

Full Length Research Paper

**An exploratory factor analysis of maternal health care pathways in rural Binga Zimbabwe.**

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**ABSTRACT:** Despite of a lot of investment in maternal health, maternal mortality is still a cause of concern in most developing countries. This paper sought to examine the patterns of relationships that exists among maternal health care services. A quantitative research approach was used to gather data, which was analyzed using factor analysis, due to the existence of very little empirical evidence around the area under study. The analysis unpacked the components of maternal health, making use of usability, availability, affordability and accessibility in pre and post natal care services. The study found conventional health care, Spiritual healing and indigenous health care to be the main providers of maternal health in Binga. The highest factor loading was recorded from the spiritual health care service which was followed by traditional health service. The last factor loading being recorded from the conventional health care service. The research concludes that unless there is recognition of other providers of maternal health in rural Zimbabwe, it would be difficult to reduce maternal mortality. The study therefore recommends government policies that are user friendly incorporating all health care services that are being used by the populace in rural Zimbabwe.

**Keywords.** Factor analysis, conventional health care, traditional health care, spiritual health, prenatal care and post natal care

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## **Methodology**

A quantitative research approach was used in the study making use of a questionnaire as a data collection tool. A total sample of 629 respondents participated in the survey and these were 284 males and 345 females, in Binga ward 1. On a five point Lickert scale respondents were asked to indicate their agreement to disagreement levels on of their use of maternal health care services. Factor analysis was used to analyze the findings making use of the Kaiser – Meyer- Olkin (KMO) measure of sampling adequacy together with principle component with the varimax rotation method. Factor analysis was seen as the most suitable analysis as there was little empirical evidence on the extent of use of all maternal health care services. However it was anticipated from the previous literature that most of the factor loadings in Zimbabwe were mainly on three health care services (Gorsuch 1983).

## **Ethics**

Ethical approval was obtained from Binga district Council to conduct the study. All research participants provided individual consent forms which they signed upon agreeing to participate in the study. Confidentiality was highly observed in the study as the interviews and data collected were securely kept and used for academic purposes only. The principle of anonymity was also observed as each questionnaire was assigned an identification number as a way of differentiating the responses and safe keeping the identity of the respondents. Voluntary participation and the right to withdraw were also observed in the study.

## **Background of the study**

Reduction of high maternal mortality has been the center of attraction in most health forums, attracting global consideration, to the extent of being one of the priority issues in the Millennium Development goals (MDGs) and the current Sustainable Development Goals (SDGs) (Mwewa and Michelo 2010). Surprising in spite of all these efforts to reduce maternal mortality research still shows that there is a minute confirmation establishing the fact that this has been achieved, evident by the continuous high maternal mortality rates in most developing countries. (Barnes, Abbott, Harkness, and Ernst,1999). Thousands of girls and women's deaths is reported to be pregnancy related in most third world countries (UNFPA 2013). These deaths have been reported

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to be as a result of a plethora of complications that occur during pregnancy, child birth and the postpartum period. The high percentage of maternal mortality in most third world countries is exacerbated by indirect causes such as cultural factors, diseases such as malaria and HIV and AIDS and poor health seeking behaviors (UN 2010). All these factors are embedded in the pathways that pregnant women follow in accessing maternal health, which are not clearly understood.

### **Literature review**

Studies by Barnes, Abbott, Harkness, and Ernst, (1999), Family Care International, (2012). Goshomi, (2009) has shown that women do not make use conventional maternal health care, despite its importance in trying to reduce maternal mortality among women. This has resulted in the failure to reduce maternal mortality amongst a number of member countries Zimbabwe included. Maternal health care is assessed through a number of ante natal care (ANC) and post natal care (PNC) visits a client would have taken. Antenatal care is very crucial in maternal health as it helps to identify potential risks that pregnant women are likely to face and plan for the best delivery (WHO, 2002). This however is not the situation on the ground, as Aryeeteyi, Aikins, Dako-Gyeke and Adongo (2015) noted that almost a quarter of pregnant women do not make use of ANC services as expected especially during the first trimester which is rendered critical in conventional health care. This on its own is a clear indication that if women are not receiving conventional maternal health care services they are receiving maternal health services from other health providers and poses a lot of questions to be worried about, as to where they are getting these services from. Aryeeteyi et al (2015) further notes that pregnant women receive ANC and PNC services from multiple health care providers in their communities who might not be recognized by the government. Traditional birth attendances for example were reported to be carrying out obstetric roles in most rural areas in Ghana (Negussie and Girma 2017). What is at stake however is the fact that there is very scant knowledge on the support and remedies that they give pregnant women that could be superior to conventional health care. This has sequentially resulted in not much being known about the number of visits that pregnant woman partake accessing such services. (Kapfunde, 2009. Studies by Redding, Conrey, Porter, Paulson, Hughes, Redding,(2014), Barnes, Abbott, Harkness and Ernst,(1999),Mwewa and Michelo, (2010),Moshabela,(2015),Chavhunduka (1982), Shimba,(2010), Dodzo and

