2002] conclude that 'at least two-thirds of all child deaths occurred in a context of a belief in harmful spirits or forces and the need to appease or combat them'. Local aetiologies that attribute illness to evil spirits are discussed in detail throughout the literature for Bangladesh and Ghana, and are often linked to culturally-prescribed action necessitating home management or local

¹ According to Bazzano et al. (2008a), *asram* was 'Universally described by caretakers as causing green veins on a baby's body, persistent crying and growing lean. It is the main serious illness (in local language terms) which affects newborns, and is thought to be transmitted to the baby by other people, intentionally (because of jealousy or antipathy) or unintentionally, either *in utero* or in the newborn period'. Closely related to *asram*, *puni* was 'Described as an illness characterised by changes in the baby's skull, specifically meaning either a gap in the middle of a baby's head, or an enlarged head with a gap...these changes in the baby's skull were not necessarily described as relating to the fontanelles'.

treatment [for Bangladesh see Rashid et al. 2001; Syed et al. 2008; Choudhury & Ahmed 2011; for Ghana see Galaa & Daare 2008; Farnes et al. 2011; Adongo et al. 2005]. Community members in Bangladesh asserted that if symptoms were caused by evil spirits, then there was 'no use going to a modern doctor because this was not their province' [Caldwell et al. 2002]. Similarly in Ghana, hospitals were regarded as useless against spiritual attack. For the Ashanti, for example, the belief in witchcraft was ubiquitous, and the threat of spiritual illness great [Farnes et al. 2011]. Convulsions were thought to have spiritual undertones [Adongo et al. 2005] and negative outcomes of childbirth were often attributed to witchcraft. In the Sylhet and Jessore districts of Bangladesh, excessive bleeding and convulsions due to eclampsia were both reported by respondents to be caused by evil spirits (*dushi*). In such cases, it was thought that the pregnant woman would not be cured if she were transferred to hospital, but rather required home-care from a local healer [Kalim et al. 2009]. There are many interpretations of 'traditional beliefs and rituals' causing delay to care-seeking in Bangladesh and Ghana [Choudhury & Ahmed 2011; Galaa & Daare 2008], but these were countered by other reports that 'traditional practices' were no longer dominant and did not act as barriers to accessing care [Mills & Bertrand 2005].

Perceptions of a condition are not only concerned with local aetiologies, but also with ideas about the normal state of wellbeing and what constitutes ill health. In Ghana, as elsewhere, diarrhoea in children was not regarded as an illness. Rather, it was a chronic condition not perceived to be life-threatening or even debilitating, and was usually left untreated [Osumanu 2008]. Similarly, in Vietnam, diarrhoea was considered a 'normal' disease that was common in childhood and did not severely affect infants [Rheinländer et al. 2011]. Across Ghana, other ailments such as coughing, vomiting, fever or fast breathing, were not seen to be abnormal or to warrant immediate treatment [Hill et al. 2003; Bazzano et al. 2008a] and even malaria, if classed as 'ordinary malaria' (malaria caused by mosquitoes or the heat of the sun), did not necessitate health facility attendance [Ahorlu et al. 2006]. Mosquito bites were considered a nuisance that led to a rash and skin irritation, but were not necessarily linked to ill health [Adongo et al. 2005].

Perceptions of normality were most clearly articulated in relation to pregnancy and childbirth. In all three countries, pregnancy and childbirth were regarded as normal events [Choudhury & Ahmed 2011] or natural phenomena [Head et al. 2011; Jansen 2006] that did not justify professional care in the first instance [Parkhurst & Rahman 2006; Mills & Bertrand 2005]. In Bangladesh, routine care-seeking was low [Syed et al. 2008] and it was frequently reported that women did not attend antenatal care (ANC) except for confirmation of pregnancy [Barnett et al. 2006; Ahmed et al. 2010; Islam & Odland 2011; Choudhury & Ahmed 2011]. Similarly, in the postpartum period, care was not frequently sought for the mother or child [Syed et al. 2008; Choudhury & Ahmed 2011]. Care-seeking outside the home or immediate environment during this time was regarded as incredibly risky as it exposed the mother and newborn to evil spirits or the evil gaze, cold and wind [Winch 2005]. In Ghana, mother and child were thought to be particularly vulnerable during pregnancy and childbirth, and this had implications for location of delivery. Some recommended birth at home, so that no one could 'see' or 'curse' the labouring mother or newborn, others a facility delivery because it was safer as 'witches are unable to

reach you in this protected environment' [Wilkinson & Callister 2010; Okyere et al. 2010]. In contrast, studies from Vietnam reported that pregnancy and childbirth were increasingly understood by the majority ethnic Kinh population as medical conditions requiring technical surveillance and communities made selective use of services, with ANC attendance being reportedly high, whilst facility deliveries remained less common [White et al. 2012].

Numerous studies reported that preparation for childbirth was lacking. In Ghana, decisions about the location of delivery were not made during pregnancy, but on analysing the progression of labour, 'the time that it takes and the suffering that she goes through help us to decide where she should deliver' [Mills & Bertrand 2005]. Syed et al. [2008] assert that 'birth preparedness is alien in much of rural South Asia' and conclude that 'the prevalent attitude was that preparing for childbirth only invites problems'. In Bangladesh, making plans in advance for the new arrival, such as buying new clothes or arranging transport to a facility, could bring 'bad luck' and, as Choudhury & Ahmed [2011] explain because the family 'were not sure whether the coming child would survive or not, money spent on her/him was considered to be unnecessary'.

It was widely reported in the literature reviewed, that facility care for childbirth would only be sought if complications arose, but perceptions of risk, danger signs, and the perceived severity of complications varied. In their study on the process of recognition and response to symptoms during childbirth in two slums and the Matlab suburb of Dhaka, Head et al. [2011] conclude that prolonged labour was not regarded as a complication in itself. They depict confusion about the onset of labour and the practice of 'waiting for delivery'. Edmonds et al. [2012] also working in Matlab, echo the observation that the 'correct progression' of labour did not reflect the biomedical model. Similarly, Kalim et al. [2009] stress that in Sylhet and Jessore districts, bleeding is viewed as normal. Rather than being regarded as a complication, bleeding is desired: it removes polluting blood and fluids and helps the woman (and her womb) to regain health and a state of purity. They conclude that 'rather than perceiving bleeding as a problem, women view a lack of bleeding as problematic'. Interestingly, in their study of husbands' involvement in delivery care utilisation in a rural area of Netronkona district, Story et al. [2012] conclude that all participating husbands perceived childbirth to be a risk, but that this, in itself, did not always lead to utilisation of formal healthcare.

In Ghana, women referred to childbirth as a 'junction of life and death' or a time when 'women walk between life and death' [Wilkinson & Callister 2010; Bazzano et al. 2008b]. For many, the fear of death was a stark reality. Respondents distinguished between 'smaller problems' (such as pain) and 'something deadly' [Bazzano et al. 2008b]. Several studies from Ghana highlighted communities' knowledge about danger signs during childbirth, and suggested a preference for facility-based deliveries in cases of difficult labour. Across the three countries, a facility-based delivery was seen to be the preserve of women who experienced 'problems' in pregnancy or childbirth, although perceptions of what constitutes a problem and how that was expressed varied [Mills & Bertrand 2005; Galaa & Daare 2008; Vo Van et al. 2004; Choudhury & Ahmed 2011; Ahmed et al. 2010]. A 'normal birth', therefore stipulates a home delivery without medical intervention, and as Parkhurst et al. [2006] state, 'it may take the idea of a

complication to justify [health facility] use in a social environment valuing independent home-birth’.

In Bangladesh, a woman’s social status was closely linked to her ability to bear children without assistance, and stigma was associated with appearing to be ill and having *angohani*, a defective body during childbirth [Afasana & Rashid 2001]. Seeking clinical care during labour was seen to contradict social norms and many avoided it because an assisted birth was believed to inhibit women from fulfilling their reproductive, household and sexual roles as a wife and mother [Head et al. 2011].

The social importance of childbearing in Ghana was also stressed in the literature [Wilkinson & Callister 2010]. It was thought that a woman who had not undergone a delivery was ‘not a woman’ [Jansen 2006]. There were reports that a mother-in-law may encourage her son to find another wife if she failed to ‘bring her husband posterity’ [Wilkinson & Callister 2010] and infertility was often linked to witchcraft [Jansen 2006]. In Vietnam, the first duty of a wife was to have a son to continue the family lineage and provide spiritual assurance, for according to the Confucian tradition, only sons should pray for the souls of the ancestors and these in return, protect and bless living family members. A woman was likely to blame herself and be blamed by her husband and family if she did not bear a son [Klingberg-Allvin et al. 2012]. As Graner et al. [2010] report a woman ‘is required to continue to give birth until she has a son. If not, [her] parents-in-law will look for another wife for the husband in order to have a son to maintain the community of the family line’.

In Ghana, a woman’s social status and respect was seen to increase if she delivered alone at home, and she was then in a position to give advice and influence others [Bazzano et al. 2008b]. The more difficult the labour, the more respect she would be given, unless intervention was required [Jansen 2006]. Seeking skilled attendance was seen to be unfortunate and could compromise both social standing and self-esteem [Bazzano et al. 2008b]. In Ghana and Bangladesh, a mother could be blamed for requiring help. It was thought that she may be responsible for causing the difficulty through negligent behaviour [Parkhurst et al. 2006] and in the Brong Ahafo Region of Ghana, numerous participants reported that misattribution of paternity led to a hospital delivery [Bazzano et al. 2008b]. Pressure was also evident due to the social and economic expenditure required to facilitate care.

