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ACCESS TO ANTENATAL CARE PROVISION IN NIGERIA: CASE OF MUTUMBIYU DISTRICT, TARABA, NIGERIA

BY

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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER IN PUBLIC POLICY AND GOVERNANCE IN THE COLLEGE OF BUSINESS, PEACE, LEADERSHIP AND GOVERNANCE

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Abstract

Access to quality health care remains a major challenge in the efforts at reversing maternal morbidity and mortality. Despite the availability of established maternal health interventions, the health of the expectant mother and the unborn child remains poor due to low utilization of interventions. Ante-natal care is the key entry point of a pregnant woman to receive broad range of health education and preventive services that are useful to improving mother and her pregnancy's health. The study sought to analyse factors affecting pregnant women access to antenatal care provision in Mutumbiyu District Taraba Nigeria. The theoretical framework of emerging behavior model of utilization was used. A cross-sectional design method using structured questionnaire and key informant interview guide were used. A total number of 280 pregnant women were randomly sampled by the proportionate multi- stage sampling technique of balloting without replacement. Descriptive analysis, percentages, frequencies, pie charts, bars and cross tabulation were used in analyzing field data. In addition, data were analyzed using Excel, SPSS 23.0 version multiple regression and significance levels of 0% and 10% were considered The results showed varying access and utilization of antenatal care provision with age, educational and occupational status as important socio-economic and cultural determinants while distance to Antenatal care, quality of service and service satisfaction were significant system factors that influenced access and utilization of antenatal care provision among pregnant women in the study area. The study findings further indicated 83.3% of the respondents do not have access to health insurance hence insurance status does not independently play much role in the Antenatal care utilization of pregnant. The findings reveal that once the free maternal healthcare policy covers antenatal care provision, pregnant mothers were not compelled to enroll on the National Health Insurance Scheme as uninsured mother's utilized Antenatal care regularly like their insured counterparts. The study concludes that stepping up of interventions aimed at improving the socio-economic status, socio-cultural orientation and addressing health system and proximity challenges can improve the health of pregnant women and their babies. The study recommends that the stakeholder approach be taken to determine interest groups including women groups who desire to promote maternal health in a holistic manner; these groups should be represented under the auspices of the Director of health of the Local Government Council. This will help to put both local and scientific knowledge on equal footing and is likely to result to the meeting of needs of pregnant women and the priorities of the health care system. The levels of engagement on education could be symposia, workshop, community group meetings, local opinion polls, role play and slide shows. The health education given to expectant mothers could be an end in itself as they become empowered to taking well-informed decisions and varied choices.

Keywords: Maternal health care, Access, Ante-natal Care, provision, policy

Declaration

I declare that this dissertation is my original work except where sources have been cited and acknowledged. The work has never been submitted, nor will it ever be submitted to another university for the award of a degree.

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Dedication

I dedicate this study to God Almighty and my Late Wife Mrs. Victoria Mark

List of Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AUREC	Africa University Research Committee
CHPS	Community-Based Health Planning and Services
FANC	Focus Antenatal Care
FMOH	Federal Ministry Of Health
HIV	Human Immunodeficiency Syndrome
ICF	International Coach Federation
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
NBSN	National Bureau of Statistics Nigeria
NAHRS	National AIDS and Reproductive household Survey
NHIS	National Health Insurance Scheme
NDHS	Nigeria Demographic Health Survey
NPCN	National Population Commission Nigeria
NPHCDA	National Primary Health Care Development Agency
ODI	One Day International (Cricket)
PHC	Primary Health Care
PNC	Post Natal Care
SBA	Skilled Birth Attendants
SDGs	Sustainable Development Goals
SPSS	Statistical Package for Social Science
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNESCO	United Nations Educational Scientific and Cultural Organization
UNICEF	United Nations International Children Emergency Fund
WHO	World Health Organization

Definition of key Terms

Antenatal Care (ANC): It is a key entry point for pregnant women to receive multiple ranges of health services such as nutritional maintenance, prevention or treatment of anemia, prevention, detection and treatment of malaria, tuberculosis and sexually transmitted infections (Berthe, 2014).

Accessibility According to the World Health Organization (1978, p 28), "accessibility implies the continuing and organized supply of care that is geographically, financially, culturally and functionally within easy reach of the whole community".

Maternal Health (MH): is the physical wellbeing of a mother during pregnancy, childbirth and postpartum (WHO, 2011). Maternal health includes prenatal care and postnatal care of the mother and the child up to the age of five years (Fadeyi, 2007)

Maternal Mortality (MM): the International statistical classification of diseases health problems, 10th revision (ICD-10) (10), WHO defines maternal death as: ''the death of a woman while pregnant or within 42 days of termination of a pregnancy, irrespective of the duration and site of the pregnancy or its management but not from accidental and incidental causes''(WHO, 2007).

Maternal Mortality Rate (MMR): This is the number of maternal deaths in a given period per 100,000 women of reproductive age during the same time period (WHO, 2007a).

Maternal Mortality Ratio (MMR): The number of maternal deaths during given time period per 100,000 live births during the same time period, usually a year (WHO, 2007)

Utilization: Utilization is the number of attendances to health care facilities by people who are in need of such services (Bour, 2003)

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CHAPTER 1 INTRODUCTION

1.1 Introduction

This chapter deals with an overview perspective in terms of access to antenatal care provision, which constitute an insight of the background to the study, statement of the problem, research objectives, research questions, assumptions of the study, significance of the study, delimitation of the study as well as limitation of the study.

1.2 Background to the study

The issue of maternal health care provision is enveloped with a lot of challenges which have affected most of nooks and crannies of the world. This has become a serious threat to pregnant mothers and children where by mothers most often risk their life as well as the life of their babies due to lack of antenatal care and ignorant. Maternal health is defined as a state of total physical, mental and social wellbeing and not just the nonexistence of illness or infirmity in all issues that has to do with the reproductive age of women (WHO, 2018). Antenatal care is a key entry point for pregnant women to receive multiple ranges of health services such as nutritional maintenance, prevention or treatment of anemia, prevention, detection and treatment of malaria, tuberculosis and sexually transmitted infections (Berthe, 2014). Several countries of the world are battling on how to solve the death rate and minimise several problems associated with maternal health and child mortility. For instance, the traditional antenatal care service model was developed in the early 1900s, this model assumed that frequent visits and classifying pregnant women into low and high risk by predicting the complications ahead of time are the best way to care for the mother and foetus (Basevi, Dimario, Gori, & Spettoli, 2005). The traditional

approach was replaced by focus antenatal care- a goal-oriented antenatal care approach, which was recommended and adopted by WHO in 2002 (Basevi,2005). This is because the care given to women during pregnancy provides interventions that enhance maternal health and survival during the period immediately before and after childbirth. This led to the commencement of the safe motherhood program. The International Safe Motherhood initiative was launched in Nairobi, Kenya in 1987 and provided focus on programs and research concerned with the improvement of maternal health in low income countries (WHO, 2015). The safe motherhood program provides awareness, educational support for the women on screening programs and identifies the problems that make the pregnancy high risk. Antenatal care was one of the key pillars of safe motherhood (WHO, 2015).

African countries are no exception, it considered antenatal care as one of its priority, this is because the problems of pregnant women before, during and after delivery has led to the inception of antenatal care which dates as far as the early twentieth century (WHO, 2010). Preparing the pregnant women for a complication free birth and effective postnatal care is seen as a challenge (WHO, 2010a). This assertion is proven by the fact that over two-thirds of pregnant women in Africa make a single visit to the Antenatal clinic which in actual fact should be four visits for a full life-saving potential that is planned by Focus antenatal care (FANC) (WHO, 2010b). In many African countries, the health reforms and health care policies do not necessarily meet the global expected level of care provision (Diamond, Smith, Sudhinaraset, Montaga, 2016) and this often leads to poor maternal and child health outcomes. World health organization recommended that countries “identify gaps in coverage and quality of care” as a way to ensure that pregnant women receive appropriate needed care (WHO & UNICEF, 2015).

Currently, antenatal care utilization in Nigeria and the proportion having a minimum of four antenatal care visits recommended by WHO are below the world's average (Fagbamigbe, 2015). With the two surveys made by Nigeria Demographic and Health Survey (NDHS) in 2013 and National AIDS and Reproductive household survey (NARHS, 2012) revealed that the proportion of pregnant women who had not attended any Ante-natal care services in Nigeria was 33.9% and 34.9% respectively. The high rate of maternal mortality is a major public health concern in Nigeria with pregnant women in rural areas of the country are at greater risk of dying during pregnancy or childbirth as compared to those that live in urban areas ((Azuh, Iweala, Adeloye, Akanbi & Mord, 2017) This is largely due to limited access to maternal health care by rural women as health facilities are often located far from where they live, with the result that they rely more on use of traditional sources of care or to no care at all (Odetola. 2015). Data from the Nigeria Demographic and Health Survey 2013 shows 86.0% of urban women in the country received antenatal care services from skilled birth attendant (doctor or midwife), only 46.5% of rural women received antenatal service from skilled birth attendant likewise 61.7% of urban women were delivered by skilled birth attendant compare to only 21.9% of rural women. By contrast, a large proportion of rural women (77%) throughout the country delivered at home or in the homes of traditional birth attendants, compared to 37% of urban women. Clearly, the tendency for rural women not to receive pregnancy care has been recognized as one of the most important social determinants of the high rate of maternal mortality in Nigeria with Mutumbiyu District inclusive (NDHS, 2014).

1.2.1 Nigeria's response to Global standards of Ante-natal Care provision

In many developing countries, the health reforms and health care policies do not necessarily meet the global expected level of care provision (Diamond, Smith, Sudhinaraset, Montaga, 2016) and this often leads to poor maternal and child health outcomes. World health organization recommended that countries "identify gaps in coverage and quality of care" as a way to ensure that pregnant women receive appropriate needed care (WHO & UNICEF, 2015). In Nigeria, the (NHIS) is a policy response to the deteriorating state of health care in the country; the body was established under Act 35 of the 1999constitution of the Federal Republic of Nigeria. It was practically designed to improve the health of all Nigerians at an affordable cost (WHO, 2018). Putting into consideration the overall poor state of the Nigeria's health care services and the extreme dependence, pressure on Government owned health facilities; the ones at National, state and local government, these features expose the declining funding of healthcare in the face of rising cost and a lag in the focus for health care policy advancements in the country. There are numerous private health insurance schemes in Nigeria but the NHIS is designed to facilitate fair financing of health care costs through equitable use and distribution of health care (WHO, 2018). The scheme eases the cost-burden for people at all levels by ensuring cost cutting and cost sharing mechanisms and these work against the high cost of health care provided by private health institutions. The NHIS represents a very encouraging and maintainable healthcare financing strategy. The agency can work progressively towards achieving universal health insurance coverage for all Nigerians regardless of socio-economic status.

On the one hand, in the case where health facilities are readily accessible, availability becomes a major constraint. The contribution that this adds in delay causes significant

setbacks in accessing health care. These challenges are prevalent across most countries in Africa (WHO, 2018). These emanate from issues surrounding policies and infrastructural development in areas of transport and implementation strategies. Given the above stated factor, when pregnant women decide to seek for antenatal care facilities, it sometimes becomes a challenge to access the facilities, and also afford available services. In addition, it is important to note that the majority of the populace in Mutumbiyu District were below the poverty datum line. These have been compounded by other socio-economic and political factors in the environment. The above-mentioned factors give further clarity as to why most of pregnant women in the area of study cannot avail themselves for the available healthcare facilities.

1.2.2 Maternal Health Care

Women and their health largely have been influenced by the African traditional culture. Owing to the patriarchal nature of most of these African societies, diverse inequities being perpetrated against women. ‘‘It is not just what is done to women, but what is not done for them’’ (Okeke, Oluwuo & Azil, 2016).

Maternal health is defined as a state of total physical, mental and social wellbeing and not just the nonexistence of illness or infirmity in all issues that has to do with the reproductive age of women (WHO, 2018). Furthermore, with peculiarity to the African societies, maternal health would include the ability to exercise reproductive rights of family planning and access to basic focused Antenatal care, without the encumbrances of patriarchy, financial or geographical inhibitions impacting on her overall health (Okeke et al, 2016). However, the health care system in Nigeria is bedevilled with the challenges of quality service delivery, poor attitudes of staff to patients, lack of expertise, lack or

poor equipment, and shortages of essential drugs. Erratic and epileptic power (electricity) and water supply and the health sector as a whole are in a state of comatose. Nigeria healthcare system ranked by 187th among 190 United Nations member states (World Health Organization, 2018).

1.2.3 Maternal Mortality

Maternal mortality refers to any loss of a woman's life resulting from pregnancy complication or death within 42 days after childbirth, notwithstanding the period or site of the pregnancy, emanating from issues that are linked or escalated by the management of the pregnancy but not from accident or incidental factors (Ibrahim, 2016). There are other known factors aside medical conditions responsible for maternal mortality in Nigeria-these factors include but are not limited to social, economic and cultural factors, which have a direct influence on maternal mortality (Muoghalu, 2016).

Interestingly, maternal mortality in most of the rural areas in Nigerian and Mutumbiyu District specifically caused by other precipitating factors that are non-medical. These factors range from poverty, low level of education or absence of it, prohibited food, low purchasing power and certain harmful cultural beliefs and practices; more so, with the introduction of user charges in state and federal-owned hospitals, high percentage of women, especially in the rural areas, now patronize faith clinics and traditional practitioners as alternative health care (Ibrahim, 2016). Maternal mortality has been on the increase in recent time with detrimental effects on the socioeconomic development of the nation. According to (WHO, 2018). Approximately 830 women die every day from preventable causes related to pregnancy and childbirth. More worrisome is the fact that 99% of all maternal deaths occur in developing countries (WHO, 2018).

More worrisome is the fact that maternal mortality, known to be the loss of lives of women in their maternity stage due to pregnancy complication, is classified among preventable deaths (Nwokocha, 2015). Maternal and infant mortality rates are social indicators used to measure the development of any country, and the situation in Nigeria is of great concern (Okeke, Oluwuo & Azil, 2016) Despite this global commitment, the loss of women's lives resulting from complications during pregnancy has been on the increase in most sub-Saharan African countries (Nwokocha, 2008). In Nigeria for instance, maternal mortality accounts for 59,000 deaths of women annually (WHO, 2018). According to (NPHRHS, 2012). Nigerian women are 500 times more probable to lose their lives in childbirth when compared to most advanced nations of the world (Owumi, 2002). He further noted that Nigeria ranked second after India in global maternal incident rate and the worst in Africa. Flowing from above, maternal and child mortality is a serious concern to the government and all interested stakeholder, and as such, it has become a vital issue for research. This study, therefore, aimed to unravel the concept of maternal mortality within the Nigerian context with Mutumbiyu District inclusive, unpack it precipitating factors and bring to the fore the debilitating effects especially in areas of socioeconomic development. Studies conducted by (Abourzahr & Wardlaw. 2001) on risk factors of maternal mortality have shown that lack of antenatal care increases the risk of maternal mortality. Antenatal care researchers have acknowledged that every pregnant woman is at risk of complications associated with pregnancy, and therefore advocates that pregnant women should receive basic healthcare and monitoring (WHO & UNICEF, 2012) it is worthy to note that pregnancy and childbirth complications are leading causes of death and disability among women of reproductive age, especially in developing countries like Nigeria

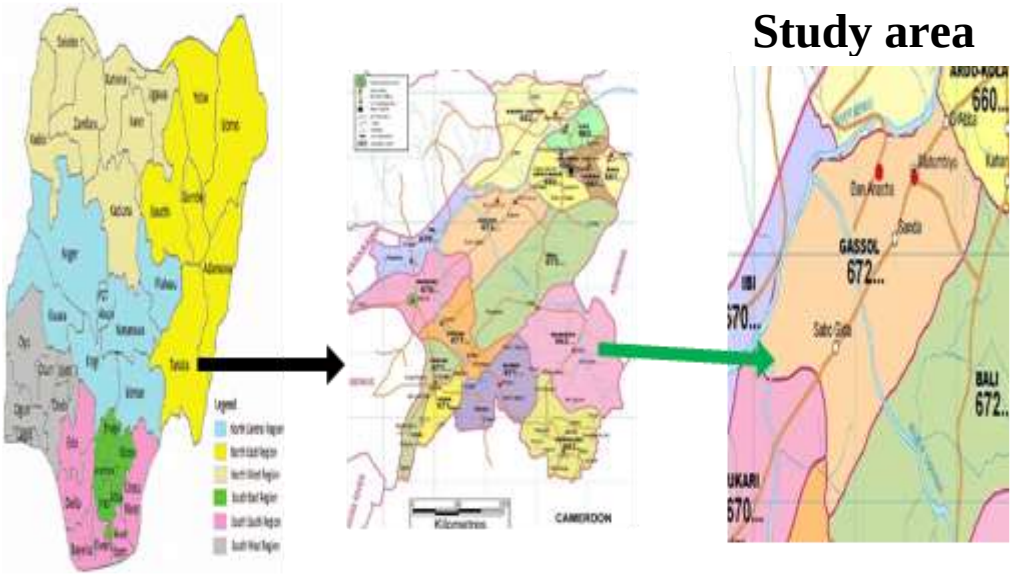
1.2.4 Historical Background of the study area

Nigeria has 36 states and 774 local Government Areas within the six geopolitical regions, with the largest population in Africa, with an estimated population of 185,989,640 million people (National Bureau of Statistics, Nigeria, 2016). In 2016, 52% of the population was rural and 48% urban. An estimated 64% of Nigerians live on less than $1.25 per day, and Nigeria is ranked 158th of 182 countries on the (United Nations 2009 Human Development Index (World Bank 2009a; UNDP, 2010; World Bank 2009; ODI 2010). There are currently 33,000 Primary Health Centre's (PHCs) located in 774 Local Government Areas (LGAs) with a minimum of ten wards per LGA in Nigeria. Each ward has a population of between 5000 to 10,000 persons, with each expected to have a PHC that provides immediate point of entry to the health care system for pregnant women seeking skilled pregnancy care. Thereafter, women with complications are referred to Secondary and Tertiary care facilities (National primary health care development agency (NPHCDA, 2012). Taraba state comprises of the pre-1976 division of Muri, Mambila, and Wukari, which was created out of former Gongola State on 27 August 1991, by the Military Head of State General Ibrahim, Badamosi, Babangida. The State is named after the Taraba River which Transverses the southern part of the state. The State is popularly known as 'Nature's Gift to the Nation' because of its abundance of Natural Resources (Abdulai & Ndekugri, 2007). The state has a total population of 2,652,900 according to (NBSN, 2016). Taraba state has 16 Local Government Area with Gassol Local Government Area inclusive.