Mhloyi,(2017) have also shown that even though pregnant women sought conventional health care they also sought alternative maternal health care like traditional medicine, herbal medicine, spiritual healing and self-medication simultaneously. Strangely the extent of seeking these care services also remains unknown to most member countries, proving the fact that the gap in maternal health care is being filled by alternative care providers.

There is also vast evidence of literature that brings out the reasons behind the use of alternative maternal health care services like the unavailability of transport services in most third world countries especially in the rural areas. Alternative health care service providers have also been seen as advantageous as they share the same socio economic conditions. Such care providers are reported by Dodzo and Mhloyi (2017) as being sensitive to economic changes that member countries will be going through. They are also accredited for having more flexible paying terms over a long period of time as compare to conventional health care services. Their referral system is also reported to be less expensive as compared to the conventional health care system referral system(Mwewa and Michelo 2010). Such care systems incorporate people's beliefs and practices hence they are sensitive to people's religious and cultural background. Under such circumstances they are reported to provide holistic care services addressing the client's fears and traditions (Dodzo and Mhloyi 2017). Due the absence of concrete literature on alternative maternal health care there have not been solid theories or models developed to try and explain the problem under study. The hypothesis round this area have been explained making use of the health belief model by scholars like Hochbaum (1958), Rosenstock (1966), Becker (1974) and Sharma and Romas (2012) who put across the reasons behind the behavior of individuals and communities in a cognitive manner. The theory proves how a pregnant woman's actions are determined by a number of beliefs and threats to his or her life which in turn affects the uptake of maternal health care services. Such scholars bring out relevant conclusions in regard to the reasons behind why people make use of other health care services.

The study also basis its arguments from the theory of planned behavior, by Ajzen(1991) and Ajzen and Madden (1986) which evolved from the theory of reasoned action by Fishbein and Ajen (1975).Such scholars conclude that the intention to act is the best predictor of individual behavior, were intentions in themselves are a combination of attitudes towards behavior, which is the positive or negative evaluation of behavior and its expected outcome. The theorists further cite that social pressures exerted on individuals result in the choice of maternal health care.

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Such theories are relevant to this study as they help in understanding why women make use of multiple maternal health care services. Despite the vast evidence of pregnant women making use of multiple maternal health care in most third world countries, there is not much that has been done to incorporate other health care services in the main stream health (Oluwatuyi, 2010).

### Study findings on prenatal care.

A factorability of 12 items were examined which were from conventional, traditional and spiritual healing pathways, in accessing pre natal care. These factors were examined from a scale of respondent's level of agreement to the health pathways. 11 out of 12 items correlated with (0, 3) with at least one item hence signifying a reasonable factorability as shown in the correlation matrix table 1 below.