Head et al. [2011] describe power processes in Bangladesh that inhibited the disclosure of labour symptoms and revolved around sentiments of shyness, modesty and shame. The normative expectation was for silence during labour as a cultural expression of femininity, respectability and self-pride [Afsana & Rashid 2001]. Women were expected to endure labour as a rite of passage that had particular social significance [Parkhurst & Rahman 2007a ; Parkhurst & Rahman 2007b]. Similarly, in Ghana, women put great value on secrecy during labour, and aimed to ‘keep quiet’ so that they could maintain control over the delivery, avoid onlookers and ‘loose talk’ about their ability to deliver [Bazzano et al 2008b]. Shouting out or ‘causing disruption’ was a sign that assistance may be required, so labouring mothers were encouraged to ‘keep the pain’ to prevent referral [Wilkinson & Callister 2010]. Also in Vietnam,

a culturally informed emphasis on silence and resilience during childbirth was evident, and was associated with rapid delivery and a positive outcome [White et al. 2012].

Several studies from Ghana and Bangladesh highlighted that the perception of a condition, when to seek care and what type of care to seek was morally justified by respondents who put their faith in divine intervention. With respect to the Mru, a marginalised indigenous minority living in Bandarban District in Bangladesh, Islam and Odland [2011] explain that if neither the ‘traditional village healer’ or ‘village doctor’ could treat a woman’s obstetric problem, they ‘pray to *Thurai* – the Mru’s god – and wait for the death of the mother’. To others, illness resulting in death was regarded as inevitable and part of a divine plan or the will of God or Allah [Caldwell et al. 2002; Kalim et al. 2009]. In Kitampo District in Ghana, women who had lost a newborn were encouraged not to grieve for too long and families focused on the fact that the mother had survived and could therefore go on to bear more children [Bazzano et al. 2008a]. Newborn deaths were not marked by solemn rites because it was felt there was a reason the child did not live. Sentiments such as ‘the baby was not coming to stay in the world’, that it was ‘not meant to bring fortune and good for the family’ [Bazzano et al. 2008a] or ‘God called the baby home’ [Wilkinson & Callister 2010] were common.

Home management and local treatment

In Bangladesh, Vietnam and Ghana, multiple pathways for care-seeking, and a multitude of treatment options were identified. Different healthcare systems co-exist, and deciding which type of provider to use and at what time, was a complex process. Patients could seek different types of care either in parallel or sequentially in an attempt to secure improved health. In Vietnam, this strategy was referred to as ‘praying in all four directions’ [Rheinländer et al. 2011]. It was hard to build a consensus around which care-provider may be best placed to manage maternal, newborn and child health issues, and the literature from each country emphasises that patients would often try numerous sources of care before seeking help from formal or professional channels. Table 3, below, illustrates various sources of care identified in the literature.

Providers of local treatment encompass a range of individuals with various skills not always clearly defined in the literature, but generalised themes concerning the physical accessibility of local treatment and patient confidence in their services was widespread. Many local providers were available day and night, were able to start treatment immediately, and were based in close proximity to a patient’s home. They were also socially close to patients, and studies reported trusting and long-established relationships between the community and local providers in whom they had confidence [Ahmed 2006; Syed et al. 2008; Kalim et al. 2009]. Because of these social networks, women in Bangladesh were able to visit certain local providers without contravening the custom of *purdah* (seclusion) that restricts their movements [Caldwell et al. 2002].² In Ghana, women spoke with respect and trust for

² *Purdah* is a religious and social institution of female seclusion. It has visual, spatial and ethical dimensions, and refers to veiling of women, segregation of the sexes, and a set of norms and attitudes that set boundaries for behaviour and women’s moral conduct [Asha 2008].

traditional birth attendants (TBAs) who were seen to have expert knowledge and experience and, in some cases, to have delivered nearly entire generations of a community [Mills & Bertrand 2005; Jansen 2006; Yakong et al. 2010; Wilkinson & Callister 2010]. Similarly, in Vietnam, TBAs were known for their good conduct and credibility [Duong et al. 2004].

Table 3 – Sources of care

Source of care		Ghana	Vietnam	Bangladesh	
Home management*	Herbs – self made	•			
	Herbs – bought from herbalist / healer	•		•	
	Herbs – unspecified source		•		
	Drugs – left over	•	•		
	Drugs – from mobile vendor	•			
	Pharmacy / drug shop (untrained vendor)	•	•	•	
	Market		•		
	Other (massage, ritual, specific food, etc.)	•		•	
	Local treatment	Herbalist / homeopathic doctor	•	•	•
		Village doctor (unqualified allopathic)			•
Other traditional healer		•		•	
Pharmacist		•	•	•	
Elders		•		•	
Traditional Birth Attendant		•	•	•	
Trained Traditional Birth Attendant		•		•	
Spiritualist		•	•	•	
Faith healer (Local, Pastor, Malam)		•		•	
Health facility		Local public facility	•	•	•
	Village health worker (public or NGO)		•	•	
	Private clinic	•	•	•	
	Non-Government Organisation clinic			•	
	Referral facility	•	•	•	

*self-administered

Certain local medicines were seen to be more beneficial than biomedicine, particularly for vulnerable patients such as neonates, infants and women in the postpartum period. In Bangladesh, herbal or homeopathic treatments were purchased from local healers, whereas in Ghana, herbal medicines were often self-prepared or bought from elders with specialist knowledge of ‘traditional treatments’ [Tolhurst & Nyonator 2006]. In Vietnam, emphasis was placed on the ‘compatibility’ of the illness and its treatment. This was a central concept that held implications for all aspects of illness management, including the perceived cause, treatment choice and outcome evaluation [Rheinländer et al. 2011]. A body had to be kept well-balanced and unexposed to unsuitable elements. If illness occurred, a suitable treatment had to be found to re-balance the body in a way perceived to be most compatible for the

specific person or specific illness, such as restricting the diet or behaviour, giving herbal treatments or administering medication from a drug vendor or health facility.

Self-medication was very common and the use of pharmacists (both trained and untrained) and drug vendors was discussed in much of the literature. Caldwell et al. [2002] report that in Bangladesh, the main access that the poor in Dhaka had to medication was through pharmacists. In Ghana, studies described communities sourcing medication from drug peddlers and unlicensed 'chemical shops' including analgesics, antipyretics, antimalarials and antibiotics [Tolhurst & Nyonator 2006; Asante et al. 2010]. Some were prescribed drugs after describing symptoms, whilst others bought 'straight from the shelf'. Frequently this led to incorrect administration and dosage, particularly as people purchased the quantity of medication they could afford, and were able to obtain credit from the vendors [Ahorlu et al. 2007]. If a patient showed improvement, they would often cease taking the medication, and drugs 'left-over' from previous illness episodes were stored for future use [Adongo et al. 2005; Asante et al. 2010]. In Vietnam, self-medication was often the first line of care, particularly if the illness was considered to be minor at the onset or if the symptoms were similar to a previous episode [Hoan et al. 2011]. Studies reported respondent's self-medicating in preference to attending health facilities, largely due to convenience: drug vendors were located in the community; drugs could be purchased at any time; and sourcing medication from the market required less logistical upheaval than attending a health facility [Hoan et al. 2011; Hoa et al 2007]. There was also suspicion or doubt about free 'Western drugs' available at local health facilities, and respondents preferred to buy drugs from private clinics or drug vendors in the expectation that price was related to effectiveness and quality [Rheinländer et al. 2011]. In Vietnam, consumers would purchase drugs on the advice of a drug vendor or according to a previous prescription, and, as in Ghana, would frequently experiment with drug dosage and duration of treatment, some increasing the dose, others decreasing it and some abandoning the medication all together after a shortened period of treatment [Hoa et al. 2007; Hoan et al. 2011]. Such practices were concerning in terms of antibiotic resistance, particularly as broad-spectrum antibiotics were commonly (or overly) administered to children [Rheinländer et al. 2011].

Seeking care from local religious or spiritual healers was imbued with particular and significant value, and several papers conclude that 'mothers felt a spiritual gain in using them' [Caldwell et al. 2002]. In their study on help-seeking behaviour by childbearing women in the Ashanti Region of Ghana, Farnes et al. [2011] report that all their participants were involved with faith healing and that there was substantial overlap between Christianity, African religion and Islam. With regards to health, wellbeing and illness, spirituality was harnessed for both preventative (and protectionist) and curative reasons. However, Farnes et al. [2011] conclude that faith healing may 'pose problems if women rely exclusively on their faith healers and do not seek appropriate biomedical care when there are potentially serious complications'. The importance of faith in Ghana is emphasised by the use of prayer at health facilities. Clinic staff frequently incorporated prayer in their service, and accompanying relatives and friends often used the waiting room to pray for the patient [Wilkinson & Callister 2010]. In contrast to Ghana, where faith plays a significant role in daily life, religion is less dominant in Vietnam due to its Communist and Confucian ideologies. However, in their study on perspectives of child

diarrhoea management among ethnic minority caregivers in Vietnam, Rheinländer et al. [2011] reported that Red Dao (highland people) always sought spiritual treatment before or in parallel with treatment from the community health centre. This was seen to be 'compatible treatment' for children affected by angry ghosts or spells from discontent ancestors, and such factors had to be eliminated in order to make the child susceptible to biomedical treatment. Interestingly, none of the Bangladesh-focused papers discussed religion or faith as a barrier to treatment-seeking.