Gassol Local Government was created in 1996 by the military head of state, General. Sani Abacha, with headquarter at Mutumbiyu located in the central senatorial zone of the state

with estimated total population of 251,191(NBSN, 2016), sharing boundary with 4 local government area namely Karim- lamido- north Ardo – Kola North-east, Bali east, and Wukari, south respectively It has two Districts, Mutumbiyu District and Gassol District respectively with 12 electoral wards, in which Mutumbiyu District has 6 wards. The local Government has two chiefdoms, such as Mutumbiyu chiefdom and Gassol chiefdom with a second class titled. The local has 45 primary health care facilities with one First Referral Hospital owns by the state government.

Figure 1 Map of the study area



1.2 Statement of the Problem

Nigeria accounts for 10 per cent of global maternal mortality figure, with 59,000 women dying annually from pregnancy and child birth complications, for every maternal death, 30 percent others suffer long-term disabilities while 40 percent (about 800,000) of global obstetric fistulas occur in Nigeria (WHO, 2014). The frightening report described the health situation in the country as being so deplorable because skilled health professionals deliver only 39 per cent of births, it also stated that the risk of a woman dying from childbirth is an alarming 1 in 18 in Nigeria compared to 1 in 61 for all developing countries and 1 in 800 in developed countries (WHO, 2014). The Federal Ministry of Health of Nigeria specifically recommends Primary Health Care as the entry point to the health care system in order to generate universal health coverage for all citizens ((NPHCDA, 2012). Despite this organized system, available evidence suggests considerable under-utilization of available PHC facilities for care by women seeking antenatal and intrapartum care in rural areas of the country with Mutumbiyu District inclusive (Egbewale & Odu. 2013). Like other sub-Saharan Africa countries, Nigeria is lagging in antenatal care provision. Currently, antenatal care utilization in Nigeria and the proportion having a minimum of four antenatal care visits recommended by WHO are below the world's average (Fagbamigbe, 2015). With the two surveys made by Nigeria Demographic and Health Survey in 2013 and National AIDS and Reproductive household survey (NARHS) in 2012, revealed that the proportion of pregnant women who had not attended any Ante-natal care services in Nigeria was 33.9% and 34.9% respectively. The high rate of maternal mortality is a major public health concern in Nigeria with pregnant women in rural areas of the country are at greater risk of dying during pregnancy or childbirth as compared to

those that live in urban areas ((Azuh, Iweala, Adeloye, Akanbi, Mord. 2017) This is largely due to limited access to maternal health care by rural women as health facilities are often located far from where they live, with the result that they rely more on use of traditional sources of care or to no care at all (Odetola. 2015). Data from the Nigeria Demographic and Health Survey 2013 shows 86.0% of urban women in the country received antenatal care services from skilled birth attendant (doctor or midwife), only 46.5% of rural women received antenatal service from skilled birth attendant likewise 61.7% of urban women were delivered by skilled birth attendant compare to only 21.9% of rural women. By contrast, a large proportion of rural women (77%) throughout the country delivered at home or in the homes of traditional birth attendants, compared to 37% of urban women. Clearly, the tendency for rural women not to receive pregnancy care has been recognized as one of the most important social determinants of the high rate of maternal mortality in Nigeria with Mutumbiyu District inclusive (NDHS, 2014). Despite free ANC services and the availability of health facilities that offer Ante-natal care at all levels of care, the utilization of health care facilities is still low due to the number of factors. Factors such as socio-demographic features, knowledge of social support on ante-natal care services, economic status, culture, environment, and development level of education, income, attitude to service, and non-availability of public transportation, contribute to low patronage of ante-natal care services (Haub, 2012). The present study sought to investigate the socio-demographic, economic, and cultural factors influencing poor access to Antenatal care provision and provide possible evidence-based recommendations for policymakers.

1.4 Research Objectives

The objectives of this research were:

1. Assess factors affecting pregnant women access to Antenatal care provision in Mutumbiyu District Taraba, Nigeria
2. Identify the enabling factors affecting pregnant women access to Antenatal care provision in Mutumbiyu District Taraba Nigeria.
3. Analyses the perceptions of pregnant women towards access to Antenatal care provision in Mutumbiyu District Taraba Nigeria.
4. Recommend how pregnant women can be helped to access antenatal care timeously.

1.5 Research Questions

The research was guided by the following research questions:

1. What are the factors affecting pregnant women access to Antenatal Care Provision in Mutumbiyu District, Taraba Nigeria?
2. What are the enabling factors affecting pregnant Women access to Antenatal Care Provision in Mutumbiyu District Taraba Nigeria?
3. In what ways does perception influence pregnant women towards accessing to Antenatal care provision in Mutumbiyu District Taraba Nigeria?
4. What recommendations can be made for pregnant women to be helped to access antenatal care timeously?

1.6 Assumptions of the Study

The study assumes that cultural background and thought influence belief, norms and values in relation to child. It assumes that financial capacity of the family in relation to the costs of facility delivery including transportation costs to health facility is one of the major reasons why women or family with low financial capacity prefer to deliver at home and thus ignore accessing Antenatal care provision. The study also assumes that Antenatal Care uptake requires travel and long waiting hours. Pregnant women and their families experience huge opportunity costs. The study assumes Long distances to health facilities as well as insufficient number of Antenatal Care providers at various Antenatal Care (ANC) clinics negatively affect Antenatal care utilization. The study also assumes that the utilization of Antenatal care services can be influenced by a woman's perception of the relative importance of modern health care services versus traditional methods of care. The study assumes that the utilization of antenatal care services can be influenced by a woman's perception of the relative importance of modern health care services versus traditional methods of care.

1.7 Purpose of the study

The main purpose of the study is to assess factors affecting pregnant women, analyses perceptions of pregnant women on access antenatal care provision and also to explore the enabling factors such as age, educational level, employment status, attitude of health staff, insurance status, religion and quality of service affecting pregnant women access to antenatal care provision in Mutumbiyu District Taraba, Nigeria.

1.8 Significance of the Study

The study will be of significant to various health care sector in trying to address the issue of maternal mortality and poor access to maternal health care facilities. Findings and recommendations of this study would also be of significant importance to antenatal care provision unit in Mutumbiyu District Gassol local Government Taraba, Nigeria. In the same vein, it will also help pregnant women to understand the importance or implications of access to antenatal care provision and how it can affect them and their fetus. Findings and recommendations of the study can serve as guides to health providers and policy makers. Equally will be of significant not only to expectant mother but also to Taraba State Ministries of Health and Information, State Health Services Management Board, Primary Health Care Agency, Policy Makers, Health Educators and all female reproductive Health Researchers. The study will add to the existing body of knowledge as regards to access to Antenatal Care Provision and serve as a pointer to future researchers. The findings of this research will contribute to body of knowledge that will be used for other review of literatures of those who would want to research on issues concerning access to Antenatal care provision.

1.9 Delimitation of the Study

The study was confined to Mutumbiyu District which is located in Gassol Local Government area under the central senatorial area of Taraba state of Nigeria. The local government has two District namely Mutumbiyu and Gassol District with also two chiefdoms (Mutumbiyu chiefdom and Gassol chiefdom) all bearing second titled. The local government was created in 1996 by the military head of state, General. Sani Abacha with headquarter in Mutumbiyu, with a total population of 251,191(National Bureau of

statistics Nigeria, 2016). The District has 6 electoral wards thus Namnai, Mutumbiyu, Gunduma, Shira, and Yerima Ward. The local government share boundary with 4 local government area namely Karim- lamido- north Ardo – Kola North-east, Bali east, and Wukari, south respectively The District has 21 primary health care facilities with one First Referral Hospital owns by the state government. This study was confined to pregnant women of 15-49 years of age attending Antenatal care services in the health facilities of Mutumbiyu District. The study was delimited to three sampled ward such as Namnai, Mutumbiyu, and Gunduma ward. Two primary health facilities were sampled from each ward, the ward with their health facility are Namnai ward, (Shagarda and Namnai health facilities), Mutumbiyu ward, (Munira and Mutumbiyu Health facilities), while Gunduma ward were (First Referral Hospital and Gunduma Primary Health care) respectively.

1.10 Limitation of the Study

This study was not immune to challenges due to the nature of the study as well as the methodology used. Some of the limitations of the study revolved around the following: Cultural barriers affected the study because most of the respondents were Muslims because of their religious belief they thought if they opened up too much they will be victimized by their parent or spouses, this challenge was mitigated by the involvement of female interpreters and some facilities staff, they helped clear the air about the objectives and purpose of the study which made the participants to open up nevertheless, was also solved by gaining the cultural orientation of the respondents and respecting the cultures involved. Using interview was also limitation in the sense that some respondents were not willing to talk with the researcher in the absence of the husband due to the fear of being accused of fidelity. These conditions facilitated the researcher to be able to blend in and

receive responses. In addition, language barrier was also a limitation encountered during the study. Most of the pregnant women were illiterate or unable to read and write in English. This barrier was overcome by the use of an interpreter. Where most of the interviews were conducted in Hausa and English. Another limitation encountered was fear of victimization especially when the respondent reported weaknesses in the health facilities. Meanwhile, this is overcome by assuring the participants that the study is not meant to punish nor victimize anyone.

1.11 Summary

This chapter established the background of the topic in question and clearly states the statement of the problem therein and the objectives of the study. It is based on this framework that the design of an appropriate data collection strategy was done which enabled the researcher in carrying out the study.

CHAPTER 2 REVIEW OF RELATED LITERATURE

2.1 Introduction

Literature review is a critical summary of research on a topic of interest often prepared to put a research problem in the context or as the basis for an implementation project (Denis, Chery, 2004). The concern in this chapter is to discuss the theoretical framework and it relevance to the study and also to review related literatures on the following areas such as factors affecting access to Antenatal Care Provision, enabling factor that influence pregnant women access to Antenatal Care Provision and perceptions of pregnant women on access to antenatal Care Provision.

2.2 Theoretical Framework

2.2.1 Emerging behaviour model of utilization

The researcher adopted Andersen and Newman's emerging behaviour model of utilization. Andersen and Newman noted that the purpose of the framework is to discover the condition that either facilitate or hinder the utilization of health care facilities. The basic goal of the model is to develop a behaviour model that provides measures of access to medical care. The evolution of the framework was developed in the 1960s, by Andersen and Newman in which it gone through fourth phases, which subsequently developed in the 1990s (Andersen, 1995). An individual's access to and use of health services is consider to the function of three characteristics thus:

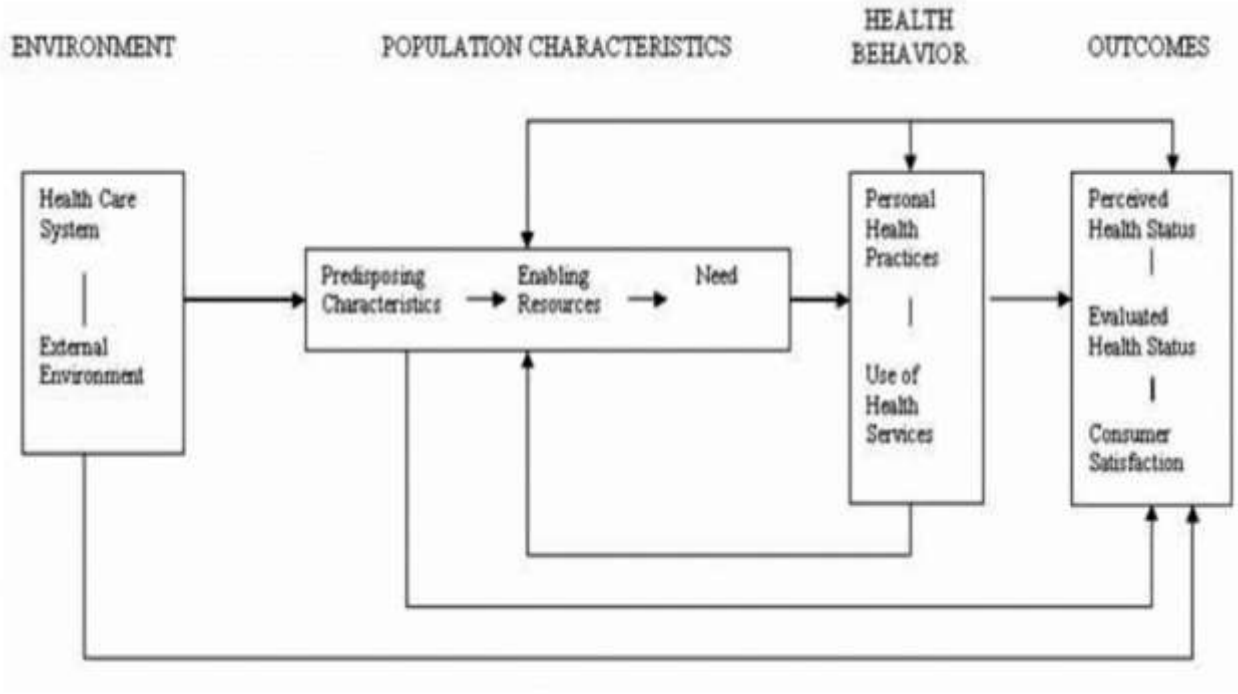
The predisposing factors which comprise of the socio-cultural characteristics of individuals that exist before their illness. Moreover, the social structure such as education, occupation, ethnicity, social networks, social interactions, and culture. Health beliefs of

people; which also encompass attitudes, values, and the knowledge people have concerning and towards the health care system. Likewise, the demographic factor, which includes age and gender.

Enabling factors include the logistical aspect of obtaining care and personal/family that involves the means and know-how to access health care services, income, health insurance, a regular source of care, travel, including the extent and quality of social relationships and community that involves, the availability of health personnel's and facilities, and waiting time in additions genetic factors and psychological characteristics.

Need factors: Involve immediate cause of health service use, from functional and health problems that generate the need for health care services. Perceived; ''How people view their general health and functional state, as well as how they experience symptoms of illness, pain, and worries about their health and whether or not they health status and their need for medical care'' (Andersen, 1995b).

Figure 2 Andersen and Newman Theoretical Framework



An Emerging Model of Health Utilization **Phase Four (4). Source: Andersen (1995)**

2.3 The Relevance of Emerging Behaviour Model of Utilization

The model suggests that people's use of health services is a function of their predisposition to use services, factors that enable or impede the use and their need for care. The characteristics of the population at risk are describe as predisposing, enabling, and need. Predisposing characteristics are those that exist before pregnancy that describes the tendency to use health care services.