**Table 1: Correlation matrix for prenatal care**

Correlation matrix	Con-avail-able	Con-accept-able	Con-acces-sible	Con-affor-dable	Tradi-avail-able	Tradi-accept-able	Tradi-acces-sible	Tradi-affor-dable	Spirit-avail-able	Spirit-accept-able	Spirit accessi-ble	Spirit-afforda-ble
Conventi- available	1.000	.623	.175	.495	-.069	-.183	-.187	-.112	.375	.345	.359	.326
Conventi- acceptable	.623	1.000	.219	.271	-.117	-.079	-.131	-.168	.228	.238	.236	.258
Conventi- accessible	.175	.219	1.000	.293	-.052	-.066	-.139	-.070	-.150	-.131	-.145	-.145
Conventi- affordable	.495	.271	.293	1.000	.083	-.023	.012	.152	.201	.160	.170	.146
Tradition- available	-.069	-.117	-.052	.083	1.000	.825	.806	.748	.051	.012	.002	.006
Tradition- acceptable	-.183	-.079	-.066	-.023	.825	1.000	.914	.809	-.109	-.111	-.132	-.107
Tradition- accessible	-.187	-.131	-.139	.012	.806	.914	1.000	.871	-.105	-.124	-.137	-.119
Tradition- affordable	-.112	-.168	-.070	.152	.748	.809	.871	1.000	-.063	-.114	-.092	-.136
spiritual available	.375	.228	-.150	.201	.051	-.109	-.105	-.063	1.000	.930	.945	.918
spiritual acceptable	.345	.238	-.131	.160	.012	-.111	-.124	-.114	.930	1.000	.962	.955
spiritual accessible	.359	.236	-.145	.170	.002	-.132	-.137	-.092	.945	.962	1.000	.955
spiritual affordable	.326	.258	-.145	.146	.006	-.107	-.119	-.136	.918	.955	.955	1.000
Sig. (1- tailed)												
Conv- available		.000	.000	.000	.041	.000	.000	.002	.000	.000	.000	.000
Conv- acceptable	.000		.000	.000	.002	.024	.000	.000	.000	.000	.000	.000
Conv-	.000	.000		.000	.097	.049	.000	.041	.000	.001	.000	.000

accessible												
Conv-affordable	.000	.000	.000		.019	.283	.385	.000	.000	.000	.000	.000
Trad-available	.041	.002	.097	.019		.000	.000	.000	.100	.384	.483	.443
Trad-acceptable	.000	.024	.049	.283	.000		.000	.000	.003	.003	.000	.004
Tradition-accessible	.000	.000	.000	.385	.000	.000		.000	.004	.001	.000	.001
Tradition-affordable	.002	.000	.041	.000	.000	.000	.000		.058	.002	.011	.000
spiritual available	.000	.000	.000	.000	.100	.003	.004	.058		.000	.000	.000
spiritual acceptable	.000	.000	.001	.000	.384	.003	.001	.002	.000		.000	.000
spiritual accessible	.000	.000	.000	.000	.483	.000	.000	.011	.000	.000		.000
spiritual affordable	.000	.000	.000	.000	.443	.004	.001	.000	.000	.000	.000	

a. Determinant = 1.04E-006

The results also showed a reasonable strength in the relationship between the measured variables. The Kaiser –Meyer- Olkin (KMO) measure of sampling adequacy was (0, 8) which was slightly above the standard recommended value of (0, 6) as shown in (table 2) below.

**Table 2: KMO and Bartlett’s test of sphericity.**

Kaiser –Meyer- Olkin (KMO) measure of sampling adequacy.		.809
Bartlett's Test of Sphericity	Approx. Chi-Square	8.586E3
	df	66
	Sig.	.000

The study results also revealed that the diagonals of the ant image correlation matrix were all above (0, 5) as shown in table 3 below. This showed that each item shared common variance with the other items. Taking into consideration all these indicators factor analysis was suitable for all the 12 selected items.