As discussed above, preference for home delivery was widespread in each country studied, and was linked to perceptions of normality and the socio-cultural role of women in the community. Frequently, women were reported to be 'more comfortable' (both socially and physically) when labouring at home, surrounded by 'their own people', and in a position to better control their surroundings and environment [Afsana & Rahid 2001]. Amongst the Hmong in northern Vietnam, important ritual processes were related to delivery, whilst for Thai communities, the communal nature of childbirth was emphasised [White et al. 2012]. In Bangladesh, as elsewhere, women often moved to their natal home during the third trimester of pregnancy and preferred to give birth there as they were likely to receive increased levels of support from their family during the postpartum period [Ahmed et al. 2006].

Conceptualising healthcare options as a dichotomy between the biomedical and local, however, risks a reductionist interpretation of the healthcare system. Biomedical care from health facilities is only one of many options available to communities. In several papers, home management and local treatment were expressed as barriers preventing timely access to health facility care (Rashid et al. 2001; Farnes et al. 2011). However, as White et al. [2012] argue with reference to the ethnic minorities in Vietnam, the representation of 'cultural practices as obstacles to service attendance can be seen to conform to prevailing stereotypes... regarding 'otherness' and 'backwardness'.

We know that patients move between different sources or providers of healthcare, but there is a need to better understand the relationship between these different sources and providers. Communities are pragmatic in 'blending treatments', seeking care from multiple providers and aiming to capitalise on the range of possibilities offered by both 'new and old institutions' [Jansen 2006; Adongo et al. 2005]. In Bangladesh, women's reports on the decision-making roles played by non-medical health practitioners were particularly notable [Parkhurst et al. 2006]. As respected and influential members of the community, the recommendation of a village doctor would often be followed, even if it were contrary to the advice of key family members [Parkhurst & Rahman 2007a]. It was also observed that these unqualified village doctors had both formal and informal links to health facilities, and Parkhurst et al. [2006; 2007a] highlight examples of untrained healers who owned and ran private facilities that employed qualified medical professionals. In Vietnam, Doung et al. [2004] found that private providers were often retired health workers who were well known to the community. If complications arose, they would take their client to the district hospital, using their own network of connections. In the Kassena-Nankana District of northern Ghana, Mills and Bertrand [2005] found that TBAs were complementing the work of professional services. TBAs would

routinely refer women with complications they could not handle, and sometimes health-centre staff would assist in arranging transportation for patients. Such examples illustrate how policy makers could build upon a variety of local providers who may play important roles in the decision-making process around accessing appropriate professional care.

Influence of family and community

Family and community can exert great influence on both individual and collective (or societal) norms and practices. Care-seekers can be influenced by what others expect (or require) of them, but also by their own motivation to comply with accepted and appropriate behaviour. This network of relations can therefore impact access to healthcare.

In all three countries, a woman's husband and mother-in-law (her child's father and parental grandmother) were regarded as particularly influential in determining the course of action. The collective society in Vietnam resulted in the experiences of grandparents greatly influencing the care-seeking choices of young people [Duong et al. 2004]. Highland groups lived according to patriarchal gender roles, with the oldest men making the major decisions and the youngest women being the main domestic labour force. Elders were the persons primarily responsible for deciding, preparing and administering treatment to a sick child, and a mother would have to seek their permission to stay at home to care for her child rather than work in the fields [Rheinländer et al. 2011]. Also in Bangladesh, it was older women (rather than a child's mother) who would identify sickness, its cause and appropriate treatment [Caldwell et al. 2002]. In Ghana, amongst the Kassena-Nankana, any attempt to treat sickness had to be preceded by a consultation with the ancestors, a role undertaken by the compound head that could impede prompt care-seeking and have a negative effect on child survival [Ngom et al. 2003]. Ngom et al. [2003] refer to this as 'gate-keeping', a social construct that appeared to be strong in villages both near and far from health facilities.

Several studies concluded that 'the attitudes of in-laws and other family members delayed mothers in seeking care from clinics' [Rashid et al. 2001]. In Bangladesh, there were numerous examples of families forbidding women from seeking ante- and post-natal care, and although the reasons were not well explained, some attributed it to a concern that ANC violated *purdah* [Rashid et al. 2001; Barnett et al. 2006; Syed et al. 2008]. Perceptions about leaving the home and minimising contact with strangers were not absolute, but again may contribute to prevention of or delay in access [Winch et al. 2005].

In general, care-seeking outside the home or local environment required permission from the household head in all three countries, as it could incur both social and financial expenditures. In Bangladesh, medication from a pharmacist or drugs vendor was usually purchased by a male relative who would need to accompany the child to the hospital if admission was required [Caldwell et al. 2002]. If no male relative was available, then the mother-in-law was likely to counsel delay until they could be consulted. In their study of child death in Dhaka slums, Caldwell et al. [2002] state that in just over half of all cases of child death, inability to contact the father was recorded. In Ghana, it was seen to be the prerogative of males and seniors to

decide on treatment, as they had social 'ownership' of the child [Tolhurst et al. 2008]. As in Vietnam and Bangladesh, decision-making was linked to economic concerns and household priorities. Bazzano et al. [2008a] found in Ghana that if a newborn child was seriously ill and likely to die, it was unlikely that scarce resources would be used to take the child to the hospital, as to do so would not be of benefit for the family as a whole.

In a paternalistic society such as Bangladesh, men were often regarded as obstacles to timely access for MNCH issues, but there was also evidence that their influence could lead to positive care-seeking. Story et al. [2012] conclude that women were more likely to utilise professional delivery care when their husbands provided emotional, instrumental and informational support during delivery and believed themselves that medical intervention was necessary. Conversely, husbands whose wives used untrained attendants at home were uninvolved with delivery and believed that childbirth should take place at home according to local traditions. Their lack of involvement was seen to be culturally appropriate as childbirth and child rearing were female domains [see also Caldwell et al. 2002]. A reverse causality may be in evidence, however, in that husbands were more likely to be involved if their wife needed to utilise professional delivery care, because their involvement was directly linked to the control of household resources.

In their study of married men's first experiences of early childbearing and their role in sexual and reproductive decision-making in a suburban district of Hanoi, Klingberg-Allvin et al. [2012] found that although male dominance continued to impact on women's health and social position, there were 'ambiguities and contradictions in their presumed role as a pillar of the family and primary decision makers'. Few young men who lived with their wives in an extended family unit had control of the household economy, and their preferred choice of delivery location may not be shared by those holding the money, most often the male household head or senior relative [Klingberg-Allvin et al. 2012; Duong et al. 2004]. This could lead to a sense of insecurity, and as Klingberg-Allvin et al. [2012] highlight, being a decision-maker but having limited insight into maternal health issues also created a sense of frustration for younger men. Decisions regarding delivery had to therefore be discussed and agreed by the whole family. Several other studies, also from Bangladesh and Ghana, emphasised that if hospital treatment were required, the cooperation of the entire family was needed, largely for logistical reasons (including financial support, to help with transport and the maintenance of livelihoods, domestic chores and child care, etc.) [Winch et al. 2005]. Decision-making with regards to health-seeking is a complex paradigm that is not always well understood, but it is clear that decisions were rarely taken in isolation and depended upon intra-household relations and the extended social network in which a large number of individuals played a role. Although it had been assumed that husbands and in-laws negatively advised mothers who did not practice optimal care-seeking behaviour, Dearden et al. [2002] found that in Vietnam, influential relations were more likely to fail to advise mothers about health than they were to provide negative advice.

There was also evidence that patterns of influence and practice evolve over time. Several studies from Vietnam highlighted a cultural shift in the engagement of husbands during delivery

[Graner et al. 2010]. In the past, women were more likely to deliver alone at home, while the current generation preferred to have their husbands attending them in the delivery room [White et al. 2012]. In analysing the decision-making responsibilities of older women, Jansen [2006] suggests that they use rational judgements to weigh risks, interests and advantages related to the cultural, spiritual and social system. With regards to childbirth, they link care-seeking not only to bodily concerns, but also to sociological and psychological concerns regarding the mother being a fully accepted and respected member of the community. He concludes that older women occupy a powerful position within the society and as the 'real decision makers' combine 'old beliefs and practices' with 'modern structures' focusing on the safety and wellbeing of mother and child. In this way, elders are in a position not only to influence, but to actively change and transform care-seeking practices. Similarly, in Bangladesh, perceptions within the community about the appropriate course of action for maternal and child health issues were seen to be changing. Elders who may have previously discouraged attendance, now influenced the use of health services. A health worker in Bangladesh reported, for example, 'Elders now tell their daughter-in-laws to bring the child to us. In the past so many people would say so many things and now I don't have any problems as they call me all the time for assistance' [Rashid et al. 2001].

Female health workers have ingratiated themselves with the community in Bangladesh by following traditional definitions of gender while redefining *purdah* as a state of mind, 'thus shifting the importance from the external and physical rules of seclusion to an internalised moral code of conduct' [Rashid et al. 2001]. This 'inner *purdah*' prevailed despite some opposition to the mobility of female health workers, and mothers increasingly accessed community-based services. As one health worker concluded, 'Pneumonia has really decreased, and mothers have become very aware. Before they would go to the traditional healer, but now they come to us for their health problems. They like us and trust us' [Rashid et al. 2001]. A similar shift was also evident in Ghana where a new pattern of influence was apparent in some communities. In Kassena-Nankana, community health officers were often the first to be consulted about child sickness, and communities deferred to their knowledge for diagnosis and treatment. They have subverted the gate-keeping system described by Ngom et al. [2003] and supplanted compound heads and husbands as authorities on care-seeking. Such examples highlight that whilst the influence of family and community may, at times, be a barrier to access, this was not always the case. Patterns of influence constantly evolve and, at certain times, the impact of family and community may actually encourage service uptake.