The model views utilization of health services as a form of individual behavior that is determined by individual characteristics of people, which are influenced by societal, and health systems determinants. The societal determinants (technology and societal norms such as health care financing) affect the individual determinants directly and through the

health system determinants (resources volume and distribution of labour and capital for health care, and organization pregnant women access to the antenatal care provision, and structure what happens after entry into the system). The individual characteristics that predict use of antenatal care services are classified into three: predisposition of an individual to use antenatal care services (predisposing factors), ability to secure services (enabling factors) and illness level (need factors). Predisposing factors include demographic characteristics such as age, sex, marital status, past illness, social structure (education, race, occupation, family size, ethnicity, religion, and residential mobility) and beliefs (values about health and illness, attitudes toward antenatal services/providers, knowledge about disease). Previous research shows that the demographic characteristics of individuals predict their health behavior. For instance, being in a marital union is associated with better health and health-related behavior (Musick & Bumpass, 2012). The past illness factor suggests that past experience of pregnancy and childbirth, parity, and experience of using a health care facility may affect the use of a primary health care facility for maternal care (Andersen & Newman, 2005).

The enabling factors refer to the means available to individuals to achieve a need to use a health service. Enabling factors include, family resources (income, level of health insurance coverage, or other source of third-party payment, type of regular source of care, the nature of that regular source of care, and accessibility of the source) and community characteristics (ratio of health personnel and facilities to population in a community, price of health services, region, urban rural location). This implies that women's ability to use maternal health facilities will depend on the availability of such facilities and their possession of the means to access the facilities. The need factors include perceived illness

or the probability of its occurrence by the individual or her family (disability, symptoms, diagnosis, general state such as, number of days during which the individual is unable to do her usual work such as house chores, care of children, experience of symptoms, self-report of general state of health), and evaluation of the condition (symptoms and diagnosis attempts to get at the actual illness and a clinical assessment of the severity). (Andersen & Newman, 2005). These factors represent the immediate determinants of health service utilization.

The need component suggests that the utilization of maternal health services can be influenced by a woman's perception of the relative importance of modern health care services versus traditional methods of care. Added to this is a woman's perception and understanding of pregnancy complications and her desire to deliver safely and attain a healthy newborn baby. Incorporated health outcomes (perceived and evaluated health status and consumer satisfaction) in addition to existing primary determinants (characteristics of the population, the health care system, and the external environment) and health behaviors (personal health practices and use of health services) which are the direct cause of health outcomes. This inclusion allowed the model to be extended to the measures of access to include dimensions that are particularly necessary for health policy and reforms (Andersen, Davidson, & Ganz, 1994).

Emerging behaviour model of utilization explains the timing and utilization of maternal health services of pregnant women. This has in turn created massive awareness and promoted women empowerment and autonomy to utilize health care and remains one of the most powerful determinants of survival of children and mothers. In the present study, the model adopted because; it would provide insights into the factors motivating pregnant

women to seek care. The model has also helped in developing a conceptual framework to illustrate the myriad factors influencing pregnant women's decision to access Antenatal care provision in the study area. Meanwhile the researcher deemed it fit to review the related literature based on the research objectives variables such as the predisposing factors affecting pregnant women access to Antenatal care provision, enabling factors affecting pregnant women accessing antenatal care provision and the perception of pregnant towards accessing to antenatal care.

2.4 Factors affecting pregnant women access to Antenatal care

2.4.1 Age at Marriage

Women of reproductive age has been defined as those between 15-49 years and these constitute more than fifth of the world's population and are repeatedly exposed to the risk of pregnancy and child bearing (Dairo & Owonyokun, 2010). Age connotes the idea of superiority in terms of ability to think and make decisions this also determines the readiness of the physiology of the mother, which expect a woman reproductive organ need to be mature before engaging into marriage. Many maternal deaths occur because of early childbearing in which Adolescents suffer disproportionately from complications related to childbearing because their bodies were not fully developed (Idowu, Osinaike & Ajayi, 2011).

A woman's age might influence her decision to initiate Antenatal care late or not to attend Antenatal care at all. Nearly one-quarter (23%) of adolescent women age 15-19 are already mothers or pregnant with their first child. Young motherhood is highest in North West Zone (36%) and lowest in South East and South West Zones (8% each) (NDHS, 2013). According to Matua (2004), as cited by (Chaabra, 2008a). Pregnant adolescents

might shunt accessing Antenatal care services for fear of being label “promiscuous”. On the other hand, an older adolescent who have had uneventful pregnancies and deliveries with previous pregnancies might see no reason to attend Antenatal care. In 19 out of 26 developing countries, women whom were 19 years or younger were reportedly less likely than older women to seek Antenatal care) from health professionals (Reynold, 2006).
Many of the factors that influence pregnant women’s’ ability across various age groups to access ANC lie beyond the health facility itself, and overlap with those documented for older. To ensure that ANC is accessible to all age groups, it is essential to address their particular needs and preferences. Recognizing that health services for adolescents often fragmented poorly coordinated and of inconsistent quality (WHO, 2015). According to (Ufford & Menkiti 2001) and (NDHS, 1999).

Many of the factors that influence pregnant women’s ability across various age groups to access ANC lie beyond the health facility itself, and overlap with those documented for older (Ufford &Menkiti, 2001). However, research suggests that adolescents grapple with additional negative individual and societal responses to early childbearing, and may therefore have less freedom to access services compared to older mothers (Pell, 2013). Previous research has reported that women who had unplanned pregnancies tend to be more hesitant to attend ANC (Exavery, 2013) this has been observed to resonate with the experiences of many adolescents in the present study, this could be as a result of embarrassment due to unexpected early pregnancy and consequently, reluctance to attend or access ANC. To ensure that ANC is accessible to all age group, it is essential to address their particular needs and preferences. Recognizing that health services for adolescents are often fragmented poorly coordinated and of inconsistent quality (WHO, 2015).

2.4.2 Lack of Maternal Education

Knowledge is power, and many women have little knowledge, illiteracy rates may be almost 50% higher for women than men (UNESCO, 1992) and women without formal education have a greater risk of maternal mortality than, educated women (Harrison, 1990 & Briggs, 1993). Maternal education is an essential indicator, in which women view healthcare, whether they follow regimens of treatment, whether they make positive decisions in their households, and multiple other factors (Anthony, 2013).There are several factors, which affect the use of antenatal care facilities, such as educational level, awareness of the importance of antenatal care (Birmeta et al., 2013). Additionally, mothers that are more educated are likely to access or visit the doctor, be more confident in asking healthcare questions, and understand the potential risks during their pregnancies. (Dayal, 2013). In a cross-sectional study World Health Organization Global study, found that lack of maternal education is relate to maternal mortality and leads to a greater likelihood of negative pregnancy outcomes (Karlsen, 2011).

The client's level of education could also influence pregnant women's utilization of the health facilities as well as the understanding of the importance of seeking health care promptly. Lack of education can also negatively affect the women's comprehension of important information and the ability to make informed decisions including the awareness of their own rights (Matua 2004). Pregnant adolescents who may have attained only low-level education may not value accessing ANC services. High educational levels of both husbands including wife have been observed to promote positive health seeking behaviours (Matha, 2004).

2.4.3 Marital Status

Marital Status could influence healthcare-seeking behaviors. According to (WHO, 2003) cited by (Chaibva, 2008), unmarried pregnant women are less likely to seek Antenatal care services due to lack of economic and social support from parents, guardians, and spouses. Married pregnant adolescents may also lack social independent and decision-making powers to seek Antenatal care these may be due to pressure or oppression from the spouse or influential members of the extended family forcing pregnant women to accept the decision made on their behalf (WHO, 2003).

2.4.4 Religion of the Mother

Studies show that Muslim women are less likely to use reproductive and sexual health services such as antenatal care because of lack of privacy (Mishra, 2004) for example, exposure of legs and arms is a taboo for Islamic and other women (Holland & Hog, 2001). Religious leaders have always played the significant role, which directly or indirectly influences maternal health (Mohammed & Babikir, 2013).

2.4.5 Distance Related Factors

Geographical accessibility of the Antenatal care clinic and place of delivery can influence the individual's choice of patronizing the facility, distance to an antenatal care service provider may be another deterrent to the pregnant mothers (Dissevelt, 1978). Antenatal clinics with 5km distance away from client residences were patronized more than those that were 10km away from the residence of pregnant women (Ewa, Lasisi,. Maduka, Ita, 2012) in another study conducted in Nigeria by (Jimoh, 2003).Therefore about five to ten kilometers to the health care facility recommended (Dissevelt, 1978). Pregnant women had to travel more than 30 km to the hospital for antenatal care. Many of these women

face challenges even when they were going to Mongomo since the vehicle only went back to the village a day or two days after arrival (Jimoh, 2003). Other studies have clearly shown that long distances affect the utilization of antenatal care and subsequently delivery in hospital (Bandyopadhyay, 2003 & Cox, 2008).

2.4.6 Access to Information

Women exposed to the mass media, especially television and radio, significantly access Antenatal care services. Mothers with high levels of exposure were more likely to seek Antenatal care services (Navaneerham, 2002). Watching television programs on health every week substantially increased the chances of women seeking Antenatal care. The information on reproductive health motivates pregnant mothers to attend antenatal care (Sharma, 2004).Accordingly, the study, which carried on across 63 expectant women enrolled in a subsidized antenatal care program in Milwaukee, Wisconsin, during two times: March-May 2011 and October-December 2011 indicated that participants relied heavily upon interpersonal sources of information and financial support, especially family and the father of the baby; rarely used the Internet for health-related information, and desired information beyond the infant and maternal health, such as finding jobs and accessing community/government resources. Participants who used family members as primary sources of information also had significantly increased levels of perceived informational support and reduced uncertainty about antenatal and other maternal issues (Neupane, 2016).

2.4.7 Women's knowledge of antenatal care

Knowledge of pregnant mothers may be a major factor in determining the extent of Antenatal services use. Reports from various parts of the world have shown that increased

levels of pregnant mothers in terms of Antenatal care has an impact on its utilization (Okafor, 2016). Health knowledge is an important factor. It enables women to be aware of their rights and health status to seek appropriate health services (Dowswell, Carroli, Duley, Gates, GuÈlmezoglu & Khan-Neelofur, 2010). The odds of utilizing ANC were more than three times for those with better knowledge of danger signs of pregnancy than those with poor knowledge (WHO, 2014). The studies have revealed that sufficient knowledge of the benefits of ANC and the complications associated with pregnancy plays an important role in the utilization of ANC services. (Acharya, Khanal, Singh, Adhikari, & Gautam, 2015). They discovered that pregnant women's level of knowledge of the importance of ANC, screening tests, and complications of diabetes and hypertension during pregnancy was poor (Mugo, Dibley & Agho, 2015).

2.4.8 Delay in Decision to Seek Medical Care

In thematic approach research carried out in Ethiopia by (Shiferaw, 2013) it was established that negligible numbers were attending to health care, which contributes to maternal complications. The study cited delay in; a decision to seek medical care, reaching health facilities and receiving adequate obstetric care as key contributing factors to maternal deaths in low-income countries. The study also observed this as a major contributor to the worldwide death toll of mothers with a maternal mortality ratio of 676 per 100,000 live births.

2.4.9 Waiting time for Antenatal Care Services

The availability of health care services is defined both as a treatment that is delivered at a time convenient for the consumer and as the availability of professional help in the area and at the time of need (UNICEF, 2011). From this definition, it concludes that individuals

who experience too long waiting time may fail to access ANC services. Several studies have shown that long waiting times are a barrier to ANC use (Chowdhury et al., 2003; Mathole et al., 2004). Studies show that young pregnant women avoid health care services and effect nullify their preventive care they put off by long waiting times among other factors (UNICEF, 2011). A study conducted in Vietnam among doctors and midwives revealed that long waiting times due to very detailed record taking were a barrier to sexual and reproductive health service delivery (Klingberg et al., 2006) this was a general problem but acted as a barrier particularly for adolescent clients as they were concerned about the need to remain anonymous and had a desire for the procedures to be completed as quickly as possible. In South Africa, both health care providers and clients agree that a host of logistical problems hinders the effective provision of comprehensive services, common constraints expressed includes the shortage of human resources and high caseloads that lead to longer waiting times and loss of clients (Farzanaet, 2013).

2.4.10 Access and Utilization of Health Facilities

Also pointed out that among the various strategies adopted to curb this menace are improvement in access and utilization of antenatal care services, an increase in the number of women who were attended to by skilled healthcare personnel during childbirth, and provision of relevant postpartum or postnatal health services to both mothers and babies.

Globally, nine out of every ten pregnant women access antenatal care from skilled personnel at least once, only six out of ten access at least four antenatal visits from a skilled provider. In regions where the rates of maternal mortality are high, such as sub–Saharan Africa even fewer women obtain at least four antenatal visits from skilled providers 49% which is less than the global average (WHO, 2015). There is also evidence

that some pregnant women do not utilize antenatal care services from any provider (WHO, 2015). The fourth visit of the pregnant woman to the facility requires the health service provider to review an individualized birth plan guide. With this guided plan, the health care provider discusses planned birth not exempting a safe place of delivery and relevance of skilled birth attendant with the client and partner (WHO, 2012). Antenatal Care has proven to be an opportunity to promote the benefits of skilled attendance at birth and to encourage women to seek postpartum care for themselves and their new-born. (Reynolds & Wongs 2014),

In a multi-country study, women who had at least four Antenatal care visits estimated to be 11% more likely to give birth with medical assistance and this effect depended largely on the content and number of antenatal care visits (Adjirwanou & Legrand, 2013). Meanwhile in the two national representative surveys conducted recently in Nigeria, Nigeria Demographic and Health Survey (NDHS) in 2013 and National AIDS and Reproductive household survey (NARHS, 2012), showed that only half (51.0%) reported making four or more ANC visits during the pregnancy. About one third (36%) of births were delivered in a health facility while 38% of all deliveries within the five years were assisted by a skilled birth assistant (SBA). In sub-Saharan Africa, overall, 75% had at least one Antenatal Care (ANC) attendance, 48% had four or more Antenatal Care (ANC) visits and skilled birth attendants supported 48% of deliveries. In comparison with Antenatal Care (ANC) coverage in Nigeria and neighboring developing country, Mali, had 57% of pregnant women having at least one prenatal contact with a skilled Antenatal Care (ANC) provider within five years preceding the Demographic Health Surveys (DHS) in 2001. In another developing country, Indonesia, about 95% of pregnant women attended at least

one Antenatal care visit and 66% of women had four Antenatal care visits within five years before the 2007 Demographic Health Surveys (DHS). This implies that Nigeria has not attained maternal healthcare success achieved over a decade ago in Mali and over 5 years ago in Indonesia. The questions are why are pregnant women not attending Antenatal Care in Nigeria? What are the limiting factors? What are the barriers? (NDHS & NARHS, 2013).

Federal government has also established primary health care facilities across the country to achieve this purpose. These efforts complemented with state governments' programs aimed at ensuring that pregnant women have access to qualitative ANC (Fatusi, 2009).

Maternal health care in Nigeria were divided into three levels such as primary, secondary and tertiary care levels, in which Primary healthcare centres are established in all the 774 local government areas of Nigeria. (Omo-Aghoja, Aisien, Akuse, Bergstrom. 2010). It is expected that pregnant women should receive antenatal care, delivery and postnatal care in the primary health centres closest to them. In case of pregnancy difficulties, they are referred to secondary care centres, under the management of state government, or tertiary centres, managed by the federal government (Omo-Aghoja et al; 2010).

2.5 The enabling factors affecting pregnant women

Enabling factors refer to factors that will empower people to be able to use health care when the need arises. These are the organizational structures (Andersen, 1995), and include the social and community networks found within the family, community and society and also cut across local, national and global spectrums. The enabling factors refer to the means available to individuals to achieve a need to use a health service. Enabling factors include, family resources (income, level of health insurance coverage, or other source of third-

party payment, type of regular source of care, the nature of that regular source of care, and accessibility of the source) and community characteristics (ratio of health personnel and facilities to population in a community, price of health services, region, urban rural location). This implies that women's ability to use maternal health facilities will depend on the availability of such facilities and their possession of the means to access the facilities. The need factors include perceived illness or the probability of its occurrence by the individual or her family (disability, symptoms, diagnosis, general state such as, number of days during which the individual is unable to do her usual work such as house chores, care of children, experience of symptoms, self-report of general state of health), and evaluation of the condition (symptoms and diagnosis attempts to get at the actual illness and a clinical assessment of the severity (Andersen & Newman,2005).