**TABLE 3: ANTI IMAGE MATRIX FOR PRENATAL CARE.**

Anti Image correlation	Conv-available	Conv-acceptable	Conv-accessible	Conv-affordable	Trad-available	Trad-acceptable	Trad-accessible	Trad-affordable	Spirit available	Spirit acceptable	Spirit accessible	Spirit affordable
Conven-available	.707 <sup>a</sup>	-.572	.027	-.359	-.127	.109	.045	-.029	-.090	-.032	-.060	.122
Conven-acceptable	-.572	.626 <sup>a</sup>	-.165	.011	.194	-.201	-.053	.171	.024	.058	.003	-.109
Conven-accessible	.027	-.165	.607 <sup>a</sup>	-.266	-.087	-.105	.214	-.043	.091	-.060	.038	.021
Conven-affordable	-.359	.011	-.266	.639 <sup>a</sup>	-.040	.152	.021	-.263	-.058	-.005	.089	-.075
Tradit-available	-.127	.194	-.087	-.040	.872 <sup>a</sup>	-.402	-.153	-.042	-.175	.021	.032	.019
Tradit-acceptable	.109	-.201	-.105	.152	-.402	.795 <sup>a</sup>	-.539	-.129	.111	-.086	.071	-.070
Tradit-accessible	.045	-.053	.214	.021	-.153	-.539	.769 <sup>a</sup>	-.539	.024	-.012	.162	-.174
Tradit-affordable	-.029	.171	-.043	-.263	-.042	-.129	-.539	.767 <sup>a</sup>	-.070	.105	-.315	.326
Spiritual available	-.090	.024	.091	-.058	-.175	.111	.024	-.070	.919 <sup>a</sup>	-.195	-.370	-.111
Spiritual acceptable	-.032	.058	-.060	-.005	.021	-.086	-.012	.105	-.195	.888 <sup>a</sup>	-.426	-.359
Spiritual accessible	-.060	.003	.038	.089	.032	.071	.162	-.315	-.370	-.426	.821 <sup>a</sup>	-.441
Spiritual affordable	.122	-.109	.021	-.075	.019	-.070	-.174	.326	-.111	-.359	-.441	.851 <sup>a</sup>

a. = Measures of Sampling Adequacy (MSA)

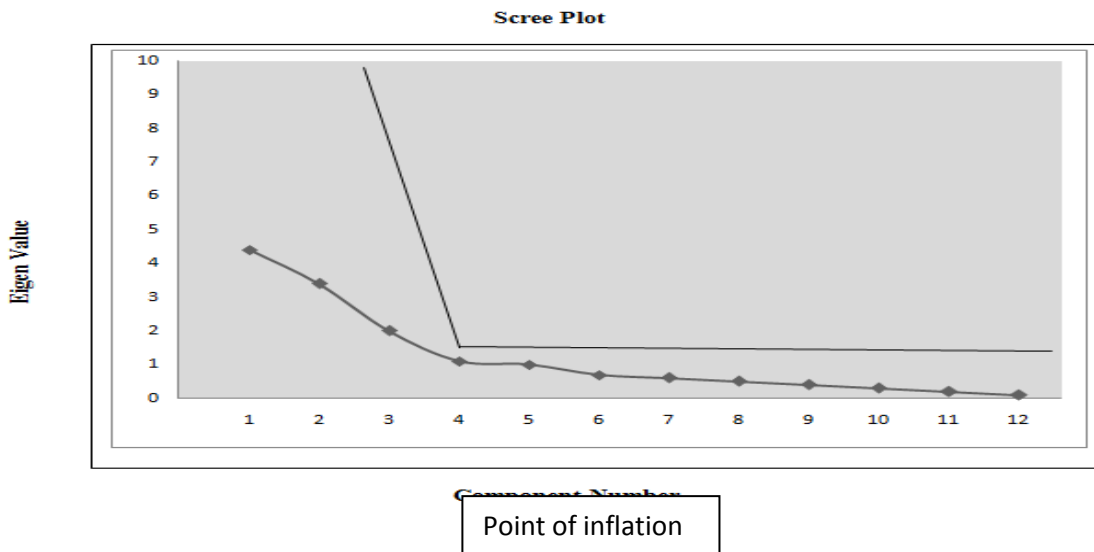
Twelve questions concerning the respondent's attitudes towards health pathways were analyzed using principal component with the varimax rotation method. From the analysis, three factors yielded a total of (79, 91%) was noted from the results of the total set of variables. The findings further revealed that factor 1 which was the Spiritual faith healing which had variables like spiritual prenatal care is accessible; Spiritual faith healing prenatal care is acceptable; Spiritual faith healing prenatal care is affordable and spiritual prenatal care is available. This factor had (33.31 %) of the variance as shown in (Table 4 below). The highest factor loading was also from this factor with the accessibility having the highest factor loading of (0,886) acceptability, affordable and availability recording 0,879; 0,766 and finally 0,863 respectively as clearly presented in the screen plot (Figure 1 below). It was also interesting to note that these factors were the main factors that were above the point of inflation as shown in the screen plot (figure 1 below).