Lack of autonomy and agency to act

Culturally, Bangladesh is a male dominated and paternalistic society. In general, women are socially and economically dependent on family, primarily male relations, and were reluctant to make decisions or take action outside the home without their husband's consent [Caldwell et al. 2002; Kalim et al. 2009; Story et al. 2012]. If children fall ill, a mother's power to act with authority in terms of care-seeking, was limited. Structurally, many women lacked the social and economic capital to act independently and young mothers were not able to either assert themselves or contradict senior relations, particularly their mother-in-law. As Caldwell et al.

[2002] conclude, 'mothers were sometimes troubled by the [causal] explanations given and courses of action decided upon [for their child's illness], but not in a single case did they override their mothers or mothers-in-law'.

Also in rural Ghana, a woman's ability to initiate decisions was restricted. Women were socialised to abide by the rules of the compound and marriage was regarded as an institution that confers onto men domestic and sexual rights over women [Ngom et al. 2003]. Because of the dowry system, women were often economically dependent and as a TBA in Kassena-Nankana District concluded, 'if there is only one goat in the house, your husband wouldn't sell it for you to go to the hospital'. Although there were strategies for assertion (such as withholding household cooperation or reporting an unsupportive husband to the elders), women have long had limited bargaining power.

Women in Ghana, as elsewhere, have differential access to productive resources, and those who lacked either short- or long-term economic support from male relatives or disagreed with their husband or family faced difficulties in accessing healthcare for children. As discussed above, women were encouraged to follow the advice of their older female relatives and to ignore or contradict them was thought to show disrespect and invite social problems [Jansen 2006]. Mothers could be blamed for treatment failure, accused of witchcraft and socially marginalised if they subverted the accepted channels of authority and decision-making [Ngom et al. 2003; Tolhurst & Nyongator 2006].

Women with higher socio-economic status, however, had more autonomy in Ghana [Mills & Bertrand 2005]. They were in a position to make-decisions and be assertive and could inform elders of their intention to seek care without having to wait for permission [Tolhurst et al. 2008]. There was evidence that accepted gender roles were changing as women were increasingly 'providers' as well as 'carers' (although without a corresponding change in men's behaviour in areas such as child rearing and care for the sick). Through his ownership of a child, a father was customarily responsible for funding a child's care, but in reality, it was often the mother who took on most of the financial burden of accessing treatment, even without the corresponding access to resources.

In Vietnam, Confucianism provided rules for social conduct and relations that were juxtaposed with a Communist ideology since the 1945 revolution. Vietnam is a society in transition, where Confucianism and patriarchal values are intertwined with official state strategies of equality and recent Euro-America influences with respect to gender, family and sexuality [Graner et al. 2010; Klingberg-Allvin et al. 2012]. Against this backdrop, women's autonomy was seen to be only slowly changing. They may be empowered to keep the household money, for example, but they had to consult their husband about how to spend it [Duong et al. 2004]. Husbands were portrayed as caring and supportive to their wives, and whilst several papers report couples discussing care-seeking options, the husband retained control and would ultimately have the final say [White et al. 2012; Duong et al. 2004; Klingberg-Allvin et al. 2012]. Their limited agency made it difficult for women to protect their reproductive health, and created a potentially negative experience of 'being in the hands of others' [Klingberg-Allvin et al. 2008].

As Duong et al. [2004] highlight in their quantitative analysis, ‘an educated woman who was fully aware of the advantages of delivery at a health setting still could not overturn the decision or influence of her mother-in-law’.

Only two papers reviewed explicitly addressed the changing construct of gender in relation to care-seeking. Tolhurst and Nyonator [2006] question how gender inequities influenced treatment-seeking behaviour, and in a later paper, Tolhurst et al. [2008] explore the gendered dynamic of intra-household bargaining over healthcare for children with fever in the Volta Region in Ghana. They argue for the adoption of a ‘gender transformatory’ approach that aims to promote women’s empowerment from the perspective of human rights and the promotion of well-being [Tolhurst & Nyonator 2006]. In policy terms, they stress that ‘agenda setting’ interventions that achieve improved access to healthcare for mothers and children should not do so at the expense of increasing women’s workloads and weakening their broader bargaining positions [Tolhurst et al. 2008]. This would risk keeping women in a subordinate position and further restrict their agency to act.

Physical accessibility

Throughout the literature, physical accessibility is one of the most frequently cited barriers preventing access to health services. In some analyses it is regarded primarily as a financial barrier, due to both the actual and opportunity costs involved with journeying to a health facility in terms of hiring transport, time spent travelling and absence from livelihood. We suggest that physical accessibility should also be considered a non-financial barrier with respect to the availability of transport and the ability to travel, both socially and logistically.

In many studies, transport is seen to be a key link between the potential and actual use of services, and delays in access to care are accounted for, in part, by the lack of readily available transport. In the highlands of Vietnam, for example, there was no available transport and communities regarded the half or full days’ walk to the community health centre to be too time consuming, especially if the child was seriously ill [Rheinländer et al. 2011]. As Edmonds et al. [2012] suggest a lack of transport ‘may bias patients towards using more easily accessible but potentially less trained providers’. In their narrative accounts of care-seeking, respondents referred to their transport options as ‘poor’, ‘unreliable’, ‘unsafe’ and ‘difficult to find’ and travelling at night was particularly problematic. Studies often make a distinction between emergency transport required suddenly for acute conditions, and the presumed ability of a family or community to make arrangements in advance (including transport arrangements in birth preparedness plans). Respondents themselves were less likely to articulate this distinction and securing a means of transport and/or the finances to pay for it were rarely considered prior to their need).

Modes of transport discussed include bicycles, rickshaws, pushcarts, three-wheel mini-taxis, motorbikes, boats and walking. In many cases, even when transport was available, difficult terrain and the lack of roads, particularly in rural areas, prohibited access. In some areas, levels of accessibility were seasonal and affected by the harvest and planting seasons, particularly if

women were a major part of the labour force, as in Vietnam [Galaa & Daare 2008; Duong et al. 2004]. In all three countries, accessibility was further curtailed during the raining season, when floodwater and mud made routes impassable [Edmonds et al. 2012; Story et al. 2012; Jansen 2006; Vo Van et al. 2004].

Many studies suggest that long distance from a patient's home to the point of service provision is detrimental to care-seeking, particularly for routine care such as ANC [Mills & Bertrand 2005]. Several studies report respondents' concern that children would become increasingly ill or die *en route* to a health facility [Dearden et al. 2002], or that labouring mothers would have to give birth at the roadside. However, the concept of 'remoteness' was seen to be relative for, as White et al. [2012] highlight, minority families in highland Vietnam routinely travel long distances to pursue their livelihoods.

Travelling to a distant health facility is not only concerned with geographic movement, but also with social movement. Evidence from Ghana indicates that women were prepared to travel longer distances to deliver at health facilities in closer proximity to relations who could offer post-delivery assistance [D'Ambruso et al. 2005]. In Bangladesh, women were socially unable to travel alone, so unless a male relative could accompany them, seeking care at a health facility was unlikely. This suggests that even if other components of physical accessibility were in place (transport, money, passable road network, etc.), culturally prescribed behaviour took precedence. Similarly, patients had to be prepared to navigate the social distance between themselves as care-seeker and the health facility as care-provider. Discussing determinants of ante- and post-natal care-seeking among the Mru, the indigenous community living in the uplands of Bandarban district, Islam and Odland [2011] conclude that 'Mru women do not utilise health facilities even if their household is close to a service centre'. This is discussed further below.

Health facility and biomedical deterrents

Although the various components of this theme are interrelated, they are delineated here for ease of reference: health service, medication and medical procedures; personal interaction, attitude and communication; physical environment; and perceived quality of care.

Health service, medication and medical procedures

Perceptions about the health service can act as deterrents against accessing care. Studies reported a lack of knowledge and awareness about the kind of services that were available [Ahmed et al. 2006; Choudhury & Ahmed 2011; Galaa & Daare 2008]. Respondents did not know where to seek care [Barnett et al. 2006] and attributed little importance to seeking care from qualified practitioners [Syed et al. 2008]. There were numerous examples of respondents claiming that conditions were 'not-for-hospital' and suggesting that they had no need for the services being provided. Several studies in Bangladesh reported the view that ANC was 'of no benefit to mother or child' [Choudhury & Ahmed 2011] and that PNC was 'useless' and 'of little

value' [Syed et al. 2008]. In Vietnam, Graner et al. [2010] report that women with high parity or who belonged to an ethnic minority were less likely to use ANC.

Even if women did attend, they were often non-compliant with the medication prescribed. Many administered smaller doses of the drugs than had been prescribed, or gave only a selection of the drugs and shifted from one drug to another if no improvement was quickly seen [Rheinländer et al. 2011]. In their study of maternal care practices among ultra-poor households in rural Bangladesh, Choudhury & Ahmed [2011] reported that the majority of women in their sample did not take the iron supplements dispensed because they perceived the tablets to be tasteless or to have a bad taste, and to make the stool black. This was in contrast to rural Vietnam, where free iron supplements were mentioned as a contributing factor for ANC attendance, and healthcare professionals had noticed lower attendance rates after the governmental supply had been withdrawn [Graner et al. 2010]. With regards to oral rehydration salts (ORS) to treat childhood diarrhoea, Osumanu [2008] claims that there was a low level of knowledge amongst mothers in the Tamale Metropolitan Area (the largest urban centre in northern Ghana), and that underutilisation was also due to its unpleasant taste. Similarly in Vietnam, respondents did not believe that a child could tolerate large quantities of powder mixed with water, nor its unpleasant taste [Rheinländer et al. 2011].