2.5.1 Poverty

A poverty-related lifestyle would ultimately reduce access to and utilization of Antenatal care services, this has constituted health inequalities in most parts of the world, especially in less-developed countries. It has allowed better-off individuals to benefit from lifestyle changes and improved health care, while the poorer ones left unattended. Mothers who live in poverty experience much higher rates of maternal mortality (Fagbamigbe *et al*., 2015). With the level of poverty in the country financial cost could pose barriers to the use of Antenatal care services by some pregnant women, particularly the most vulnerable the poorest of the poor, on an individual level, poverty may limit use of quality health care service especially among women in the reproductive period (Fagbamigbe, 2015). Poverty is a major cause of maternal mortality, as it prevents many women from just not seeking Antenatal care, but also taking time to rest and eating balanced diet which are essential to

safe pregnancy are absent (Lanre-Abass, 2008). There are also indirect factors caused by poverty, such as psychological stress, gender dynamics, social standing, self-esteem, ethnicity, and race that have an influence on the rates of maternal mortality in a community (Dayal, 2013).

2.5.2 Women Economic Status

In a study on the determinants of maternal health services in rural India, found that there is a correlation between household income and utilization of maternal health services. It was evident that because of the lack of productive resources for women, income earned by women had negative influence on utilization of Antenatal care and post-natal care (Sharif, &Singh, 2002).In Zaria, Nigeria a study found that from free to fee-based services for obstetric care reduced admission overall, but significantly increased emergency cases. The number of maternal deaths rose correspondingly (Harrison, 1997).

2.5.3 Income Levels on Antenatal Care Utilisation

Economic accessibility also seen as a problem associated with Antenatal care utilization, the financial capacity of the family with the costs of a facility delivery including transportation costs in moving to the hospital is one of the major reasons why women/ family with low financial capacity choose to deliver at home and thus ignore antenatal care services (Ambe et al., 2000a). The Socio-economic factors responsible for poor utilization of primary health care services in rural community in Nigeria discovered that low economic status of community members coupled with the lack of social security, welfare, and the health insurance system have deteriorating effects and further widens up the social gradient on choice of health providers (Katun, 2001).

Though social structures and conditions, norms and values can limit the influences of people on what is possible, yet individuals act healthily in a voluntary manner when they are empowered (Mildred Blaxter, 2004). According to (Hadi et al., 2007) in their research on "the inaccessibility and utilization of Antenatal care services in Balkh Province of Afghanistan", the utilization of Antenatal care services was differentiated by the participation of women in activities. The use of each of the ANC services was significantly lower among women who were involved in economic activities than among those not economically active. This indicates that involvement in such activities might have created an extra burden on them and reduced the time they had available for receiving such services. Again, they said that the age of the women appeared to be negatively associated with the use of Antenatal Care. Achieving empowerment is closely connect in addressing the root causes of dis-empowerment and tackling disadvantage caused by how power relations shape choices, opportunities, and wellbeing of vulnerable people. Hence, there is a need to empower pregnant women to acquire a degree of power and control in making wider choices (Tones & Green, 2004).

2.5.4 Supportive Spouse/Partner

Partner support is defined as an open communication and emotional connection between partners that leads to availability by one to fulfil the other's needs. In studies of women asked about partner support during pregnancy, many relayed anxieties about the relationship itself (Stepleton, Dunkel, Schetter & Westling. 2012).

Having a spouse or partner who is not supportive was reported to be associated with initiating ANC late for both adolescents and adult women (Khanal, Brites, Cruz, Mishra & Karkee, 2015). In the studies, the researchers concluded that women who had no

support from their spouses or partners utilized ANC services almost three weeks later than those who were given support (Khanal *et al*., 2015). Similarly, the utilization of ANC was almost nine times more likely for women reported their husbands to approve ANC than women with those whose husbands did not approve ANC service (Mugo, Dibley & Agho, 2015).

2.5.5 Delays in

However, the majority of maternal mortality occurs in rural communities in developing countries as a result of delay in, this is one of the three delays, which documented by maternal mortality studies in recent years, the delays are delays in the decision to seek care, delay in reaching care, and delay in receiving adequate care (Smith-Fawzi, 2011). In countries, such as India, women traditionally give birth in the home with female family members or local midwives attending. When a complication occurs with the mother, the midwife or family members often try to resolve the bleeding or infection. Most women who live in rural communities in developing countries live in most isolated areas, farther away from cities and health care centers. However, families living in these remote communities have a long journey to these medical centers and cannot bring these mothers to the clinics in time. Additionally, the method of transportation and roads also present problems (Nour, 2008).

2.5.6 The attitude of Health Care Providers

The attitude of health care workers plays a crucial role as regards to utilization of any health-related service and antenatal care is no exception. On a more serious note, the attitude of health care providers is very crucial in getting people on board for this very

important service, it is explained that the poor attitude of health care providers towards pregnant women contribute to the low utilization of antenatal care service (Mathole,2004). In addition, many of these mothers prefer to deliver with unskilled birth attendants in the villages since they probably treated them better and were much acclimatize with them and their environment (Mathole, 2004).

In a study on determinants of maternal choices for the place of delivery in Ayiru County, Uganda, indicates that women sometimes feel reluctant to use maternity care services because health care providers are perceived to be rude, insensitive and intimidating to young mothers (Matua, 2004). Pregnant women have reported several of the negative attitudes put up by health care providers. He indicates further that women are sometimes unwilling to use maternity care services because health care providers were perceived to be offensive, indifferent and threatening to young mothers. Hence, pregnant women can also base their behaviour on previous negative experiences and perceptions of care received (Matua & Ziyani, 2004).

2.5.7 Health Insurance status of pregnant women

A key economic ingredient under enabling factor to health care utilization of pregnant mothers is health insurance which is least exploited in developing countries. Health insurance serving as health guarantee has the potential to increase access to health utilization (WHO, 2005), Benefits of health insurance interventions should be precise and target oriented (Mechanic, 1979 cited in Andersen, 1995). According to Buor (2004), in developing countries where health insurance exists, access to health care utilization is higher for insured patients than the uninsured patients.

2.6 The perceptions of pregnant women

Societal norms, cultural beliefs, morals and practices, therefore, influence health seeking behaviors of people and often lead individuals to consult with traditional healers, which may not meet the needs of patients (Shaikh & Hatcher, 2005). According to (Yakong, 2008). In Cameroun, one reason why women continue to seek care from traditional Midwives in spite of the sufficient number of government maternity units is to guarantee appropriate disposal of the placenta, which plays a vital role in their culture (Coma, 1960). There are certain cultural practices that has been observed as responsible for incidences of maternal and infant mortality in Nigeria and other parts of the sub-Saharan African societies (Salami & Taiwo, 2012). study conducted among Ibani people in Rivers State on pregnancy outcomes that incidences of maternal mortality rate are on the increase and outcome of pregnancy (which could either be positive or negative) is affected by socio-cultural factors (Elem & Nyeche, 2016). A study by (Carolen & Cassar, 2010) aimed at determining the experiences concerns and of an African-born sample of pregnant women receiving antenatal care in Melbourne, Australia. This study results proved that, these women had perceived Antenatal Care as a form of care received by pregnant women that covers education on pregnancy, medication and preparation for delivery.

A study conducted in a cottage hospital in Port Harcourt. According to the researchers of this study, antenatal care was identified to be a care that presented a vibrant opportunity to pregnant women to adequately prevent and treat diseases as well as behavioural changes that are associated with pregnancy. It also sets the platform for healthy pregnancy as well as a healthy fetal development (Ekott, Ovwigbo & Ethigieba, 2013).

Many expectant women seek care from different sources aside the formal health sector this is due to negative perceptions resulting from few poor service quality experiences in

health facilities. In a qualitative study, using focus groups, to examine beliefs, knowledge and perceptions about pregnancy and delivery and care-seeking behavior among pregnant women in urban Accra, Ghana, found out that perceived threats, which often given socio-cultural interpretations, increased women's anxieties hence driving them away from seeking Antenatal care (Dako-Gyeke, 2013). Use of multiple sources of care in some cases disrupted continued use of skilled provider care. This study concluded that socio-cultural interpretations of threats to pregnancy mediate pregnant women's use of available healthcare services. Most of these interpretations are misconceived and have no factual backing (Dynes, Stephenson, Rubardt & Bartel, 2012).

2.6.1 Culture influences

The perception of illness is influence by, different belief systems in societies and these kinds of beliefs appear to be relatively common in rural communities and discouraged pregnant women from visiting public places, especially antenatal clinics, where a visit would be perceiving as a public declaration of pregnancy. (Jegede, 1998). Cultural background and thought influence belief, norms and values in relation to childbirth have also been an influencing factor to quality ANC. Cultures or traditions have been reported to significantly influence millions of women and have negative implications on women's health (UNPF, 2017).The cultural belief in northern Nigeria that woman's, nakedness should not be seen by another man outside her husband is believed to be another reason why women choose to ignore antenatal services (Agus, Hoiruchi & Porter, 2012). Traditional beliefs about pregnancy have an influence on antenatal care use and have been a key factor associated with low number of antenatal care visits. Women with strong

traditional beliefs perceive that following suggestions from family would make them safer and healthier during pregnancy (Agus, et al; 2012).

2.6.2 Belief System

Perception of illness is influence by, different belief systems in societies and these kinds of beliefs appear to be relatively common in rural communities and discouraged pregnant women from visiting public places, especially antenatal clinics, where a visit would be perceiving as a public declaration of pregnancy. (Jegede, 1998). Cultural background and thought influence belief, norms and values in relation to childbirth have also been an influencing factor to quality ANC. Cultures or traditions have been reported to significantly influence millions of women and have negative implications on women's health (UNPF, 2017). The cultural belief in northern Nigeria that woman's, nakedness should not be seen by another man outside her husband is believed to be another reason why women choose to ignore antenatal services (Agus, Hoiruchi & Porter, 2012). Traditional beliefs about pregnancy have an influence on antenatal care use and have been a key factor associated with low number of antenatal care visits. Women with strong traditional beliefs perceive that following suggestions from family would make them safer and healthier during pregnancy (Agus, et al; 2012).

2.7 Summary

In summary the chapter discussed the theoretical framework and model adopted is Andersen and Newman's emerging behaviour model of utilisation, the purpose of the framework is to discover the condition that either facilitate or hinder the utilisation of health care facilities. The basic goal of the model is to develop a behaviour model that provide measures of access to medical care. The characteristics of the population at risk

are describe as predisposing, enabling, and need. The individual characteristics that predict use of antenatal care services are classified into three: predisposition of an individual to use antenatal care services (predisposing factors), ability to secure services (enabling factors) and illness level (need factors).While the review of related literatures was done based on three basic research objectives in which the objectives are predisposing factors affecting pregnant women access to Antenatal Care Provision, enabling factor that influence pregnant women access to Antenatal Care Provision and perceptions of pregnant women on accessing antenatal Care Provision**.**

CHAPTER 3 METHODOLOGY

3.1 Introduction

This chapter covers the research methodology and will cover essential elements such as, research design, research sampling method, sample size, research instruments, ethical consideration, data collection procedures, data analysis.

3.2 Research Design

The study implemented the practical research paradigm strengthened by mixed design methods to explore access and utilization of antenatal care provision as a component of a broad study in rural areas. The research design for this study was the Cross-sectional design. The design is exploratory in nature allowing easy description of phenomena at one point as they exist in their natural settings (Nworgu, 1999) he also views the design as one of the best available designs to the researcher interested in collecting original data for the purpose of describing a population not fairly large. He also viewed the design as the simultaneous study of different categories of such objects in setting. Cross-sectional design is used in studying a variety of health-related problems involving data collection for answering pertinent research questions concerning the present status of the particular subjects studied (Nwana, 1981). He further noted that this design permits the description of conditions as they are in their natural settings. The successful application of the cross-sectional design by (Kibret, 2005) to asses' reproductive health attitude and practice among high school students in Bahr in Ethiopia suggest its use for the present study. The cross-sectional design, therefore, is considered most appropriate for this study to determine access to Antenatal care provision in Mutumbiyu District, Taraba, Nigeria the

participants for the study were selected based on the inclusion and exclusion criteria set for the study. The researcher follows the study to assess the exposure and the outcomes based on the fact that it allows the collection of information from a representative sample of a target population.

3.3 Population and Sampling

The study population were pregnant women of (15-49 years of age) registered in six health care facilities in the District such as Namnai, Shagarda, Mutumbiyu, Munira, First Referral hospital and Gunduma health facilities in Mutumbiyu District of Gassol Local Government Area, Taraba State, Nigeria. The District had an estimated population of 12757 pregnant women attending antenatal care service (GLS, 2018). It is from this population that a sample is selected to represent the whole District and also serve as the source of data collection. The population is two hundred and eighty (280) pregnant women attending antenatal care services in the sampled facilities.

3.4 Sampling Technique

The study used probability sampling techniques which is multi-stage sampling method was used to select respondents for the study using the sampling frame of three electoral wards (Namnai, Mutumbiyu, and Gunduma wards) in Mutumbiyu District. Two health facilities were randomly selected from each ward using (balloting) simple random sampling making six health facilities the facilities are Namnai ward (Namnai health facility and Shagarda health facility) Mutumbiyu ward (Mutumbiyu health facility and Munira health facility) while Gunduma ward comprises of First Referral hospital and Gunduma health facilty.

In deriving the sample size for this study, the researcher employed Dobson formula for calculating the sample size. According to (Dobson,1984) in determining the sample size needed to estimate a proportion, the evaluator must make several assumptions regarding the larger population studied. The formula given as:

$$n = \frac{NPQ}{(N-1)(e^2/z^2) + (PQ)}$$

Where:

$n = sample\ size$ Required

$P = true\ proportion\ of\ the\ population$

$N = populationsize$

$e = the\ level\ of precision = 0.05$

Therefore, 12757 registered pregnant women in Mutumbiyu District (GLS, 2018).

We have:

$$n = \frac{12757(0.5)(1-0.5)}{(12757-1)(0.05^2/1.96^2) + (0.5)(1-0.5)}$$

$$n = \frac{12757(0.25)}{(12757-1)(0.0025/2.8561) + (0.25)}$$

$$n = \frac{3189.25}{(12756)(0.000875319) + (0.25)}$$

$$n = \frac{3189.25}{11.16557 + 0.25}$$

$$n = \frac{3189.25}{11.4155}$$

$$n = 279.75$$

Approximately, $n = 280$ sample size.

Table 1 sampled ward/health care facilities and number of respondents,

S/no	Name of Ward	Names of Health Facilities	Number of Respondents
1	Namnai	1. Namnai Primary Health Care 2. Shagarda Primary Health Care	45 45
2	Mutum- Biyu	1. Mutm Biyu Primary Health Care 2. Munira Clinic and Maternity	50 50
3	Gunduma	1. Gunduma Primary Health care 2. First Referral Hospital	45 45
	Total		**280**

3.5 Data Collection Instruments

In order to collect the required data to feed into the objectives of this study the researcher used primary and secondary method of data collection method, which are quantitative and qualitative in nature. The primary data collections instruments used was structured questionnaire and Key informant interview guide, while the secondary data was obtained through reviewing of relevant literature which includes books, journal, articles, dissertations and thesis and internet sources.

3.5.1 Primary source of data

The primary source of data collection used for the study are the structured questionnaire and the key informant interview guides.

3.5.1.1 Structured questionnaire

Quantitative data were obtained through structured Questionnaire on Access to Antenatal care provision. This is a research designed questionnaire (see appendix 1) the questionnaire has three sections 1, 2, 3. Section 1 subsection A and B deals with

demographics variables; of the respondents and their spouses and subsection one c and section 2 and 3 their concern is on items based on the research objectives.

3.5.1.2 Key informant interview guide

The qualitative data collection was collected through the use of key informant interviews guides. The key informants' interview guide was structured in such a way that, the first required the respondents to provide background information about themselves whilst keeping their identity anonymous then the following questions sought to get the respondent lived experience with regard to access to antenatal care provision. The key objectives of these set of questions was to reveal how poor access of antenatal care provision affect pregnant women in the study. The last part of the interview guide concentrated on key informant participation in policy framing and action. The in-depth interview helped the researcher to explore general areas of interest in depth. It involved asking open ended questions and probing wherever necessary, it also gave the researcher chance to seek clarification where not sure or unsatisfied answers, hence deemed useful for this research. Respondents also had a chance to seek clarification on the purpose of the study and questions that they did not understand well

3.5.2 Secondary source of data

In order to improve the quality of dependability, clarification as well as enhancing the primary data, secondary data were also used. The secondary data were collected from both published and unpublished sources including journals, articles, books, official reports and the internet sources. Sources of secondary data included those from the Mutumbiyu District health and other relevant publications and records were accessed for the study.