**Table 4: Factor analysis table for responses towards health pathways.**

	<u>Factor 1</u>	<u>Factor 2</u>	<u>Factor 3</u>	<u>communality</u>
Spiritual faith healing prenatal is accessible	.886	.377	-.190	.964
Spiritual faith healing prenatal is acceptable	.879	.379	-.192	.953
Spiritual faith healing prenatal is affordable	.876	.372	-.202	.946
Spiritual faith healing prenatal is available	.863	.405	-.164	.935
Traditional prenatal is available	-.331	.843		.825
Traditional prenatal is accessible	-.490	.828		.927
Traditional prenatal is acceptable	-.477	.815		.895
Traditional prenatal is affordable	-.443	.801	.118	.853
Conventional prenatal is affordable	.260	.179	.685	.568
Conventional prenatal available	.551		.642	.720
Conventional prenatal is accessible		-.179	.641	.443
Conventional prenatal acceptable	.431		.611	.559
Eigen value	4,10	3.52	2.06	
% of Total Variance	33.31	29.35	17.25	
Total Variance	79,91			

The second factor was reported to be the traditional health pathway which had variables like traditional prenatal care is accessible; traditional prenatal care acceptable and traditional prenatal care is affordable and finally traditional prenatal care is available. This factor also had (29.35 %) of the variance as in (Table 4 above). It was interesting to note that this factor was slightly below the first factor, its highest variable was reported to be the availability, accessibility, acceptability and affordability of prenatal care services reporting 0,843; 0,828; 0,815 and 0,801 respectively. Surprisingly all these variables were below the point of inflation as indicated in (Figure 1 below).



**Figure 1: Scree plot for responses towards health pathways.**

Finally the last factor was the conventional health pathway which had the same variables as noted above. This factor had the lowest variance (17, 25) as revealed in (Table 4) above. The study further revealed that the highest variable was affordability (0,685) while the variable availability (0,642) was slightly above the variable accessibility (0,641) with the lowest variable being from acceptability which had (0,611) amazingly all these variables were also below the point of inflation as indicated in (Figure 1) above.

### **Study findings on post natal care.**

Similar to the factorability of prenatal care 12 items were also examined in the post natal care, which were also from conventional, traditional and spiritual healing pathway in accessing post natal care. These factors were also examined from a scale of respondents view on the way they disagree to the way they strongly agreed. 5 of the 12 items correlated at least (0, 3) with at least one item hence signifying a reasonable factorability as shown in (Table 5 below).

The results thus showed there was no reasonable strength in all the relationship between the measured variables hence another factor analysis of (5) items was examined and these were conventional post natal care is affordable, traditional post natal care is available, traditional post natal care is acceptable, traditional post natal care is accessible traditional post natal care is affordable. The other (7) items were disregarded.

**TABLE 5: CORELATION MATRIX FOR POST NATAL CARE.**

Correlati- on Matrix	Con- avai- lable	Con- accepta- ble	Con- access- ible	Conv- afford- able	Trad- availab- le	Trad- acceptab- le	Trad- accessi- ble	Trad- afforda- ble	Spirit- availab- le	Spirit- accepta- ble	Spirit- accessi- ble	Spiritu- al afforda- ble
Conv- available	1.000	.534	.190	.509	-.131	-.178	-.206	-.229	.324	.298	.302	.298
Conv- acceptable	.534	1.000	.241	.191	-.151	-.132	-.184	-.226	.231	.239	.226	.226
Conv- accessible	.190	.241	1.000	.312	-.161	-.076	-.151	-.150	-.146	-.127	-.140	-.145
Conv- affordable	.509	.191	.312	1.000	.055	-.007	.012	.009	.176	.123	.139	.141
Trad- available	-.131	-.151	-.161	.055	1.000	.891	.860	.814	-.113	-.152	-.177	-.173
Trad- acceptable	-.178	-.132	-.076	-.007	.891	1.000	.901	.842	-.158	-.166	-.181	-.175
Trad- accessible	-.206	-.184	-.151	.012	.860	.901	1.000	.932	-.130	-.157	-.162	-.158
Trad- affordable	-.229	-.226	-.150	.009	.814	.842	.932	1.000	-.105	-.139	-.137	-.133
Spiritual available	.324	.231	-.146	.176	-.113	-.158	-.130	-.105	1.000	.931	.934	.930
Spiritual acceptable	.298	.239	-.127	.123	-.152	-.166	-.157	-.139	.931	1.000	.975	.971
Spiritual accessible	.302	.226	-.140	.139	-.177	-.181	-.162	-.137	.934	.975	1.000	.996
Spiritual affordable	.298	.226	-.145	.141	-.173	-.175	-.158	-.133	.930	.971	.996	1.000
Sig. (1- tailed)												
Conv- available		.000	.000	.000	.001	.000	.000	.000	.000	.000	.000	.000
Conv- acceptable	.000		.000	.000	.000	.000	.000	.000	.000	.000	.000	.000
Conv- accessible	.000	.000		.000	.000	.029	.000	.000	.000	.001	.000	.000
Conv- affordable	.000	.000	.000		.084	.431	.379	.406	.000	.001	.000	.000
Trad- available	.001	.000	.000	.084		.000	.000	.000	.002	.000	.000	.000
Trad- acceptable	.000	.000	.029	.431	.000		.000	.000	.000	.000	.000	.000
Trad- accessible	.000	.000	.000	.379	.000	.000		.000	.001	.000	.000	.000
Trad- affordable	.000	.000	.000	.406	.000	.000	.000		.004	.000	.000	.000
Spiritual available	.000	.000	.000	.000	.002	.000	.001	.004		.000	.000	.000
Spiritual acceptable	.000	.000	.001	.001	.000	.000	.000	.000	.000		.000	.000
Spiritual accessible	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000		.000
Spiritual affordable	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	