There was widespread concern across the three countries about the strength and potentially harmful effect of biomedicine. In Vietnam, 'Western drugs', particularly antibiotics, were seen to be very powerful and potentially 'incompatible' with the body as they were 'too hard', 'too strong' or 'too sweet', for sick children and could be 'harmful for the stomach' [Rheinländer et al. 2011; Hoa et al. 2007]. Other studies suggested concern about the harmful effect medication given to a pregnant woman may have on an unborn child [Syed et al. 2008]. Because allopathic medicine was seen to be 'too strong', alternative forms of homeopathic or herbal treatments were often preferred [Winch et al. 2005; Hoa et al. 2007]. In Ghana, Bazzano et al. [2008a] reported a commonly-held perception that hospitalised babies were likely to die, a view that may have dissuaded parents from presenting their child for treatment.

As discussed above, there was a pervasive desire across the three countries for home delivery, and attending a health facility was often not considered for 'normal' childbirth. Women expressed fear and reluctance for medical intervention during labour [Head et al. 2011] and health facilities were not always regarded as the best option to manage maternal complications [Story et al. 2012]. There was a perception amongst some respondents that all facility births required surgery. In Bangladesh, any form of incision (abdominal or perineal) was associated with social stigma and facility births were negatively associated with caesarean sections [Afsana & Rashid 2001]. Women were concerned that after a caesarean, they would no longer be capable of heavy work or vaginal and unassisted births in the future, and in failing to meet critical social responsibilities, their status as women and wives would be undermined. Requiring medical intervention rendered them vulnerable to ridicule and rejection, and some women feared divorce [Khan et al. 2012]. Women discussed feelings of shame and guilt, and the risk of being blamed for their need to have professional care that burdened their family socially and economically. One mother recounted having been removed from a clinic by her

husband and father-in-law due to the presumed cost of the procedure [Parkhurst and Rahman 2007b]. Parkhurst and Rahman [2007b] conclude that such perceptions were an active deterrent to respondents already engaged with facility-based care, and frightened some women to the point of absconding from the health facility. They stress, however, that these concerns may have been legitimate and an indication of poor medical practice. In line with Head et al. [2011], Khan et al. [2012] conclude that there was widespread distrust about the need for caesarean sections because communities perceived the intervention to be a mechanism for the health provider to make money, rather than a life-saving procedure. Parkhurst and Rahman [2007b] explain that conflicting financial incentives for doctors to perform caesareans and for nurses and midwives to support vaginal deliveries, resulted in staff disagreement about the way to proceed as both cadres looked 'to supplement their income'. A fear of caesarean section and a perception that doctors performed the procedure for the slightest complication was also evident in Ghana [Bazzano et al. 2008b; Wilkinson & Callister 2010] and Mills & Bertrand [2005] report women's fear of acquiring infections during facility-based deliveries.

Personal interaction, attitude and communication

Poor communication was an issue highlighted throughout the literature. Differences in language could make communication difficult, particularly with regards to sensitive health issues, and several studies claimed that patients felt 'shy' or 'embarrassed' to discuss their problems [Islam & Odland 2011]. In Vietnam, most health staff were Kinh, the majority ethnic group, and could rarely speak local minority languages [White et al. 2012; Vo Van et al. 2004]. Rheinländer et al. [2011] observed that 'to avoid being misunderstood or perceived as backwards, [patients] never shared ideas about causes of diseases, asked clarifying questions about the prescribed drugs or told any health staff... about home-made treatments'. Both patients and health staff found it frustrating that they could not communicate accurately and were forced to use over simplistic language. Occasionally other waiting patients were reportedly used as translators [Rheinländer et al. 2011].

In their observations of facility births in Bangladesh, Afsana & Rashid [2001] recorded that patients were not routinely provided with necessary information. They were not informed about the reasons for physical examinations, why medicines were required, the progress of labour, condition of the baby, or if the delivery would require surgical intervention. This, they concluded, left women 'worrying and anxious about many things and at worst [they] were made to feel like passive objects'. Yakong et al. [2010] working with remote communities in the Talensi-Nabdam District of northern Ghana found explanations and health education to be lacking to such an extent that it was difficult for women to make informed decisions about maternal and child health issues. As in Vietnam, nurses spent little time with patients and disregarded their questions [Klingbert-Allvin et al. 2008]. Information needs were clearly unmet, yet Yakong et al. [2010] observed nurses referring to women as 'ignorant, uneducated, rural, and local people who lacked simple understanding'.

Concern was also expressed about personal interaction with health workers. In Bangladesh, there were social restrictions preventing women from receiving care from male doctors [Head et al. 2011], and many studies detailed the perception that it was 'shameful' for a woman to be examined by a male health worker [Syed et al. 2008; Kalim et al. 2009; Story et al. 2012]. Similarly, in Vietnam, women reported that they felt ashamed to be attended by a male health worker [Vo Van et al. 2004]. In Ghana, problems appeared magnified when seeking care from male nurses, and often contributed to mothers delaying or discontinuing care [Yakong et al. 2010].

Chouhury and Ahmed [2011] describe problems arising in rural Bangladesh when multiple health services were provided by a single person in the community. If the 'same individual was responsible for providing contraceptive pills as well as for antenatal care, the women felt shy and sometimes scared to share their pregnancy news with the healthcare provider in fear of being scolded for discontinuation of the contraception'. In Vietnam, because of the State's two-child policy, women expecting their third or more child would often try to conceal their pregnancy to avoid being criticised by health workers [Graner et al. 2010; Duong et al. 2004]. The policy was abolished in 2003, yet family planning campaigns continued to encourage couples to have only one or two children. Many women were reluctant to attend ANC or have a facility-based birth for fear of censure, although there was no actual penalty for additional children [Vo Van et al. 2004].

As discussed above, the social distance between patient and provider was described in the literature as an obstacle to care. Experiences of stigma and discrimination were frequently reported and exacerbated by poverty that could lead to social exclusion [Ahmed et al. 2006; Choudhury & Ahmed 2011]. In Ghana, Mills and Bertrand [2005] report that some women 'would rather deliver at home where nobody could see that they were poor' and 'were embarrassed to go to the hospital because they did not have nice clothes for themselves and the newborn'. In a health facility, underlying hierarchical and class distinctions could be starkly apparent and to many patients, 'modern doctors seem beyond reach' [Caldwell et al. 2002]. Yakong et al. [2010] assert that dominant discourses in Ghanaian society which devalue women and reinforce power relations are played out in interactions at health facilities, for example, even pregnant women routinely stood up when speaking to nurses. In Vietnam, ethnic minorities were seen to be discriminated against by Kinh health staff [White et al. 2012] and other forms of social stigma, such as being unmarried and pregnant, discouraged some of the most disadvantaged and vulnerable from seeking care [Rheinländer et al. 2011; Duong et al. 2004].

Such sentiments were further exacerbated by the poor attitude and misconduct of health workers that was frequently reported in the literature for each country. Studies detailed the 'harsh words', 'low tolerance', 'disrespect', 'intimidation', 'physical abuse', 'abusive language', 'dismissive attitude' and 'lack of compassion' of health workers. Participants acknowledged the efficacy of facility-based care, but the attitudes of health staff were a source of major concern. Patients were critical of their condescending attitude (particularly in relation to delivery) and deplored what they perceived to be unnecessarily harsh behaviour [Mills & Bertrand 2005];

Galaa & Daare 2008]. Interpersonal aspects of care can be key to a patient's expectation and govern satisfaction. D'Ambruoso et al. [2005] found that in the Greater Accra Region some women consciously changed their place of delivery if they experienced degrading behaviour and would recommend others to do the same. However, the majority of studies report respondents appearing fearful of being reprimanded, and there were numerous examples of patients being refused a service or threatened with treatment withdrawal [Choudhury & Ahmed 2011; Yakong et al. 2010]. Afsana and Rashid [2001] found that in rural Bangladesh, many women felt intimidated accessing services and 'believed that the good behaviour of staff depended on their own good behaviour'. In Vietnam, it was perceived to be 'normal' to be ignored and patronised by health staff [Klingberg-Allvin et al. 2012]. In rural Ghana, Yakong et al. [2010] found that patients sought to avoid conflict and 'women believed that they needed to accept the disrespect, intimidation and scolding they received from nurses in order to obtain the care needed'. Similarly, D'Ambruoso et al. [2005] working in an urban setting, concluded that many women would attend health facilities despite abusive behaviour in order to have a 'safe' birth, thereby underlining the importance of a successful birth outcome in care-seeking decisions.

Physical environment

Several studies highlighted differences between the environment at state facilities and the preferred environment for treatment as expressed by case-seekers. In Bangladesh, childbirth was socially and culturally associated with shame and impurity, and women were therefore reluctant to give birth in a 'public space' [Story et al. 2012]. A lack of privacy was most evident with regards to the position of birth. Most women greatly preferred to squat or kneel, positions used for generations and regarded as both comfortable and appropriate [Afsana and Rashid 2001]. The position of birth was also a factor in Vietnam, where women would choose to squat, kneel or sit [White et al. 2012]. Having to lie prostrate, often with their legs in stirrups was seen to be exposing and undignified. Restrictions on husband and family presence were also seen as detrimental [Klingberg-Allvin et al. 2008]. White et al. [2012] report that when women directly requested for their husband to be present in the delivery room, their requests were refused.

Poor layout and a lack of privacy were also concerns expressed in Ghana. Women feared being publically visible, and were concerned that if they were seen attending a facility it may expose them to potential gossip, particularly if they were seeking contraception [Yakong et al. 2010]. Women also reported feeling constrained by what information they could share with nurses who talked in loud voices and took case histories in the reception area [Yakong et al. 2010].