3.6 Data collection Procedures

In order to facilitate access to the area of study a letter of introduction was collected from college of Business peace, leadership and governance, Africa University Mutare Zimbabwe and was submitted to the Chairman Gassol local government Area Taraba State, Nigeria for their permission to allow the researcher to collect required data. The chairman of the Local government accepted the researcher and also wrote a letter of acceptance too the University. He authorized the Director of health of the local government to communicate the sampled health facilities to allow the researcher undergo the data collection. Six dully trained staff each from the units visited was used as research assistants. They helped to interviewed and collect filled questionnaires returned by the respondent who come late for prenatal or antenatal which usually hold on Mondays and Thursdays due to the distant and logistic problems. Two hundred and Eighty questionnaires were issued to the respondents. The qualitative data collection was collected through the use of key informant interviews guides. The key informants used for the study were six (6) in charges of the sampled facilities and the Director primary health care Gassol Local Government Area, Taraba, Nigeria.

3.7 Analysis and Organization of Data

The data analysis method used for the study are descriptive statistics method which comprises of univariate analysis (frequency distribution and simple percentage), bivariate analysis (cross tabulations), Graphic analysis (bar chart, pie chart) SPSS 23.0 version and excel for quantitative analysis and Thematic data analysis. The logistic regression was used to model the relationship between the dependent and independent variables at the bivariate level. The dependent variables were modelled using significant variables from

bivariate analysis and were adjusted for in multiple logistic regression models. Logistic regression model determines the association between a dichotomy dependent variable and independent variables by converting the dependent variable to probability scores taking on values between zero and one. Thematic data analysis was used by the researcher as a process of solving data into its constituent components, to reveal its characteristic element and structure. The researcher made use of coding to organize mass data logically. The main purpose of coding data was to simplify many individual responses by classifying them into smaller number of groups including responses that are similar in content. This was followed by interpretational method, which was means to understand the internal logic of an excerpt of data from different sources. The researcher used Microsoft excel to present data in form of charts and graphs as well as calculating percentages of respondents in line with the category. Excel and SPSS were also useful in the presentation of data in numbers.

3.8 Ethical Considerations

Applying ethical consideration was important in ensuring that the researcher obtained data from informed and willing participants. Ethical principles play an important role in obtaining informed consent by the respondents. Participant remained anonymous and no information that will describe their connection to the data collected was recorded such as names during or after data collection. Participant were also made aware about the confidentiality of all conversations and which were deleted as soon as the researcher was done analyzing the data Before issuing the questionnaires or conducting the interviews, all participants were presented with the option of declining to answer any of the questions. Furthermore, participants were made aware of the fact that they may withdraw from the

study at any point in time. Participants' safety was assured and confidentiality of responses was ensured. They were informed that recordings will be available and accessible only to research team during the course of the study and safely stored after the study. The Researcher ensured that all data were kept under lock and key and not to be shared with those not in the study. The researcher showed respondents the result of the study and the findings were destroyed after the study.

3.9 Summary

In conclusion this chapter looks at the research analysis on the research materials and the design during the research process. The chapter has outlined the approach and research design used, research instruments mixed method involving structured questionnaires and key informant interview guide focused on the research methodology, which incorporates research design, population, sampling techniques, and sample size, tools of data collection and analysis, and ethical consideration. The study used a combination of qualitative and quantitative research.

CHAPTER 4 DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter presents quantitative results of the study from 280 pregnant women who attended ante-natal care clinic in Mutumbiyu District. The descriptive part of the study deals with the demographic characteristics of the respondents, predisposing factors, the enabling factors characteristics and perceptions of pregnant women on access to Antenatal care provision in the study setting. The second section of the presentation is quantitative results covers descriptive statistics from the data obtained. Qualitative result obtained from 7 keys informants from the six health facilities plus the Director of Health presented in this chapter to highlight the factors affecting pregnant women access to ante-natal care provision in the study setting. This chapter covers presentation and analysis of data. The study was presented in frequency distribution tables, graphics and comments.

4.2 Analysis of Quantitative Results

4.2.1 The Demographic Data

Table 2 Age of respondents

S/NO	PARAMETER	VARIABLE	FREQUENCY	PERCENTAGE
	Age of respondent	15-20	70	25.9
		21-29	98	36.3
		30-39	60	22.2
		40-49	39	14.4
		50 and above	3	1.1
		Total	**270**	**100.0**

(Source: field data collected by author, August, 2019)

Table 2. Shows age of respondents 15-20 years of age 25.9%, 21-29 years of age 36.3%, 30-39 with (22.2%), while, 40-49 of age have (14.4%) and lastly, and above is (1.1%).

Table 3 Educational status

	Parameter	Variable	Frequency	Percentage
	Educational Status	Primary	55	20.4
		Secondary	74	27.4
		Tertiary	62	23.0
		No Formal Education	66	24.4
		Others	13	4.8
		Total	**270**	**100.0**

(Source: field data collected by author, August, 2019)

Table 3 shows 27.4% had secondary school qualification, 24.4% non-formal education, 23.0% had tertiary education, and 20.4% had primary education respectively.

Table 4 Marital status

	Parameter	Variable	Frequency	Percentage
	Marital Status	Single	35	13.0
		Married	199	73.7
		Divorced	20	7.4
		Widowed	11	4.1
		Separated	5	1.9
		Total	**270**	**100.0**

(Source: field data collected by author, August, 2019)

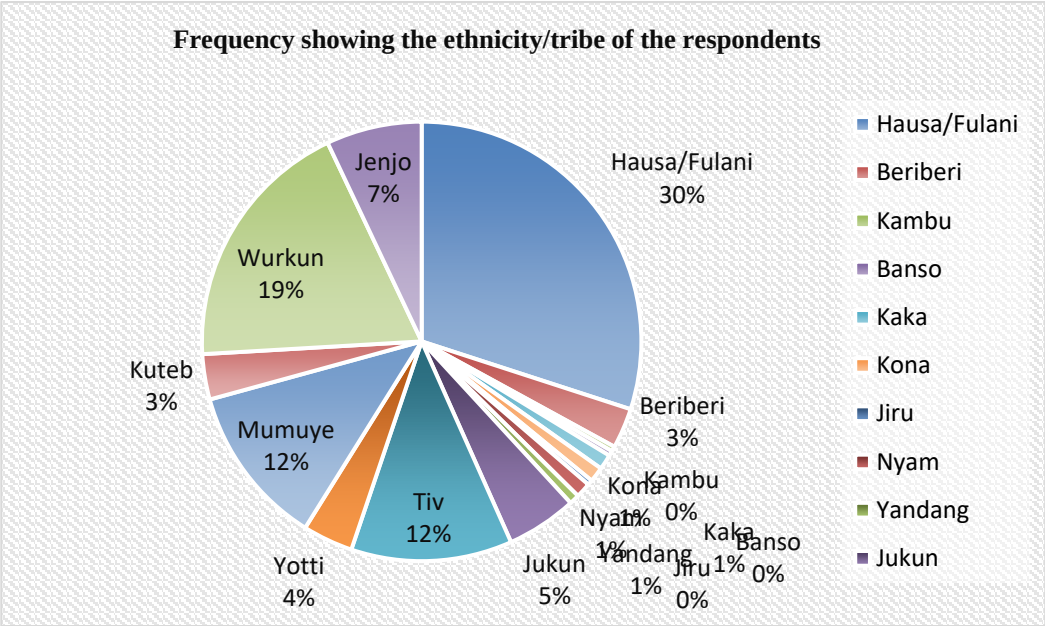
Table 4 shows 73.7% were married, 13.0 were single, Divorce 7.4% while 4.1% widowed and 1.9% separated respectively

Table 5 Religion

	Parameter	Variable	Frequency	Percentage
	Religion	Christianity	148	54.8
		Islam	111	41.1
		Traditional	8	3.0
		Free Thinker	3	1.1
		Total	**270**	**100.0**

(Source: field data collected by author, August, 2019)

Table 5 shows 54.8% of the respondents were Christians, 41.1% of the respondents belonged to Muslims. While 3% traditionalists and 1% free thinkers respectively.



(Source: field data collected by author, August, 2019)

Figure 3 Diagram showing the ethnicity/tribe of the respondents

Figure 3 shows Hausa/Fulani 30%. 19% Wurkun while Mumuye, and Tiv were 12% respectively. The remaining ethnic group/tribes made little fractions of the respondents.

4.2.2 Enabling factors

Table 6 Occupation status

S/no	Parameter	Variable	Frequency	Percentage
	Occupational status	Employed	64	23.7
		Unemployed	206	76.3
		Total	**270**	**100.0**

(Source: field data collected by author, August, 2019)

Table 6 shows 23.7% had employment while majorities of the respondents were unemployed 76.3%.

Table 7 Occupational status of spouse

S/no	Parameter	Variable	Frequency	Percentage

	Occupational status of spouse	Employed	176	65.1
		Unemployed	94	34.8
		Total	**270**	**100.0**

(Source: field data collected by author, August, 2019)

Table 7 shows 65.1% employed and 34.8% unemployed.

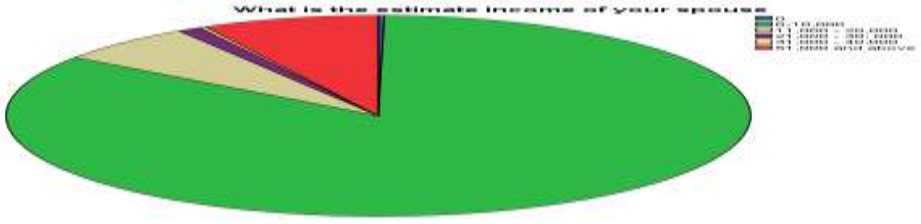
Table 8 Nature of occupational status of the spouse

S/no	Parameter	Variable	Frequency	Percentage
	Nature of Occupational status of your spouse	Trader	97	35.9
		Farmer	157	58.1
		Public/Civil Servant	16	5.9
		Total	**270**	**100.0**

(Source: field data collected by author, August, 2019)

Table 8 reflect that 35.9% were farmers, 58.1%, public and civil servant, and 5.9% respectively were the nature of occupational status of the respondent spouses.

Figure 4 Estimated income of the spouse



(Source: field data collected by author, August, 2019)

Figure 4 reflects that those who earn 0-10,000 were 84.4%, those who earn 11,000-20,000 were 5.6%, those who earn 21,000-30,000 were 0.7% and lastly those who earn 41,000 and above were 9.3%.

Table 9 Estimated income per month of the spouse

S/no	Parameter	Variable	Frequency	Percentage
	Estimate on income of spouse	0-10,000	229	84.8
		11,000 - 20,000	16	5.9
		21,000 - 30, 000	1	.4
		31,000 - 40,000	1	.4
		41,000 and above	23	8.5
		No	228	84.4
		Total	16	5.9

(Source: field data collected by author, August, 2019)

Table 9 shows those who earn 0-10,000 were 84.8%, 11,000- 20,000 were 0.4%, 21,000-30,000 0.4%, 31,000-40,000 were 8.5%, 41,000 and above were 7.7%.

Table 10 Spouse/partner gives money for antenatal care services

S/no	Parameter	Variable	Frequency	Percentage
	Spouse/partner assists with money for antenatal care services	Yes	117	43.3
		No	110	40.7
		Not enough	41	15.2
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 10 shows 43.3% agreed While, 40.7% responded NO and 15.7% not enough

Table 11 Husband accompaniment to Ante-natal Care facility

S/no	Parameter	Variable	Frequency	Percentage
	Husband accompaniment to antenatal care facility	Yes	117	43.3
		No	151	55.9
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 11 reflects 55% responded NO, they don't accompany them to antenatal facility, while 43.3% of the responded Yes, and they used to accompany them to antenatal care facility.

Responses on the Pattern of Antenatal Care Attendant

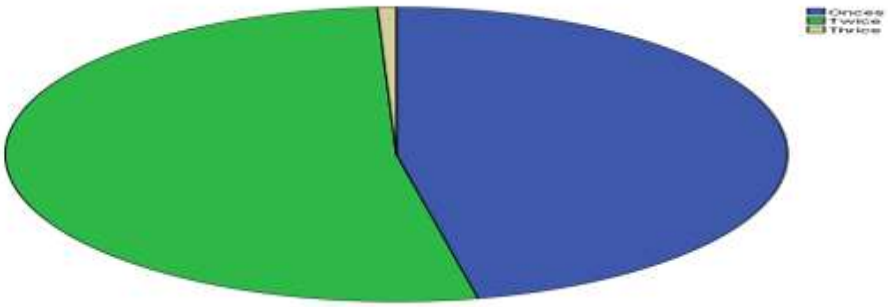
Table 12 Access to Ante-natal Care during pregnancy

S/no	Parameter	Variable	Frequency	Percentage
	Access to Antenatal care during pregnancy	Yes	44	16.3
		No	226	83.7
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 12 shows 16.3% has access to antenatal care during pregnancy, while 83.2% has no access to ante-natal care services during pregnancy.

Figure 5 Number of visits to seek Ante-natal care services during the entire period of pregnancy



(Source: field data collected by author, August, 2019)

Figure 5 reflects 11.9% visited once, 24.8% visited twice, 20.4% visited thrice and lastly, a majority of the respondents making 33.3% of them visited four times and a small percentage 5.6% were not sure.

Table 13 Where Ante-natal Care Services received

S/no	Parameter	Variable	Frequency	Percentage
	Where Antenatal care service is received	Government hospital	157	58.1
		Private hospital	22	8.1
		Maternity birth attendants	80	29.6
		Non attendants	11	4.0
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 13 Shows 58.1% at government hospitals, 8.1% private hospital, 29.6% maternity birth attendant and 4% with non-attendants.

Table 14 Where Ante-natal Care Services rendered

S/no	Parameter	Variable	Frequency	Percentage
	Where Antenatal Care Service is rendered	Room built for Antenatal	172	63.7
		Under a tree	35	13.0
		On a veranda	63	23.3
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 14 reflects 63.7% rendered in room built for antenatal care services, 13% under a tree, while 23.3% rendered on a veranda.

Table 15 Waiting time during Ante-natal Care services at the facility

S/no	Parameter	Variable	Frequency	Percentage
	Waiting time during Antenatal Care Service at the facility	Less than 20 minutes	58	21.5
		20 to 40 minutes	57	21.1
		40 to 60 minutes	95	35.2
		More than 60 minutes	58	21.5
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 15 shows 21.5% accessed by the health workers at the facilities at less than 20 minutes, 21.1% were access between 20-40 minutes, 35.2% at 40-60 minutes while 21.5 accessed in more than 60 minutes.

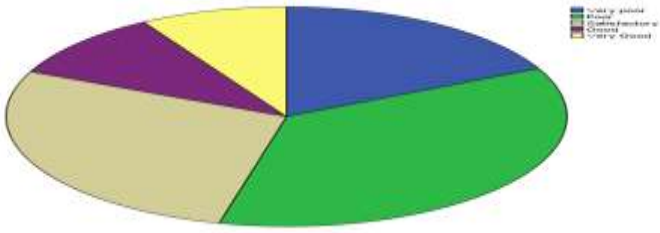
Table 16 Referral in case of any complication

S/no	Parameter	Variable	Frequency	Percentage
	Referral in case of pregnancy complication	Yes	141	52.2
		No	127	47.0
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 16 reflects 52.2% responded that were referred. While 45.1% were not referred in cases of complications.

Figure 6 Level of satisfaction

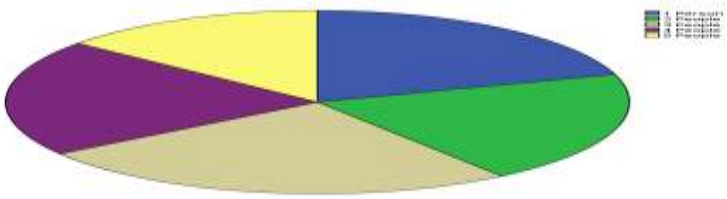


(Source: field data collected by author, August, 2019)

Figure 6 shows 19.6% very poor, 38.9% poor, 25.2% satisfactory, 8.5% good, and lastly 7.8% gave their comment as very good.