a. Determinant = 4.66E-008

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The Kaiser –Meyer- Olkin (KMO) measure of sampling adequacy of these 5 items was (0, 816) which was slightly above the standard recommended value of (0, 6) as shown in (table 6) below.

**TABLE 6: KMO and BARTLETT’S TEST OF SPHERICITY.**

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.	.816
Bartlett's Test of Approx. Chi-Square	3.376E3
Sphericity Df	10
Sig.	.000

The research further revealed that (4) of the diagonals of the anti image correlation matrix were above (0, 5) as shown in (table 7 below). This showed that each of the (4) items on traditional post natal care shared common variance with the other items excluding the item on conventional post natal care which was at (0,107) as shown in (table 7 below).

**Table 7: Anti image matrix for post natal care**

Anti-image Correlation	Conventional PNC is affordable	Traditional PNC is available	Traditional PNC is acceptable	Traditional PNC is Accessible	Traditional PNC is affordable
Conventional PNC is affordable	.107 <sup>a</sup>	-.129	.103	-.013	.014
Traditional PNC is available	-.129	.871 <sup>a</sup>	-.532	-.146	-.072
Traditional PNC is acceptable	.103	-.532	.831 <sup>a</sup>	-.421	.028
Traditional accessible	-.013	-.146	-.421	.771 <sup>a</sup>	-.721
Traditional PNC is affordable	.014	-.072	.028	-.721	.810 <sup>a</sup>

a. Measures of Sampling Adequacy (MSA)

Taking into consideration all these indicators factor analysis was suitable for only (4) selected items. Hence another factor analysis was done on the (4) items that shared a common variance. The Kaiser –Meyer- Olkin (KMO) measure of sampling adequacy for the four factors was (0, 82) which was slightly above the standard recommended value of (0, 6) as shown in (table 8 below). The research further revealed that (4) of the diagonals of the ant image correlation matrix were above (0, 5). This showed that each of the (4) items on traditional post natal care shared common variance with each other.

**TABLE 8: KMO and BARTLETT’S TEST OF SPHERICITY.**

<b>KMO and Bartlett's Test</b>		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.821
Bartlett's Test of Sphericity	Approx. Chi-Square	3.366E3
	df	6
	Sig.	.000