Additional environmental concerns included limited space, particularly when 'babies were crowded on the same bed' [D'Ambruoso et al. 2005], a lack of orderliness and poor sanitation. Vo Van et al. [2004] reported women having to relieve themselves in the forest because toilets at the health centre were not clean. Other infrastructure issues, such as a lack of electricity, were also raised [White et al. 2012].

Perceived quality of care

Many studies detailed patient dissatisfaction with health facility services and highlighted the deficiencies and inconsistencies they perceived in the quality of care. The technical capabilities of staff were often questioned with respondents criticising facilities for their 'lack of qualified personnel' [Ahmed et al. 2006; Duong et al. 2004; Dearden et al. 2002]. The customary health staff response that 'everything is fine', made patients doubt their competency and medical judgement [Klingberg-Allvin et al. 2008].

Excessive waiting times were also problematic, and there was a perception that health professionals were not readily available, partly because many facilities were closed at night and over public holidays. Thus, community members considered local facilities to be of limited use for emergency care, and as Caldwell et al. [2002] conclude in Bangladesh, it may be a contributing factor to the high number of child deaths that occurred before dawn (i.e. when the health facility was closed, or was thought to be).

There was widespread distrust and dislike of referrals, not only because of the cost and distance involved, but also because of the perception that the local health facility was not responsive [Ahmed et al. 2010; Jansen 2006]. Patients discussed feeling betrayed by the facility if onwards referral was required [Afsana & Rashid 2001]. Similarly, negative experiences or previous poor outcomes were a deterrent for seeking care at facilities [Bazzano et al. 2008a].

In their perception of quality care, some respondents listed supply-side issues such as a lack of drugs or equipment. The majority, however, did not use a clinical standard, but prioritised being treated with respect and dignity, and in a timely fashion [Ahmed et al. 2006]. There was limited accommodation of individual health needs [Yakong et al. 2010] and a generalised low level of satisfaction was evident [Martinez et al. 2012]. In Vietnam, there was suspicion or doubt about free drugs dispensed from the local health facilities, and if the drugs prescribed 'according to facility guidelines' did not match the expectations of patients, the quality of care was questioned [Hoan et al. 2011]. Similarly, disregard for socio-cultural practices were interpreted negatively. In both Ghana and Vietnam, burying the placenta was an important practice, yet the placenta was rarely given to the family after facility-based deliveries [Jansen 2006; White et al. 2012]. There was a lack of cultural acceptance regarding health beliefs that were juxtaposed to the biomedical framework, and many of the values appreciated in the local healthcare context (trust in the provider, social proximity, emotional support etc.) were perceived as being absent from facility-based care. For the complex and interwoven reasons discussed in this review, accessing facility-based care was, for many, often their last resort [Rashid et al. 2001; Parkhurst et al. 2006; Head et al. 2011; Storey et al. 2012; Ngom et al. 2003; Osumanu 2008].

DISCUSSION

Access is more than simply the opportunity to use healthcare services. It is a multidimensional concept based on the interaction between healthcare systems and individuals, households and the community. Access can be seen to have several core dimensions: availability; affordability; approachability; appropriateness; and acceptability. Availability is the degree of fit between suitable healthcare services and providers being at the right place and at the right time, and the prevailing needs of the population. Affordability is the degree of fit between the full and accumulative costs to the individual using a service, and that individual's ability or capacity to pay in the context of their household budget. Approachability is the degree of fit between the healthcare services and providers in place, and the identification or recognition of such services by individuals, households and communities who may require them. Appropriateness is the degree of fit between both the content (quality) and delivery of services, and the expectations of individuals, households and communities who may seek care. Acceptability is the degree of fit between the mutual expectations of the provider and (potential) patient, and an individual's, household's and community's attitude towards the healthcare system.

According to McIntyre et al. [2009], acceptability is the dimension most neglected in the empirical literature, yet it is critical to ensuring the empowerment of an individual, household and community to use appropriate services. Similarly, evidence from O'Connell's study of health insurance [O'Connell 2012] suggests appropriateness as a major issue. In the current thematic synthesis, much of the focus has rested on components of acceptability, approachability and appropriateness. These areas are where qualitative research can add value to the study of access with equity.

A limitation levelled at qualitative research is that it is not easily generalisable, yet in the context of health systems research, its strategic insight into local specificities is exactly what it is needed. Many of the barriers identified in the qualitative studies focus on the demand-side of access, whereas health systems research traditionally focuses on supply-side issues. There is a need to think innovatively about how to address the 'lack of fit' between services and those people who require them, from the latter's viewpoint. Qualitative research can explore and analyse the lived realities of target populations to provide a better understanding of the barriers and facilitators that affect access from the perspective of different users (both individual and collective) and sub-populations often regarded as 'difficult to reach': the poor, vulnerable and marginalised. These are groups with the highest unmet needs. There is increasing demand to integrate anthropological and sociological approaches into health systems research because they can provide robust evidence on the causes and impact of specific barriers to access faced by specific groups over time.

Developing rigorous mixed methodologies that combine qualitative and quantitative research can provide rich and textured results. In line with this qualitative review, a second workstream reviewed literature that used quantitative analysis to identify and assess non-financial barriers to access using household survey data [Thiede & Koltermann 2013]. One conclusion was that because of the dominance of data sources representing only the national and first sub-national

levels, household surveys (eg. USAID's demographic and health surveys, UNICEF's multiple cluster surveys, WHO's world health survey, the World Bank's living standards measurement studies) can only provide one side of the access paradigm that occurs at the local level where clients should be able to access services. The analysis of household surveys provides important orientation as to the interrelationship of different access barriers, but the complex interactions between various predisposing, enabling and need factors are hardly reflected. Synthesising the results of the qualitative and quantitative workstreams allows for analysis that moves between the national, sub-national and local levels, and can be mutually enforcing. Combining methods provides insight into the extent that issues identified through the quantitative analysis of household survey data are reflected in the lived realities of individuals, households and communities as depicted in qualitative studies. Similarly, it allows us to explore if issues identified at the local level, and from the perspective of a particular population, are reflected on a larger scale, and if so how. We need to move beyond just reporting the inequities in healthcare use and pay more attention to the overall process of differential access to explain its root causes and effects.

This project has afforded an opportunity for the qualitative and quantitative reviews to be collaborative. Preliminary analysis of key findings from the two workstreams highlights areas of particular interest. In the following summary, the quantitative material has been drawn directly from the study by Thiede and Koltermann [2013], and readers are referred to their full report for a more in-depth critique of the quantitative analysis and also to the various surveys upon which the papers reviewed were based.

Education

All the surveys captured the education level of the respondent. In Bangladesh, all showed a positive relationship between education level and attendance at a health facility, not only of the respondent or prospective patient, but also in the household context. The level of education of a household head was a significant predictor of seeking general care. In Ghana, there was also a positive relationship between a woman's level of formal education and health knowledge. Each additional year of formal education significantly increased the predicted probability of health service use. Information was seen to be a crucial enabler of health service uptake, however, lack of information about health and illness and the availability of services appears to have been assigned greater significance in the quantitative studies. In the qualitative literature, education level (both individual and in a household context) was seen to be influential in terms of knowledge, decision-making and autonomy, but it was not often discussed as an independent determinate of care-seeking.

Gender

In Ghana, analysis in the Ashanti Region demonstrated that despite their greater need, women utilised health services less than men. The perceived quality of services impacted more on men's uptake than on women's, but income levels had a greater impact on women's utilisation than on men's utilisation. The reasons for this cannot be fully explained from the quantitative

analysis, but a qualitative reading of these findings suggests that if male care-seeking is required, it is likely to be given greater priority within a household's economy than that of female care-seeking, and consequently when men seek care, they can afford to be more discerning about the quality of care than women.

Decision-making and autonomy

Quantitative studies were unable to provide clarity on socio-cultural and socio-economic patterns promoting decision-making. However, in Bangladesh, quantitative analysis did indicate that the individual characteristics of a mother should not be regarded separately from household characteristics. This speaks to the level of a woman's autonomy in relation to care-seeking and decision-making and suggests that the household context may have greater significance on determining action adopted than the mother's characteristics alone. This finding is supported by the qualitative analysis of authority in health-related decision-making in Bangladesh, where structural components of the paternalistic society limit a mother's agency to act. Quantitative studies show that autonomy increases with age, level of education, participation in paid employment, and with the number of living children. Education levels and paid employment were not addressed in the qualitative studies, yet their findings do corroborate that autonomy and influence increase with both age and number of children successfully delivered (as seen in the socially important positions of mother-in-law, female elder and grand-multiparous women).

Use of maternal health services and location of delivery

Quantitative analysis showed that in Bangladesh, the age of a woman had a strong impact on whether she used facility-based care. The higher the age of a woman giving birth, the more likely she was to use professional delivery services. Also, women who married at younger than 15 years of age, were less likely to use maternal health services than women who were married at older than 15 years.

In Ghana, a predisposing factor in the use of maternal health services was the respondent's religious background. Women who had 'traditional beliefs' used ANC significantly less and were far less likely to give birth in an institutional setting than members of other religions. Having controlled for socio-economic variables, results indicated that Christian women were more likely to deliver at a health facility and use ANC more frequently than women of other religions. The importance of faith and spirituality was also emphasised in many of the qualitative studies from Ghana.

In Vietnam, quantitative analysis showed the use of maternal health services was highly inequitable and was determined by wealth, education and ethnicity. There was a significantly positive relationship between wealth and the uptake of delivery services by any provider. The higher a woman's level of education, the more likely she was to deliver in an institutional environment, and the more likely she was to choose a facility birth for her first child than for later children. Again, parity was influential, with the likelihood of giving birth at a facility

decreasing with an increasing number of births. Also, women living within an extended family were more likely to give birth at home.