The Relationship between the Expectant Mothers and Health Care Staffs

Figure 7 Number of staff that attend to pregnant women



(Source: field data collected by author, August, 2019)

Figure 7 shows 21.1% were attended to by 1 staff, 19.6% 2 staffs, 27.4% 3 staffs, and 17.8% by 4 staffs and 14% 5staffs.

Table 5 the use of words of encouragement by medical staff

S/no	Parameter	Variable	Frequency	Percentage
	The use of words of encouragement by Medical staff	Yes	118	43.7
		No	149	55.1
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 17 Shows 43.7% agreed that medical staff use words of encouragement to pregnant women. While 55.1% responded No, they do not use words of encouragement to them.

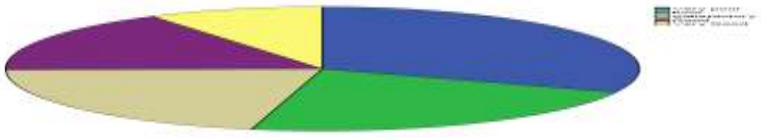
Table 6 the friendliness of health workers

S/no	Parameter	Variable	Frequency	Percentage
	The friendliness of health workers at the facility towards pregnant mothers	Yes	79	29.2
		No	191	70.7
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 18 Reflects that 29.2% responded the staff were friendly to them and 70.7% the staff were not friendly to them

Figure 8 Attitude of Health staff towards pregnant women at the health facility



(Source: field data collected by author, August, 2019)

Figure 8 shows that, 35.2% were very poor, 23.7% were poor, 19.3% were satisfactory, 12.6% were good, and 8.5% were very good.

Table 7 Access of Ante-natal Care Services

S/no	Parameter	Variable	Frequency	Percentage
	Accessibility of Antenatal Care Services	Yes	117	43.3
		No	150	55.5
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 18 shows that, 43.3% agreed to have access to the facilities. While 55.5% responded NO, they do not have access to ante-natal care services.

Table 20 Means of accessing Antenatal care services

S/no	Parameter	Variable	Frequency	Percentage
	Means of accessing antenatal care services	Walk	174	64.4
		By car	57	21.1
		Other means	37	13.7
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 20 shows 64.4% accessed the facility through walking, 21.1%, accessed by car, and then 13.7% accessed through other means.

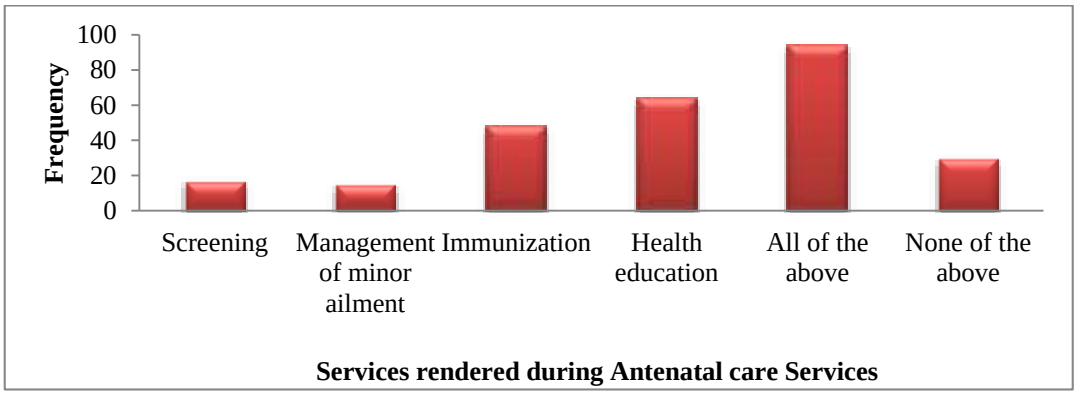
Table 8 Access to Health Insurance

S/no	Parameter	Variable	Frequency	Percentage
	Access to health insurance	Yes	43	15.9
		No	225	83.3
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 21 shows 15.9% have access to health insurance while 83.3% do not have access to health insurance

Figure 9 Services rendered during Antenatal care



(Source: field data collected by author, August, 2019)

Figure 9 showing the frequency distribution of the services rendered during Antenatal Care Services in the MutumBiyu District.

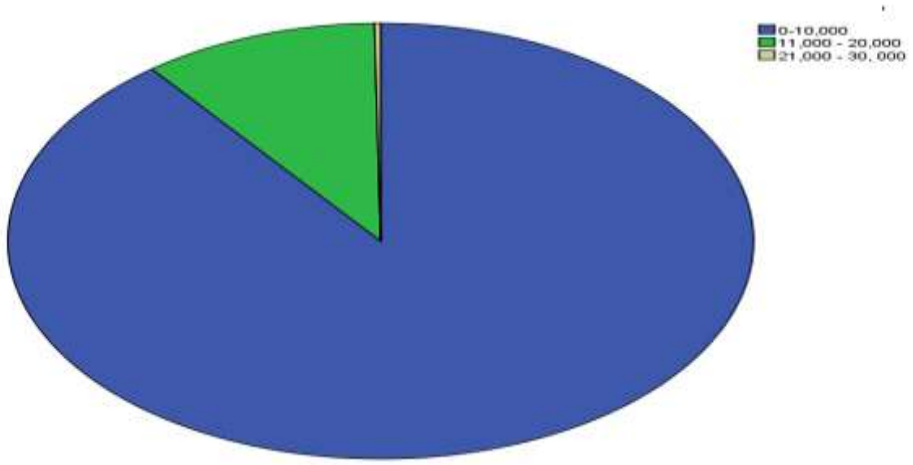
Table 9 Payment of ante-natal care services

S/no	Parameter	Variable	Frequency	Percentage
	Payment of Antenatal care Services	Yes	240	88.9
		No	30	11.1
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 22 revealed that, 88.9% pay for antenatal care services, while 11.1% responded that they do not pay.

Figure 10 Amount paid for accessing ante-natal care services



(Source: field data collected by author, August, 2019)

Figure 10 Indicate that 87% of the pregnant women pay 0-10,000, 12.6%, pay 11,000-20,000, and 0.4% pay 21,000-30,000 in the study area.

Table 10 Relief from free Antenatal Care Services by the Government.

S/no	Parameter	Variable	Frequency	Percentage
	Relief from free Antenatal Care Services by the government	Yes	69	25.5
		No	201	74.4
		Total	**270**	**100**

(Source: field data collected by author, August, 2019

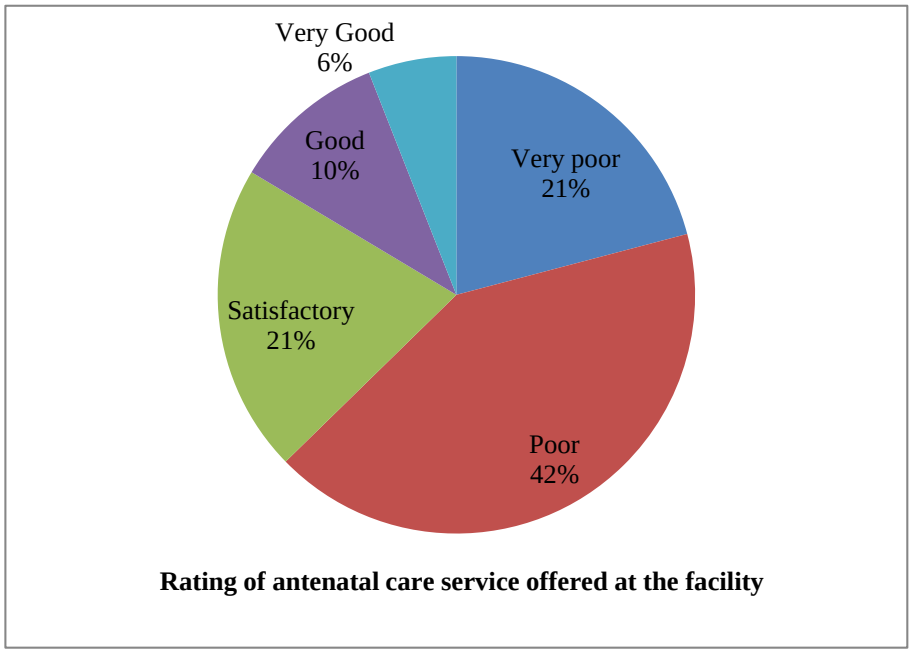
Table 23 shows, 25.5% agreed to have benefited while 74.4% responded NO

Table 11 Rating of Antenatal care service offered in the facility

S/no	Parameter	Variable	Frequency	Percentage
	Rating of antenatal care service offered at the facility	Very poor	56	20.7
		Poor	112	41.5
		Satisfactory	56	20.7
		Good	28	10.4
		Very Good	16	5.9
		Total	**270**	**100**

(Source: field data collected by author, August, 2019

Table 24 shows 41.5% responded poor, 20.7% very poor & satisfactory while 10.4% and 5.9% were good and very good respectively



(Source: field data collected by author, August, 2019

Figure 11 A pie chart showing the Rating of antenatal care service offered at the facilities, 40% poor, very poor 21%, then 21% satisfactory, 10% Good, and 6% very good.

4.2.3 The perceptions of pregnant women

Frequency distribution showing the responses on the socio-cultural orientation of the respondents

Table 25 Cultural beliefs and it effect on pregnancy.

S/no	Parameter	Variable	Frequency	Percentage
42	Cultural beliefs and it effect on pregnancy	Yes	131	48.5
		No	139	51.4
		Total	**270**	**100**

(Source: field data collected by author, August, 2019

Table 25 Shows 48.5% agreed that cultural beliefs affect the pregnancy, while 51.4% do not

Table 26 Cultural/Traditional practice observed during pregnancy.

S/no	Parameter	Variable	Frequency	Percentage
	Cultural/traditional practices observed during pregnancy	Yes	133	49.3
		No	137	50.7
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 26 Shows 49.3% say there are certain cultural or traditional practices they observed during pregnancy, while 50.7% do not necessary observe traditions.

Table 12 Existence of forbidden food during pregnancy.

S/no	**Parameter**	**Variable**	**Frequency**	**Percentage**
	Existence of forbidden food to eat during pregnancy	Yes	138	51.1
		No	132	48.9
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 27 Shows 51.1% of the responded they were forbidden by some food during pregnancy and 48.9% do not.

Table 28 Visiting of Mission Homes and Traditional homes during pregnancy

S/no	Parameter	Variable	Frequency	Percentage
	Visiting of Mission Homes and Traditional Homes during pregnancy	Yes	138	51.1
		No	132	48.9
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

The table 28 shows 51.1% they use to visit mission home and traditional homes while 48.9% they don't.

Table 13 Preference to Antenatal Care Services than Mission/traditional Homes

S/no	Parameter	Variable	Frequency	Percentage
	preference to Antenatal Care Services than Mission/ Traditional Homes	Yes	120	44.4
		No	147	54.5
		Total	**270**	**100**

(Source: field data collected by author, August, 2019)

Table 29 Shows 44.4% of the respondents prefer Antenatal Care Services to Mission/Traditional Homes whereas; a majority of the respondents (54.4%) rather prefers mission/traditional homes than antenatal care services.

4.3 Discussion and Interpretation

4.3.1 Demographic Data

The findings on access to antenatal care provision in Mutumbiyu District revealed that Age as a factor, has been revealed as one of the reasons of poor access of Antenatal Care provision in Mutumbiyu District. The result shows that majority of the age group who attended Antenatal Care Services fall within the ages of 21 – 29 years of age 36.3 followed by 25.9% 15 – 20 age group, young age of women identified as a predisposing determinant for utilization of ANC services such age groups find it difficult to access antenatal care services in the study area which could be as a results of pressure from the guardian parent and fiancées and grandmothers.

In relation to educational status of the respondents shows that 74% of the respondents in the study area only had secondary certificate while 66% has no formal education in the study area. Therefore, pregnant women with lower level of education are more likely to have a negative perception about Antenatal care provision than pregnant women with higher level of education. This is because; women with lower level of education tend to have less knowledge or interest in the knowledge of Antenatal Care provision. Women with high level of education have greater opportunities to receive health information and pay more attention to maternal healthcare; pregnant women with higher education were more than two times more likely to access ANC services as compared with those who had no education. The study recommends for the wellbeing of the mother and their unborn child, then encouraged every pregnant woman irrespective of their level of education to access ante-natal care provision because it aids healthy and safe delivery.

Findings on the marital status of the respondents revealed that majority of the respondents 73.7% were married and single 13.0%. With these findings, it shows that the married pregnant women do access ante-natal care services compare to the single pregnant lady, this may be as a result of the single one usually shunts antenatal care services because of fear of being label promiscuous. On the religion of the respondents, the majority 54% of the respondents were Christian, 41% of the respondents belonged to Muslim while the remaining 3% and 1% were traditional worshipers and free thinkers respectively. The finding revealed that Christians do access antenatal care services than the Muslim counterpart in the study area. Even though the Muslim counterpart believe that another man that is not a husband to a woman should not see the nakedness of another man's wife such believe hinder some of the Muslims women in accessing antenatal care services in which the prefer to deliver at home. Ethnicity of the respondents finding shows 30% of the respondents were Hausa Fulani then 18% were Wurkun. This finding really shows that in the study area majority of the respondents are Hausa Fulani ethnic group.

Age at marriage is one of the variables that either facilitate or hinder pregnant women to access ante-natal care services, the finding revealed that 43.7% of the respondents were within the age range of 16-20 years, while age 26-30years were 33.7%. With these results, it shows that in the study area there is risk in the life of the adolescent because the age aggregate indicated early marriage and such pose risk to the community at large. With regard to the age of the spouse of the respondents 38.9% responded that they don't know the age of their spouse at last birthday, while those that indicated that their age at birth 50 and above 31.1%, 40-49 age were12.6%, while age 30-39 were 11.9% this finding really

shows that majority of the respondents in the study area don't even know the age of their spouse because of high level of illiteracy and like of exposure.

Educational status of respondent's spouse showcases that 45.9% attended Tertiary education, 24.1% attended secondary education, while 13.7% has no formal education. Meanwhile with this finding it signifies that majority of spouse of the respondents had tertiary education but still they could not get a white color job that will at least support their women to access antenatal services in the study area. The majority of the respondent's spouse religion were Christian with 54.8% and 41.9% were Muslims while the remaining 2.2% and 1.1% were traditional and free thinkers respectively. The finding shows that Christian in the study area use to support and encourage their partner to access ante-natal care services. The ethnicity of the spouse of respondents shows Hausa Fulani top the majority with 46.3%, and Wurkun 13.7% the results correlate with that of the respondent's ethnic group.

The majority 60% of the respondent revealed that the pregnancy is not the first pregnancy, while 40.0% responded yes as their first pregnancy. The findings revealed that those that usually access ante-natal care services were only the experience one in the study area. On the issue of age at first child, the findings revealed that majority 80% of the respondents had their first child at the age of 16-25years of age in the study area while those that had their first child at the age of 26-30 were 17%. This shows that most of the respondents had their first child at tender age.

The findings also show that the majority 51.5% of the respondents indicated that they had their delivery at health clinic while 33.3% of the respondents deliver at home. The results

really show that the percentage different between those that deliver at health clinic and home were not much this indicate there is possibility of high risk of complication and maternal and newborn mortality rate in the study area. Awareness of ante-natal care services finding shows 73.0% of the respondents agree that they heard about ante-natal care services while 27.0% respondents indicated that they were not aware of ante-natal care services in the study area.

While on information about antenatal services 31.9% of the respondents indicated that they got information about antenatal care services during their visit to the health clinic. While 31.1% were through friends and 21, 9% through relatives. Then 15.2% through the media. The findings show there is poor information dissemination about access to ante-natal care provision in the study area. With the regards to weeks or month that the respondent had, their first ante-natal care services shows 67.8% months while 18% in weeks and 13.7% don't know their pregnancy stage when they had their antenatal care services. Proximity to the facilities also has an effect on the frequencies of services been used. Averagely, the study showed that the proximity of health facility to pregnant women in the study area is about 30 minutes or more drive. Increase in distance to the nearest health facility led to fewer antenatal care visits.

4.3.2 Enabling factors analysis

On the occupational status of the respondents, the findings revealed that 76.3% of the respondents were unemployed and 23.7% had employment. With these findings, so far it shows that poverty is one of the factors affecting the access of utilization of Antenatal Care provision in Mutumbiyu District. This is because of financial difficulties of the pregnant women and that of their spouses. It revealed that a good number of the

respondents are unemployed and those employed, have low income per month. This could be due to their low educational qualification which can only earn them low income jobs meanwhile women who had higher household income were more likely to have adequately utilized ANC services.