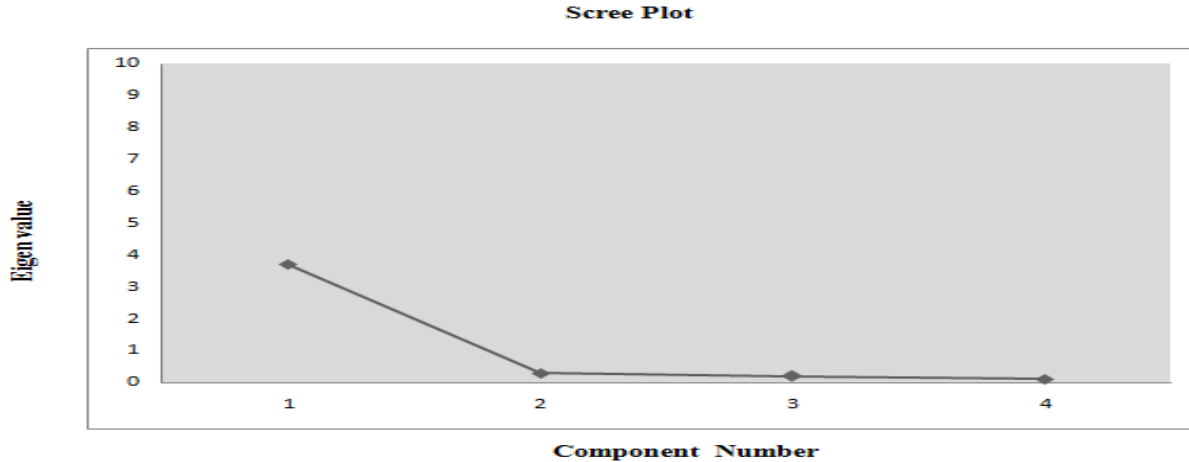
From the study four questions from the traditional pathway on respondent’s attitudes towards health pathways were analyzed using principal component with the varimax rotation method. The results showed that the factors had a total variance of (90, 52%) from the set of variables as indicated in (table 9 below). The findings further revealed that the highest factor loading was traditional post natal care is accessible (0, 97) while traditional post natal care is acceptable, traditional post natal care is affordable and traditional post natal care is available recorded 0,955, 0,943 and 0,936 respectively as shown in (Table 9) below.

**Table 9 factor analysis for responses towards health pathways.**

	Factor 1	Communality
Traditional PNC accessible	.971	.877
Traditional PNC acceptable	.955	.912
Traditional PNC affordable	.943	.943
Traditional PNC available	.936	.889
Eigen value	3,62	
% of Total Variance	90,52	
Total Variance	90,52	

It was also interesting to note that from this factor there was only one factor that was above the point of inflation which was the variable traditional post natal care is accessible while the rest were below the point of inflation as shown in the scree plot (figure 2) below. Showing a big variance between the highest traditional postnatal care is accessible as compared to traditional post natal care is acceptable, traditional post natal care is affordable and traditional post natal care is available which had lower numbers and was flat in the scree plot (figure 2) below.

**Figure 2: Scree plot for responses towards health pathways.**



### Discussion of findings

It can thus be concluded that in rural Zimbabwe most pregnant women prefer making use of the spiritual health care in their quest for pre natal care, as compared to the other forms of health care as this form of health care had the highest factor loading as compared to the other two health care systems. The spiritual health care service was followed by traditional health care. The less frequently visited health care was the conventional health care which ironically is widely financed as compared to their health care services. This clearly shows that there is a big discrepancy between what service providers are offering with what the service users are making use of resulting in more money being invested in what people are not making use of. This supports the health belief model which proves how a pregnant woman's actions are determined by a number of beliefs and threats to her life and not necessarily the medical model of health care. Such beliefs and threats in turn have an effect on women's uptake of maternal health care services. On the other hand most people in rural Zimbabwe are more likely to make use of traditional post natal care as it was the only health care service that had a high factor loading. This health care service was reported to be more accessible and acceptable in rural Zimbabwe. The other health care services were not as widely used in post natal care as compared to the traditional health care service. This clearly shows that maternal health care is being mainly offered by other health care services. Addressing the gap of knowledge of where women are accessing their maternal health care and the main health care service that they are using. The study results are in line with the conclusions made by Aryeeteyi, Aikins, Dako-Gyeke and Adongo

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(2015) who notes that most pregnant women make use of all the health care services that are available in the communities resulting in pregnant women not making use of conventional health care.

### **Conclusion**

It was thus concluded that pregnant women made use of spiritual health care service which was followed by the traditional health care service and finally the conventional health care service as shown by the results of the factor analysis in their quest for prenatal care. On the other hand women mainly were more comfortable with traditional Post natal care services as compared to the other health care services when it came to post natal care services.

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