Ethnicity was an important predictor of care-seeking, particularly in Bangladesh and Vietnam. In Bangladesh, the probability of a person of non-Bengali ethnicity seeking care was significantly lower than a person of Bengali ethnicity, and the impact of ethnicity on health-seeking behaviour was more pronounced than that of gender or distance to the point of service delivery. This was supported by qualitative findings that describe, for example, how women from the Mru indigenous community did not utilise health services, even if their household was in close proximity to a facility. In Vietnam, quantitative analysis concluded that ethnicity was a highly relevant determinant of health service uptake: professionally attended births were more likely if the mother was Kinh than any other ethnicity; Kinh women were nearly four times more likely than ethnic minorities to give birth at health facilities; and maternal mortality amongst minorities was four times higher than Kinh maternal mortality. Again, qualitative studies provide further evidence of the low utilisation of maternal health services by ethnic minorities in Vietnam and describe in detail the stigma and marginalisation patients experienced when seeking care. It is concerning, therefore, that a recent situational analysis commissioned by UNICEF that reviewed all available studies on maternal mortality failed to distinguish ethnicity as a contributory factor due to data limitations [Knowles et al. 2009].

Use of child health services

In both literature reviews, there was a dominant focus on maternal rather than child health, however key findings are apparent. The qualitative analysis indicated that the age of a child had an impact on whether care was sought during an illness and the quantitative review highlighted that in Bangladesh, the likelihood of a child being taken to a formal health provider due to illness decreased with increasing age. Being aged under-two was positively related to the uptake of health services compared with children between two and five years. Findings also suggested that girls were far less likely to be taken to a doctor (formal professional provider) than boys, and there was a higher likelihood that boys would benefit from health services during illness. Gender discrimination in relation to care-seeking for children was not raised in the qualitative studies; although mothers who had needed emergency Caesarean sections did report that they were 'lucky' it was a boy so that money had been spent on a son and the family were not indebted for the sake of a girl [Khan et al. 2012].

In Vietnam, maternal ethnicity had the strongest effect on mothers seeking advice on treatment for their children with diarrhoea. Kinh mothers were more than twice as likely to seek healthcare for their child than mothers of ethnic minorities. Maternal education and the severity of the disease were also important predictors of service uptake. Again, the influence of ethnicity and the severity of the condition on care-seeking were evident in many of the qualitative studies reviewed.

Developing a mixed-methods approach to the analysis of non-financial access barriers highlighted a number of key areas for future research and in-depth analysis that seek to better

articulate the relationship between different dimensions of access. The following examples are not meant to be comprehensive, but are based on observations and suggestions from collaborators involved with the project:

- Does increased wealth/increased education and/or other factors mediate expectations that infant death is normal and would this lead to changes in care-seeking?
- With regards to decision-making paradigms, is there any linkage to income quintiles, wealth assets or education? Are helpful behaviours more common among richer or better-educated households?
- Do sentiments of shyness or inhibition associated with seeking care vary with socio-economic status or a mother's education?
- What impact does socio-economic status have on traditionally gendered roles such as provider and carer?
- What is the impact of a child's gender on care-seeking? Given the importance of a male heir in many societies, are individuals/households/communities more motivated to seek treatment to ensure the survival of a son rather than a daughter?
- What influence does parity have in decision-making about facility births? Are individuals/households/communities more likely to attend a facility for a woman's first delivery or for subsequent deliveries?
- How does birth order influence attendance for child illness? Are individuals/households/communities more likely to attend a facility for the illness of a first-born child or for other children? How do notions of risk contribute to these decisions?

Drawing on both the qualitative synthesis presented in this study, and the joint analysis of qualitative and quantitative data, certain implications for policy and programming may be extrapolated. For instance, strategies (such as those adopted under the UN initiative Every Women, Every Child) should take account of the fact that pregnancy and childbirth are often regarded as normal events or natural phenomena that do not justify professional care in the first instance. What is perceived to be the 'correct progression' of labour, does not necessarily reflect the biomedical model. Similarly, in conceptualising 'quality' of care, definitions tend to rely on terms acceptable in the developed economies of the global north, instead of using benchmarking criteria that better reflect the clients' real concerns and needs. In developing messages to overcome barriers and encourage appropriate care-seeking, policy makers should therefore target actual beliefs and behaviour patterns in a pragmatic manner. It is more a matter of assessing how to change the perceived value of early care-seeking, rather than suppressing one type of behaviour to encourage another. In policy terms, increasing access to and utilisation of services requires the management of intricate social dynamics and this implies a cross-sectoral response involving health, education and other actors involved with aspects of social welfare. Investing in local providers who may play important roles in the decision-making process around accessing appropriate professional care, is worthy of consideration. For example, traditional birth attendants (TBAs) often occupy influential positions in local society,

and numerous studies have reported positive and long-established relationships between them and the community. Rather than implementing policies that try to suppress TBA activity in favour of replacing them with health workers external to the community, training TBAs to become skilled birth attendants could build upon existing networks of trust and potentially lead to increased access and coverage. A related consideration is the upgrading of skills for village doctors, to shape their existing practice and networks towards providing more appropriate and higher quality services. The assessment of such policies, through ongoing monitoring and evaluation and operational research, is critical and should seek to include any unintended consequences of equity-enhancing interventions.

In the literature reviewed, qualitative methods were used to analyse factors preventing access to care, largely from the perspective of intended or actual users, including contextual factors. The studies included used a variety of methods including in-depth interviews, focus groups, participatory methods and observation, in addition to more innovative approaches such as social network analysis, health-mobility mapping, role-plays and transect walks at the community level (see Table 3). Appraisal of the studies highlighted gaps in the reporting of qualitative research (see Table 2), but the methods used were themselves seen to be sound. The fourth objective of this study was to make recommendations on how qualitative tools could contribute to the equity-focused diagnostic and monitoring components of UNICEF's DHSS approach. Although we included a careful assessment of the methods used in each paper, it was not possible to give a rigorous appraisal of the methodological approaches that usefully feed into the DHSS approach to 'diagnose' and 'monitor' non-financial access barriers. It is intended that this aspect receive further attention and be incorporated into a subsequent workstream of the overall project. This workstream will also seek to provide a comprehensive analytical framework that can assess both financial barriers and non-financial barriers simultaneously, weighing their relative impact across different at risk groups. This will be an important development, as to date, the majority of studies address financial barriers or non-financial barriers in isolation rather than exploring the critical interactions between them.

CONCLUSION AND RECOMMENDATIONS

This review has analysed non-financial barriers preventing equitable access to maternal and child health services in Bangladesh, Ghana and Vietnam through a synthesis of qualitative literature. In the study, equity was understood to be the just distribution of healthcare according to need leading to equal utilisation for equal need across socioeconomic groups. Access was seen as a multidimensional process of interaction between the health system and individuals, households and communities, influenced by diverse factors and dependent on empowerment. Barriers were defined as the manifestation of a 'lack of fit' between a potential healthcare need and the actual service that is supposed to be addressing that need.

Non-financial barriers constitute significant constraints to the equitable access of the full range of health services included under national UHC policies. However, they have different expressions and weight depending on context (and depending on how financial barriers are

themselves defined and measured). There are differences in how individuals use health services, even if their nominal access to those services is apparently equal. This reflects different barriers faced, as well as different choices individuals, households and communities make in relation to their exercising empowerment to use the services [McIntyre et al. 2009]. It also takes into consideration behavioural issues and recognises that there can be variations between intended and actual behaviour. In each country studied, there is virtually no data available to assess the relative importance of various financial and non-financial barriers to access and utilisation. There is, therefore, a pressing need for further research on how specific barriers interrelate and what their role and contribution is to accessing healthcare. Much of the information currently available allows us to identify barriers at the local level, but not the 'who, what, why and how' related to those barriers. For example, when medication is provided free of charge at the point of service delivery, some people still chose to buy their drugs from the private or informal sector. This suggests that acquiring medicine is not only shaped by financial concerns. Similarly, people make decisions about where to seek care based on preferences that are contextual. They may choose to travel to a health facility that is further from their home and expend more resources (in terms of time and cost) to do so, rather than attend the facility in the closest proximity.

Given the contextually-dependent features of care-seeking, we need to better understand the processes that could lead to universal healthcare with equity of access. This requires a reflexive examination of the nature and quality of services and whether they best serve the user's need – how close is the fit? As McIntyre et al. [2009] conclude, there is an obligation not only to make services available, but also to actively empower individuals to use those services when needed.

In recent years, resources and efforts have flowed into policy interventions addressing the affordability of healthcare. The present analysis of non-financial access barriers gives rise to a call for increased efforts to address other dimensions of access, such as acceptability, that can be tackled effectively at both national and sub-national levels. It also emphasise the need to better articulate the interaction between financial and non-financial barriers. UHC is not exclusively about providing free services and removing user fees, but also about designing services to be dynamic enough that they can tailor their interactions to populations with different characteristics and needs, and respond to a sub-population's capacity to digest and react. It should not be assumed that once UHC is reached, equity will necessary follow.