Responses on the nature of occupational status of the spouses shows 58.1% were farmers, 35.9% were traders and 5.9% were civil servant. Estimated income per months of the respondent findings shows those that earned 0-10,000 per month 84%, while those that earned 11, 0000-20,000 were 5.6%, 21,000-30,000 0 were 0.7% likewise 41,000 and above 9.3%. This finding of the respondent and their spouse-estimated income per month has really proved that the level of poverty in the study area is at the alarming rate. Economic accessibility also seen as a problem associated with antenatal care. The financial capacity of the family in relation to the costs of a facility delivery including transportation costs in moving to the hospital is one of the major reasons why women/family with low financial capacity choose to deliver at home and thus ignore antenatal care services.

Responses on spouse's support show that only 43.7% support their wives during pregnancy with money to access Antenatal Care Services while response of those not supported with money for antenatal care services were 40.7%. Women described their husbands' support manifested in many ways. Been encouraged by their husbands to book at the antenatal clinic on time were financially supported by their husbands and were pampered with purchasing fruits and vegetables for them. Moreover, the husbands also engaged in assisting with house chores and received kind words from their husbands. Likewise, only 43.3% of the spouse were kind enough to accompany their pregnant women to health facilities for Antenatal Care Services while their wives did not

accompany the remaining 55.9% to antenatal care facility. Generally, the result has proven there is no significant support to pregnant women, by their spouses towards antenatal care service in Mutumbiyu District.

Access to antenatal care during pregnancy the findings shows 83.7% doesn't have access to antenatal care provision in the study area, while those that has access to antenatal care provision were only16.3% this could be as a result of poverty, lack of transportation.

The number of visits for antenatal care provision in the study showed that only 33.3% of the respondents attended antenatal care service for four times as recommended by the World Health organization. The rest of the respondents' attendance was less than this recommendation. This ANC prevalence is far below the recommended target of 90% attendance.

On the Level of satisfaction of the Antenatal Care provision rendered at the facility, the result show poor level of satisfaction. This could be because of the place where ANC service is been rendered. About 36.3% of the respondents agreed to have received ANC services on either under the tree or on a veranda. In addition, the waiting time showed that a majority (56.7%) of the respondents do wait for 40 to 60 minutes or more before been attended. Whereas women's criticisms were related mainly to lack of services, citing reasons such as being sent home without receiving services owing to insufficient staff, and having to purchase drugs, cards or diagnostic tests, although the service was supposed to be free. Findings on the relationship between the expectant mothers and health care staff revealed that a single staff attended to only 21.1% of the respondents. More than one staff attended to the rest of the majority population. This poses a challenge, as it will bridge patients' trust, privacy and confidentiality. Women were reported to initiate ANC late owing to the perceived bad quality of service at the healthcare facility.

The use of words of encouragement by medical staff findings shows 55.1% of the respondents responded that the medical personnel doesn't use words of encouragement to them they were rude to pregnant women. Likewise, on the aspect of staff being sociable to pregnant women findings revealed that 70.7% of the respondent indicated NO while only 29.2% responded that they are sociable. This attributed to the poor sense of social ability of health workers at the facility, and poor use words of encouragement.

The study showed Attitude ratings of health staff towards pregnant women to be very poor. That could be the reason why women sometimes feel reluctant to access Antenatal Care provision because health care providers are perceived to be rude, insensitive and intimidating to young mothers.The attitude of health care providers towards pregnant mothers is a significant factor that determines acceptability and utilisation of health care facilities. The results on the means of accessing Antenatal Care provision by pregnant women in Mutumbiyu District show that 64.4% access ANC facilities through walk While by car 21.1% and other means 13.7%. This factor also discourages pregnant women accessing antenatal care services because of the stress of walking.

Access to health insurance showed that most pregnant women (83.3%) do not have access to health insurance. In developing countries where health insurance exists, access to health care utilization is higher for insured patients than the uninsured patients. Hence, such intervention is seen as an end in itself by ensuring and sustaining social equity, this could be also because of poor level of education in the District and employment status of the respondents, and that of their spouses. The prevalence was higher particularly among women who were urban residents, had higher educational and wealth status. In general, insurance coverage for services such as ANC, childbirth and post-natal care supposed to be higher in rural areas, but reverse is the case in the study area.

The views of pregnant women on antenatal care service in Mutumbiyu District showed that there is poor relief from free Antenatal care services by the government, owing to the fact that the pregnant women still pay for antenatal care services in the study area those that paid 0-10,000, 88.9% while 11,000-20,000, 12'6%. This finding showed that women especially paid for drugs and ultrasound scan services. Some women were unable to afford payments due to poverty and had to forgo treatment. Logistics collectively constituted nearly half of all the reasons why pregnant women did not use the ANC services. They identified inability to pay for ANC services or prescribed treatment as an important barrier to utilization of ANC.

4.3.3 Findings on perceptions of pregnant women

Finding on the Cultural orientation, thought influence belief, norms and values in relation to childbirth has also shown to have significant effect on the pregnant women access to Antenatal Care Services in the study area. The finding shows 48.5% agreed that cultural beliefs affect the pregnancy, while 51.4%that it does not affect their cultural believe. Likewise, 49.3% say there are certain cultural or traditional practices they observed during pregnancy, while 50.7% don't necessary observe traditions practices.

On the aspect forbidden food to eat during pregnancy 51.1% of the responded they were forbidden by some food during pregnancy and 48.9% they were not forbidden. On the preference of either antenatal care or Mission/traditional homes indicates, 44.4% of the respondents prefer Antenatal care services to Mission/Traditional Homes whereas; a majority of the respondents (54.4%) rather prefer mission/traditional homes than Antenatal care services. This could be as a result of the cultural belief in Northern Nigeria that another man outside her husband should not see a woman's nakedness is believed to

be another reason why women choose to ignore antenatal services. Culture, religion and personal beliefs, and the availability of certain foods, has been revealed to influence the respondent's ideas about an appropriate diet to maintain their health status, or to ensure good health at particular times of the year or during periods of stress in the study area. There are those who hold definite ideas about the kinds of food, and amounts of food, appropriate for women during pregnancy, childbirth and the postpartum period. Being part of the health system, in Nigerian, Antenatal Care Service delivery system faced with the challenges of a ravaging health sector due to the cultural orientation of the people concerning Antenatal Care Services.

4.4 Qualitative analysis

What is your area of specialization?

According to the interview data, the researcher gathers that out of the 7 participants, all were highly qualified personals with National certification. Three out of the 7 all held the Community Health Officer (SCHEW) qualification. The other qualification is listed as follows:

a) B.Sc. Health Education

b) B.Sc. Community Health

c) Senior Community Health Extension Worker:

d) Bachelor of Medicine, Bachelor of Surgery (MBBS)

What are some of the possible reasons for poor access to antenatal provision?

The result of the findings in this research shows that their inappropriate appreciations of current antenatal care provision in the District due to, the socio-cultural and economic

context of some women in Mutumbiyu district greatly contributes to participation. Respondent complained about proximity of facility, lack of orientation and information, extended waiting time at facility and lack of maternal education as well as attitude of the health workers.

Do you agree that attitude of health workers affect the response of pregnant women in attending Antenatal care services?

On this question, 6 respondents answered 'Yes' and 1 answered 'No' when one of the respondents was prompted about why he answered 'No', the respondent believed that pregnant women should be treated with empathy and not sympathy. The respondent believed professionalism should take precedence over emotions.

Do cultural orientation influence women not attend antenatal care services?

Some of the respondents explained cultural orientation play a vital role in participation. However, they also expressed that it stands the chance of becoming an advantage if policies rightfully channel to make local midwives' agents of Antenatal care awareness and training.

Do you think the economic status of pregnant women affect their access to antenatal care provision?

In this section, 5 out of 7 respondents agreed that that the Economic status of the pregnant women affects participation in antenatal care provision. 2 others responded otherwise.

What do you think, will be the solution to poor attendance of antenatal care services?

The respondents appear to all tune to the fact that increased maternal education and empowerment, proper orientation, good access of information and timely management of resource and activities could increase participation and ensure advancements in antenatal care services.

4.5 Summary

Empirical evidence shows that four visits are sufficient for uncomplicated pregnancies and more are necessary only in cases of complications; hence the World Health Organization currently recommends at least four ANC visits in the course of pregnancy. Several studies have examined factors affecting ANC utilization but none has systematically summarized them in developing countries.

CHAPTER 5: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary

Antenatal care is the routine health control of presumed healthy pregnant women without symptoms (screening), in order to diagnose diseases or complicating obstetric conditions without symptoms, and to provide information about lifestyle, pregnancy and delivery. These definitions, perceptions and beliefs depend on the socio-demographic, socio-economic, cultural factors. Hence, according to Conrad (2012) argue that experience from countries, which have achieved low maternal mortality, suggests that access to good-quality maternity services is critical to the improvement of maternal health. The study was on the Access of Antenatal care in Nigeria: Case of Mutumbiyu District Taraba, Nigeria, the aimed of the study is to analyse the factors affecting pregnant women access to Antenatal care provision. With the following objectives Thus: to analyse the predisposing factors affecting pregnant women access to Antenatal care provision, to examine the enabling factors affecting pregnant women access to Antenatal care provision and also to analyze the perceptions of pregnant women toward access to Antenatal care provision in Mutumbiyu District Taraba Nigeria. The study adopted theoretical frame work, and model adopted is Andersen and Newman's emerging behavior model of utilization, the purpose of the framework is to discover the condition that either facilitate or hinder the utilization of health care facilities. While the review of related literatures was done based on three basic research objectives of the study such as the predisposing factors affecting pregnant women access to Antenatal Care Provision, enabling factor that influence access to Antenatal Care Provision and perceptions of pregnant women on access to antenatal Care Provision. The study employed cross-sectional design method using structured

questionnaire and key informant interview guide. Sampling six health facilities, with sample population 280 pregnant women, using multistage sampling technique. Descriptive analysis method adopted, Percentages, frequencies, pie charts, bars and cross tabulation was used in analyzing field data. In addition, data were also analyzed using Excel, SPSS 23.0 version multiple regression and significance levels of o% and 10% was considered. Major findings indicate that preventable maternal and perinatal mortality is highest among disadvantaged populations, which are at greater risk of various health problems, such as nutritional deficiencies and infections that predispose women to poor pregnancy outcomes. This suggests that more and better quality contact between pregnant women with health-care providers would help to address health inequalities. Providers have also raised concerns about the difficulty of incorporating all of the ANC components into reasonably short appointments, especially in Mutumbiyu District and the Qualitative evidence suggests that some health care providers in Mutumbiyu District feel that the reduced visit to health centers is a more efficient use of staff time and is less likely to deplete interest of pregnant women from attending to their antenatal need, on the other hand, stressed the importance of the need for local government to address community-based intervention through providing adequate equipment, supplies, infrastructure and training for midwives and health promotion.

5.2 Conclusion

In the study, antenatal care services have been found to limited by the pregnant woman's attitude and this has been attributed to certain psychological factors. These factors include Predisposing, enabling and factors and perceptions of pregnant women on access to Antenatal care provision. The psychological aspects relating to what happened will make

the pregnant women to fail to accept what has happened. It would lead to self-denial to the reality, leading to nonattendance to antenatal care services. Taking women's experiences of ANC as a key metric for reporting the quality of the care is more likely to lead to increased utilization of ANC services by women in highly disadvantaged communities. The findings suggest that the degree to which women feel that they are respected, informed, and engaged in their care has potential favorable implications for ANC response in the study area.

Potential negative ramifications, including women's increased confusion, their risk of acting on inaccurate information or failing to act, and, for a few, an increased tendency to dismiss scientific advice after accessing unsound non-evidence-based but persuasively presented information are the limitations. The key concepts of women's confidence and competence (the two not necessarily positively relate in relation to nutrition knowledge) were identified. The results of the study provide valuable insights that can inform antenatal practices and contribute to better health outcomes for mothers and their babies. Being the first and regular contact with pregnant, Health Workers considered increasing the opportunity to support women during their visits to ANC centres and provide them with care and necessary information. The study findings indicate that need factor like insurance status does not independently play much role in the ANC utilization of rural pregnant mothers. The findings reveal that once the free maternal healthcare policy covers antenatal care services, pregnant mothers were not compelled to enroll on the National Health Insurance Scheme as uninsured mothers utilized ANC regularly like their insured counterparts. Again, the study recognizes the relevance of restrictive factors such as

satisfaction by respondents, attitude of health staff and service quality on antenatal care utilization.

5.3 Implications

Antenatal care is central to the realization of maternal and child health goals. However, this study has identified factors and processes that facilitate or hinder the achievement of such health indicators. These are predisposing factors, socio-economic and socio-cultural factors. The study indicates that women will seek ANC during pregnancy, and seek related information if they see the need. Certain barriers and enablers can enhance their perception and experience in gaining such information. Clearly, Health Workers have an important role to play in supporting pregnant women and enhancing ANC during pregnancy. These could be supplemented by research into educational interventions for women as well as the design, content, and timing of information on ANC provided for, as this research has shown, it is not simply a matter of information alone but of when you provide it and how you provide it. It must respond to each woman's needs across pregnancy.

Hence, locally adopted, national and international ANC policies and guidelines must be put in place to offer free qualitative ANC services to women, irrespective of their socioeconomic status, tribes, religions, or places of residence. The policies should focus on eliminating health inequalities by effectively removing all forms of barriers in accessing ANC utilization by the less privileged. This will go a long way in reducing health gaps among individuals in Nigeria. Government and her partners may have to go far beyond providing free maternal health services to adequately empower the women with quality formal education and functioning health education and promotion.

One of the strategies of free ANC policy should be implementing free ANC services accompanied with free drugs and consumables to the doorsteps of the pregnant women. Either building cottage hospitals in every locality or engaging and empowering community health officers and extension workers to effectively reach out to the expectant mothers can achieve this. Beyond mere contact with ANC providers, an adequate number of ANC visits must be encouraged in Nigeria and in other countries facing poor ANC utilization. Barriers to accessing ANC such as finances and long distances should be eradicated through implementation of free ANC services while spouses are encouraged to support their wives in accessing ANC services.

5.4 Recommendations

Regarding the findings of the study indicated by the views expressed by the respondents (pregnant women) who were involved in the study the following recommendations were acknowledged ways of advancing access of antenatal care provision to promote the development of maternal health care.

Health promotion

There is the need to promote rural health education especially during ANC services to enable pregnant women increase control over their health especially at pregnancy stage since such moments bring pregnant women to the pinnacle of crossroads. It was observed that there is low knowledge on health education by respondents during ANC sessions the pregnant women should be educated on the need to attend the required and recommended antenatal care visits. In this direction, pregnancy complications could be detected early

and remedial actions taken to ensure sustainable rural communities as good health of mothers becomes their wealth.

Involvement of stakeholders

It is thus suggested that the stakeholder approach be taken to determine interest groups including women group who desire to promote maternal health in a holistic manner are represented under the auspices of the Director of health of the Local Government Council. This will help to put both local and scientific knowledge on equal footing and likely to result to the needs of pregnant women and the priorities of the health care system. The levels of engagement on education could be symposia, workshop, community group meetings, local opinion polls, role play and slide shows. The health education given to expectant mothers could be an end in itself as they become empowered to taking well-informed decisions and varied choices. This ultimately would have a spillover effect both at the District, Local, State and National levels. Promotion of rural health education through sensitization programme shall be an upstream approach to reducing institutional barriers on maternal health care. Special attention should be paid to people of low socio-economic level because of the severity of maternal problems in that population.

Manpower

Encouraging uneven distribution of health care staff in various facilities significantly influenced antenatal care utilisation by rural pregnant women. The local government should liaise with the Taraba State Primary Health Care Development Agency to employ more health care professionals to both public and private health facilities to reduce the lack of manpower syndrome.

Effective Supervision of Health Facilities

It was observed by the study that service variables such as service satisfaction and quality of service influence the level and utilization of antenatal care of pregnant women in the District. Because attitude, level of education and workload of health staff significantly influences the health care Utilization of pregnant mothers.It is recommended that the Director of health of the Local Government should renders appropriate, effective and target-oriented supervision in both public and private health facilities and. Antenatal registers should be monitored to ensure that ANC services are well taken and that pregnant mothers are well treated by health staff at all times in various facilities.