This suggests that we need to take local contexts into account in the design of conceptual frameworks that guide analysis and shape policy at different administrative levels of a health system. The Frenz and Vega model is particularly useful in this respect [Frenz & Vega 2010]. It aims to understand the access process and identify the sources of barriers and facilitators by taking account of supply and demand factors. In so doing, it identifies unmet need and proposes that the achievement of UHC with equity should be addressed from a population perspective with the goal of providing effective coverage to care for all, across socio-economic, socio-cultural and needs gradients. Health systems research has shown conclusively that the poorest and most vulnerable in society often shoulder the greatest burden of ill health, and that those individuals who are least likely to act (i.e. seek timely and appropriate care) are

those who are least able to (due to limited access opportunities, lack of knowledge, lack of perceived value or acceptability, etc.) Systems that fail to ensure equitable provision and access to healthcare, especially for women and children, continue to deepen health disparities and hinder both national and international development.

Creating equitable access requires a wide range of evidence-based interventions to overcome (or at the least, to minimise the impact of) specific barriers, beyond increasing the availability of services by expanding healthcare facilities to underserved areas. With respect to the three countries included in this review, there is obvious scope for increasing the fit between the identified or potential health need and the service supposed to be addressing that need. As part of the wider project to support UHC with equity through health system reorientation and strengthening from national through to local levels, this review should be used as a platform for developing a strong base of qualitative evidence. By the application of its findings and methods, it can contribute to efforts aimed at bringing about tangible benefits for targeted populations in terms of equity of access. In conclusion, three next steps are recommended.

1. Complete a more comprehensive synthesis of the findings from this and the quantitative review [Thiede & Koltermann 2013]. This will further develop the 'mixed-methods' approach, and will allow for greater insight into non-financial access barriers in Bangladesh, Vietnam and Ghana. The quantitative evidence can be illustrated and substantiated with results from the qualitative studies, and the empirical findings of the qualitative studies can be verified through quantitative analysis.
2. Use the synthesised analysis as a guide for targeted research to explore barriers in specific contexts, or address knowledge gaps. In addition to the numerous areas for future study and analysis presented above, the lack of data on non-financial access barriers for maternal and child health services in Rwanda (hence its non-inclusion in this review) signifies an obvious direction for future research.
3. Support UNICEF to operationalise qualitative and quantitative analysis in the equity-focused diagnostic and monitoring components of their DHSS approach (using the 'DIVA' framework of Diagnosis, Intervention, Verification and Adjustment). Findings from the qualitative review should be used to support a subsequent workstream of the larger project, a feasibility study to examine how an assessment of non-financial access barriers could be incorporated into DHSS. This should include a) a critical appraisal of the qualitative methods that may be used within DHSS, and b) the development of an analytical framework that can assess both financial barriers and non-financial barriers simultaneously, weighing their relative impact across different at risk groups and taking into account the complex interrelationships within and between the dimensions of access.

Appendix 1 – UNICEF key MNCH interventions

HOUSEHOLD AND COMMUNITY-BASED SERVICES

Family neonatal care

- Postnatal care for mothers at home within 48 hours
- Postnatal care for newborns at home within 48 hours
- Treatment of newborn infections (sepsis, pneumonia, diarrhoea) at community level

Infant and young child feeding

- Promotion of early and exclusive breastfeeding (community)

Integrated management of newborn and childhood illnesses

- ORS and zinc (community)
- Malaria treatment (community)
- Antibiotics for pneumonia (community)

OUTREACH AND SCHEDULABLE SERVICES

Preventive care for adolescent girls and women

- Promotion of family planning/Modern contraceptive use (schedulable)
- Condoms promotion and use for primary prevention of HIV infection

Preventive pregnancy care

- Focused antenatal care
- Tetanus Toxoid (TT) vaccination in pregnancy

HIV/AIDS prevention and care

- Antiretroviral for prevention of mother-to-child transmission of HIV
- CD4 testing and ART referral for women in need of HIV treatment for their own health
- HIV testing and counselling (HTC) in ANC
- Early HIV testing for HIV-exposed infants

Preventive infant and child care

- Full immunisation
- Exclusive breastfeeding among HIV-exposed infants

INDIVIDUALISED FACILITY-BASED CLINICAL SERVICES

Clinical primary level skilled maternal and neonatal care

- Promotion of family planning/Modern contraceptive use (facility based)
- Skilled birth delivery
- Kangaroo mother care
- Postnatal care for newborn in facilities within 48 hours

Clinical integrated management of childhood illnesses

- Antibiotics for pneumonia (facility)
- Antibiotics for dysentery and enteric fevers
- ORS and zinc (facility)
- Malaria treatment (facility)

Appendix 2 – Search strings per country

Bangladesh

((Bangladesh*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*)) OR ((Bangladesh*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*) AND (access* OR uptake OR utili*)) OR ((Bangladesh*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*) AND (barrier* OR imped* OR obstacle* OR bottleneck* OR constrain*)) OR ((Bangladesh*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*) AND (*seek* OR demand*))

Vietnam

("Viet nam" OR vietnam*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*)) OR ("Viet nam" OR vietnam*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*) AND (access* OR uptake OR utili*)) OR ("Viet nam" OR vietnam*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*) AND (barrier* OR imped* OR obstacle* OR bottleneck* OR constrain*)) OR ("Viet nam" OR vietnam*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*) AND (*seek* OR demand*))

Ghana

((Ghana*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*)) OR ((Ghana*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*) AND (access* OR uptake OR utili*)) OR ((Ghana*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*) AND (barrier* OR imped* OR obstacle* OR bottleneck* OR constrain*)) OR ((Ghana*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*) AND (*seek* OR demand*))

Rwanda

((Rwanda*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*)) OR ((Rwanda*) AND Health* AND (maternal OR natal OR newborn OR infan* OR child*) AND (access* OR uptake OR utili*)) OR ((Rwanda*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*) AND (barrier* OR imped* OR obstacle* OR bottleneck* OR constrain*)) OR ((Rwanda*) AND Health* AND (maternal OR *natal OR newborn OR infan* OR child*) AND (*seek* OR demand*))

Appendix 3 – Methodological appraisal tool

DOMAIN 1 – RESEARCH AND ANALYTICAL QUESTION

Research question	Does the study have a clear and well-defined research/analytical question? The overall aim and possible subsequent specific research question(s) should be clearly stated.
Background	Does the study motivate its research question? The rationale for the study may include references to other studies, an empirical policy problem, or a theoretical issue of relevance.

DOMAIN 2 – RESEARCH TEAM AND REFLEXIVITY

Personal Characteristics	
Interviewer/facilitator	Who (which authors) conducted the study (interview, focus groups etc.)?
Credentials	What were the researcher's credentials? (<i>eg. PhD, MD, etc.</i>)
Occupation	What was their occupation at the time of the study?
Gender	Was the researcher male or female?
Experience and training	What experience or training did the researcher have?
Relationship With Participants	
Relationship established	Was a relationship established prior to study commencement?
Participant knowledge of study team	What did the participants know about the researchers? (<i>eg. personal goals, reasons for research</i>)
Interviewer characteristics	What characteristics were reported about the researcher? (<i>eg. bias, assumptions, etc.</i>)

DOMAIN 3 – METHODOLOGY AND STUDY DESIGN

Theoretical Framework	
Methodological orientation and theory	What methodological orientation was stated to underpin the study? (<i>eg. ground theory, discourse analysis, ethnography, content analysis, phenomenology, etc.</i>)
Participant Selection	
Sampling	How were participants selected? (<i>eg. purposive, convenience, consecutive, snowball etc.</i>)
Approach / contact	How were participants approached/contacted? (<i>eg. face-to-face, telephone, mail, email etc.</i>)
Sample size	How many participants were in the study (different sections of the study)?
Non-participation	How many participants refused to participate or dropped out? The reasons should be given.
Data saturation	Is data saturation discussed?
Setting	
Location	Where was the data collected? (<i>i.e. home, clinic, workplace, etc.</i>)
Field-site	Is the field site described? (<i>eg. rural/urban</i>)
Description of sample	What are the important characteristics of the sample? (<i>eg. demographic data</i>)
Consent / Ethics	
Ethics	Did the study receive ethical clearance? From who?
Consent	Were the participants asked for informed consent? Written or verbal?
Confidentiality	Was the data kept confidential/stored anonymously?

DATA COLLECTION

Time period	When was the data collected? (<i>eg. when and over what time period</i>)
Methods used	What methods were used? The methods used to answer the research question and why these methods were chosen should be made clear.
Development of tools	How were tools developed and by who? (<i>eg. literature review, topic guide, interview, FGD frameworks, pilot tested, translated, back-translated</i>)
Presentation of tools	Are tools (<i>eg. interview framework</i>) included in the paper?
Audio/visual recordings	Were audio and/or visual recordings used to collect data?
Field notes	Were field notes made during and/or after the data collection?
Duration	What was the duration of the interviews/focus groups?
Transcripts	Were transcripts made?
Translation	Was the primary material translated/back-translated and by who?
Participant review	Were the transcripts or data returned to the participants for comments/correction?

DOMAIN 4 – ANALYSIS AND FINDINGS

DATA ANALYSIS

Method	What method of analysis was used?
Iterative/deductive	Were themes identified in advance or derived from the data?
Coders	How many researchers coded/analysed the data?
Coding process	Does the paper include a description of example of the coding process (<i>eg. coding tree</i>)?
Software	Was a software package used to manage the data? The software package should be named.
Participant checking	Did participants provide feedback on the findings?

REPORTING

Use of primary data	Does the study make use of primary data for its key analyses? (<i>eg. were quotes presented to illustrate the findings? If so, were quotations identified?</i>)
Clarity of major themes	Were major themes clearly presented in the findings?
Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?
Outcomes	Are all findings and results the outcome of the study? Are they supported by evidence originating from the study? It should be clear when any other data has been incorporated.
Credibility	Are the results/findings credible with respect to the methods used and data collected?
Limitations	Does the study critically discuss possible limitations?

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