Capacity building

Again, health care providers in various health facilities should be well trained with in-service training given and newly recruited staff should be given refresher course before their assumption of duty. Government should equip health facilities with more health personnel. Ministry of Health should build and strengthen the capacity of the staff of Primary Health Care Centres through special workshops and seminars on access to Antenatal care provision.

Women empowerment

The researcher also advocate the need for women empowerment through education, increasing employment opportunities for women and young girls, establishing and supporting programs that will provide sustainable income generation for women as these will help to eliminate structural barriers to access to Antenatal care caused by poverty and gender inequality, reduce maternal mortality in Nigeria and improve maternal and wellbeing of women. Safe motherhood initiatives should be propagated and made

accessible to all mothers of child bearing age. Mothers should be educated on the factors responsible for both infant and maternal mortality and ways to prevent them.

Policy

Policy makers should implement changes in the health care delivery system towards access to Antenatal care provision. It is therefore the sole responsibility of all stakeholders especially policy makers to adopt operative and appropriate maternal health care interventions to reduce the gaps that exist in accessing maternal health care. Researcher still recommend policies that will increase the opportunity for women to have more years of education as this would have effective impact on utilization of healthcare in terms of number of antenatal visits.

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Appendices

Appendix 1: Informed Consent

My name is Mark Abdullahi Tukur, a final year (Master in Public Policy and Governance) student from Africa University (AU). I am carrying out a study on access to Antenatal Care Provision in Nigeria: Case of Mutumbiyu District Taraba State, Nigeria. I am kindly asking you to participate in this study by answering questions /filling in the space provided on the questionnaire.

What you should know about the study:
The purpose of the study is to analyse factors affecting pregnant women access to Antenatal care provision in Mutumbiyu District, Gassol Local Government Area Taraba State, Nigeria. Specifically, the study seeks
Assess factors affecting pregnant women access to Antenatal care provision. Identify the enabling factors affecting pregnant women access to Antenatal care provision and to analyse the perceptions of pregnant women towards access to Antenatal care provision in Mutumbiyu District Gassol Local Government Taraba, Nigeria.

You will be asked to answer a certain number of questions orally or by writing. It is expected that this will take about thirty (30) minutes and there is no risk for that because the study is only for academic purposes.

The benefit for this study is that its results will help child bearing women, Taraba State Ministries of Health, Information, Taraba State Health Services Management Board, Primary Health Care Agency, Policy makers, Health Educators and all female reproductive health intervention researchers and pregnant women's response to Antenatal Care Services.

As informant, you are free to make your choice to participate or not in this study by answering or responding to the questionnaire or questions. If you decide to participate in this enquiry, be assured that the respect of anonymity and confidentiality is ensured. If not, your decision cannot affect our future relationship. Or your relationship with the institutions involved here.

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

Finally, if you have decided to participate in this study please sign this form in the space provided below as an indication that you have read and understood the information provided above and have agreed to participate freely.

---------- ----------

Name of Research Participant (please print) Date

Signature of Research Participant or legally authorised representative

If you have any questions concerning this study or consent form beyond those answered by the researcher including questions about the research, your rights as a research participant, or if you feel that you have been treated unfairly and would like to talk to someone other than the researcher, please feel free to contact the Africa University Research Ethics Committee on telephone (020) 60075 or 60026 extension 1156 email aurec@africau.edu

Name of Researcher ---------- Date……..

Appendix 2: Structured Questionnaire

Instruments of Data collection

SECTION 1- SOCIO-DEMOGRAPHIC DATA

1. Age of respondent

a) 15– 20

b) 21 – 29

c) 30 – 39

d) 40 – 49

e) 50 & above

2. Educational status

a) Primary

b) Secondary

c) Tertiary

d) No formal Education

e) Others specify

3. Marital Status:

a) Single

b) Married

c) Divorced

d) Widowed

e) Separated

4. What is your religion?

a) Christianity

b) Islam

c) Traditional

d) Free thinker

e) Other, specify……please.

5. Ethnicity / Tribe……...

6. What was your age at marriage? ……

SECTION B- PARTNER'S SOCIO-DEMOGRAPHIC BACKGROUND

7. How old was your Spouse/Partner as at his last birth day? …….
8. 10. Education status of your spouse

a) Primary

b) Secondary

c) Tertiary

d) No formal Education

e) Others specify ……

9. What is your spouse's/partner's religion?

a) Christianity

b) Islam

c) Traditional

d) Other, please specify……

10. Your spouse Ethnicity ……..

SECTION C- Factors Affecting Pregnant women Access to Antenatal care provision.

Is this your first pregnant?

(A) No (B) Yes

11. If NO, to question 11, how old were you when you had your first child? ……

12. Where did you give birth to your last child?

a) Health clinic

b) Traditional Birth Attendant

c) Spiritual home

d) Home

13. Have you heard of Antenatal Care Services? Yes [ ] No [ ]

14. How did you get to know about Antenatal care Services?

a) Through friends

b) Through relatives

c) During a visit to health facility

d) Through the media

15. How many weeks or months pregnant were you when you had your first antenatal care visit?

(A) Weeks (B) Months (C) I never had

16. How far is the health Centre from your house in minutes? (A) Less than 15minutes drive (B) 16 to 20 minutes' drive (C) 20 to 30minutes drive (D) More than 30 minutes' drive

SECTION 2. The enabling factors.

17. Occupational status

(A) Employed (B) Unemployed

18. Occupational status of your spouse?

(A) Employed (B) Unemployed

19. Which occupation type is your spouse?

a) Trader

b) Farmer

c) Housewife

d) Public/civil servant

e) Other (specify

21. In your estimate, how much do you get as income per month……..

22. What is the estimate income of your spouse……

23. Does your husband/partner give you money for antenatal treatment?

(A) No (B) Yes (C) Not enough.

24. Did your Husband use to accompany you to antenatal care facility?

(A) Yes (B). No

SECTION B: PATTERN OF ANTENATAL CARE PROVISION

25. Do you access Antenatal care anytime you are pregnant? A. Yes B. No

26. How many visits do you seek for Antenatal Care Services during the entire period of pregnancy?

1 2 3 4 More than 4 (Specify)

27. Where do you attend Antenatal care service?

a) Government hospital

b) Private hospital

c) Maternity home

d) Traditional birth attendants

e) Non attendants

28. Can you give any reason for your choice of Antenatal Care Services? …….

29. Where is Antenatal Care Service rendered?

a) Room built for Antenatal

b) under a tree

c) on a veranda

30. How long does it take you to access Antenatal Care Service at the facility?

a) 0-5 Km

b) 6-10Km

c) 11-15Km

d) 16Km and above

31. Are you always given a referral in case of pregnancy complication?

(A) Yes (B) No

32. Are you satisfied with the Antenatal Care Services rendered in the facility?

a) Very poor

b) Poor

c) Satisfactory

d) Good

e) very Good

SECTION C: RELATIONSHIP BETWEEN THE EXPECTANT MOTHER AND THE HEALTH CARE STAFF

33. How many people attend to you when you access Antenatal Care Services in the facility?

a) 1 Staff

b) 2 Staff

c) 3 Staff

d) 4 Staff

e) 5 Staff

34. Do the medical staff use words of encouragement?

(A) Yes (B) No

35. Are the health workers of this facility sociable to pregnant mothers?

(A) Yes (B) No

36. How will you rate the attitude of health staff towards pregnant mothers at this health facility?

a) Very poor

b) Poor

c) Satisfactory

d) Good

e) Very good

SECTION D: ANTENATAL CARE ACCESS BY THE PREGNANT WOMEN

37. Are Antenatal Care Services easily accessible in this facility?

(A) Yes (B) No

38. By what means do you access antenatal care services in this facility?

a) Walk

b) By car

c) Others (Specify)

39. Which of the following services do they render for Antenatal care Services?

a) Screening

b) Management of minor ailment

c) Immunization

d) Health education

e) All of the above

f) None of the above

40. Do you have access to health insurance? A, Yes B. No

SECTION E: Views of pregnant women on antenatal care

41. Do you pay for the Antenatal care Services?

(A) Yes (B) No

42. How much do you pay for accessing Antenatal Care Services?

……

43. Does the free Antenatal Care Services by the government help as a relief?

(A) Yes (B) No

44. How will you rate the antenatal care service offered to you in the facility?

g) A. Very poor

h) B. Poor

i) C. Satisfactory

j) D. Good

k) E. Very good

SECTION 3. The perceptions of pregnant women.

45. Does the cultural beliefs affect your pregnancy? A. Yes B. No

46. Are there certain cultural/traditional practices you observe during pregnancy?

A. Yes B. No

47. Are there certain foods you are forbidden to eat during pregnancy A Yes B. No

If YES, what are they? ……

48. Do you go to Mission Homes or Traditional Healers when you are pregnant? A. Yes. B. No.

49. Would you prefer Antenatal Care Services to Mission or Traditional Homes?

A. YES B. NO

Appendix 3: Key Informant Interview Guide

Key Informant Interview Guide (For Health Personnel): Questions

1. What is your area of specialization?
2. What are the some of the possible reasons for poor access to antenatal care provision?
3. Do you agree that attitude of health workers affect the response of pregnant women in attending antenatal care services? (Yes/No)
4. Does cultural orientation influence women not attend antenatal care services?
5. Do you think the economic status of pregnant women affect their response to antenatal care?
6. What do you think, will be the solution to poor attendance of antenatal care services?

Thank you.

Appendix 4: Hausa Translated version of Questionnaire

Hausa translated version of the Questionnaire

1. Shekara na mai amsawa

A.) 15-20 B). 20-29 C). 30-39 D). 40-49 E). 50 da sama

2. Matsayin aure

A). Ba aure, B). Ma'aurata C). An sake ni E). Gwauruwa F). Zaman Dadiro

3. Mene ne addininki?

A). Kristanci B). Islama C). Gargajiya D). Ba adini E). In akwai wasu saka saka……

Yanayi / Yanki..... 5.

Mene ne shekarun ki a lokacin aure? ……

Sashi Na B. Abun hulďar zamantakewar zamantakewar al'umma ta abokin tarayya

6. Shekaru nawa ne mijimki / abokin tarayya? …….....

7. Harkokin ilimi na mijinki

A). Farfesa B). Na biyu C). jamiya D). Babu ilimi na al'ada E). wasu saka

8. Mene ne addinin shi?

A). Kristanci B). Islama C). gargajiya D).Ba adini E). wasu don Allah a saka.

9. yanayin 'yan uwan ……

Sashi na C. Tarihin haifuwa

12.Cikin ki nan na wa ne? A}. NO B). Ee

13. Ina ne kika haifi jaririnku na karshe?

A). Kiwon lafiya B). Tsohon haihuwar haihuwa C). Gidan ruhaniya D) A gida

14. Yaya kika ji game da sabis na kulawa da haihuwa?

A). Ta hanyar abokai B). Ta hanyar dangi C). A lokacin ziyara a wurin kiwon lafiya D). Ta hanyar watsa labarai

15. Tsawon makonni ko watanni masu ciki kika kasance lokacin da kika sami ziyarar kulawa na farko naku?

A) makonni ko ..... Watanni B). Ban taba da

16. Yaya nisan dakin kula dalafiya da gidan ki a K / m?

Sashe na 2. Dalili na zamantakewa da tattalin arziki Bayanin iyayen mata

17. Yanayin sana'a A). Ana yin aiki B). Ba a yi aiki ba

18. Matsayi na mijiki

A). Ana yin aiki B). Ba a yi aiki ba

19. Wace nau'in nau'i ne mijinki?

A). Dankasuwa B). Manomi C). Gidan gida D). Ma'aikacin bawan jama'a E). Wasu don Allah saka

20. A cikin kimaninki, nawa kike samun asusun kuɗi a wata

21. Mene ne kimanin kudin shiga na mijink.....

22. Shin mijinki / abokin tarayya yana ba ki kuɗi domin kula da cutar haihuwa?

A). A'a B). Ee C). Bai isa ba

23. Shin mijinki ya yi amfani da shi don ya kasance tare da ke zuwa wurin kulawa da haihuwa?

A). Na'am B). A'a

Sashi Na B. Tsarin Ma'aikatar Kula da Kula da Tsuntsauran Hoto

24. Shin kuna samun damar kula da bazara a kowane lokaci? A). Ee B). A'a

25. Yawancin ziyara da kuke nema don hidimar kulawa da haihuwa a cikin dukan lokacin da kuka yi ciki?

A). 1 B). 2. C).3 D). 4 E). Fiye da 4 (saka)

26. Ina za ku halarci sabis na kulawa na?

A). Gidan gwamnati B). Gidan asibiti C). Gidan yara D) Jami'an gargajiya na haihuwa E). Ba mai hidima

27. A ina ne aka ba da sabis na kulawa da haihuwa ta asibiti?

A). A Daki da aka gina don kula da masu ciki B). A karkashin itace C). A kan gidan waya

28. Yaya tsawon lokacin da ya kai ka don samun damar kula da kula da lafiyar Ante-natal?

A). 1-20 minti- (mai kyau) B). minti 20-40- (mai kyau) C). 40-60 minti- (mai gamsarwa) D). minti 60- (matalauci)

29. Ko wane lokaci ka ba da mahimmanci idan akwai ciki? A). Ee B). A'a

30. Shin, kin gamsu da ayyukan kulawa na masu ciki da aka sanya a cikin makaman?

A). muni sosai B). Sharri C). Gaskiya D). Kyau E). kyau sosai

31. Kina iya ba da wani dalili na zaɓin ayyukan kula da kulawa da haihuwa?

....

Sashi na C: Saduwa tsakanin mahaifiyar da ke jiran da kuma masu kiwon lafiya

32. Mutane da yawa suna halarta a gare ki idan kin sami damar kulawa da kulawa a cikin gida

A). 1 mutum- (mai kyau) B). 2 mutane- (mai kyau) C). 3 mutane- (gaskiya) D.4 mutane- (ba kyau) E). 5 mutane- (sosai sharri)

33. Shin ma'aikatan kiwon lafiya suna amfani da kalmomi na ƙarfafawa?

34. Shin ma'aikatan kiwon lafiya na cibiyar kiwon lafiya sun fi dacewa ga iyaye mata?

35. Ta yaya za ku fahimci irin halin da ma'aikatan lafiyar suka yi game da iyaye masu ciki a wannan wurin kiwon lafiya?

A). muni sosai B). Ba kyau C). Gamsarwa D). Kyau E). kyau sosai

Sashe na D: Hanyar kulawa ta hanyar kula da haihuwa ta mata da mata

36. Shin ayyukan sabis na gaggawa ba su iya samun dama a wannan wurin kiwon lafiya ba?

A). Ee B). BA

37. Ta wace hanya kike samun damar kula da kulawa da haihuwa a cikin wannan gidan kiwon lafiya?

A). tafiya B). Ta mota C). wasu (saka)

38. Wadanne daga cikin ayyukan da suke bayarwa suna ba da ita ga hidimar kiwon lafiya na mata?

A). Gwagaje B). Amincewa da ƙananan ciwo C). Alurar rigakafi D). Ilimin kiwon lafiya E). Dukkanin da ke samaF). babu daga cikin sama

39. Kuna da damar shiga inshorar lafiya?

Sashe Na: ra'ayi game da mata masu juna biyu a kan ayyukan kula da mata

40. Kina biya bashin sabis na kulawa da mata?

A). Ee B). A'a

41. Nawa ne ku biya don samun dama ga ayyukan kulawa da haihuwa?

....

42. Mene ne kike yi game da mahaifiyar ku? kulawa a tsarin kiwon lafiya?

A). gamsu B). Ba a gamsu ba

Sashe na 3: Harkokin zamantakewar al'adu na iyayen mata.

43. Menene al'ada / al'adun gargajiya da kike amfani da ke a lokacin daukar ciki?

....

44. Shin al'amuran al'adu sun shafi rayuwarki?

45. Wadanne matakan da kika dauka a kan su zo? .....

46. Kuna gaskanta zuwa gidan mishan KO Alfa lokacin da kake ciki?

Mahimmin bayani mai kula da tambayoyin mai kulawa (don ma'aikatan lafiya

1). Menene kwarewarka?

2). menene dalilan da ke da alaka na rashin kasancewa ga mata masu juna biyu zuwa kulawa da rashin lafiya?

3). Kuna yarda, halin da ma'aikatan kiwon lafiya ke iya shafar mata masu juna biyu don halartar sabis na kulawa da marasa lafiya?

4). Shin al'adun al'adu ya shafi mata masu ciki ba su halarci hidimar kulawa ba?

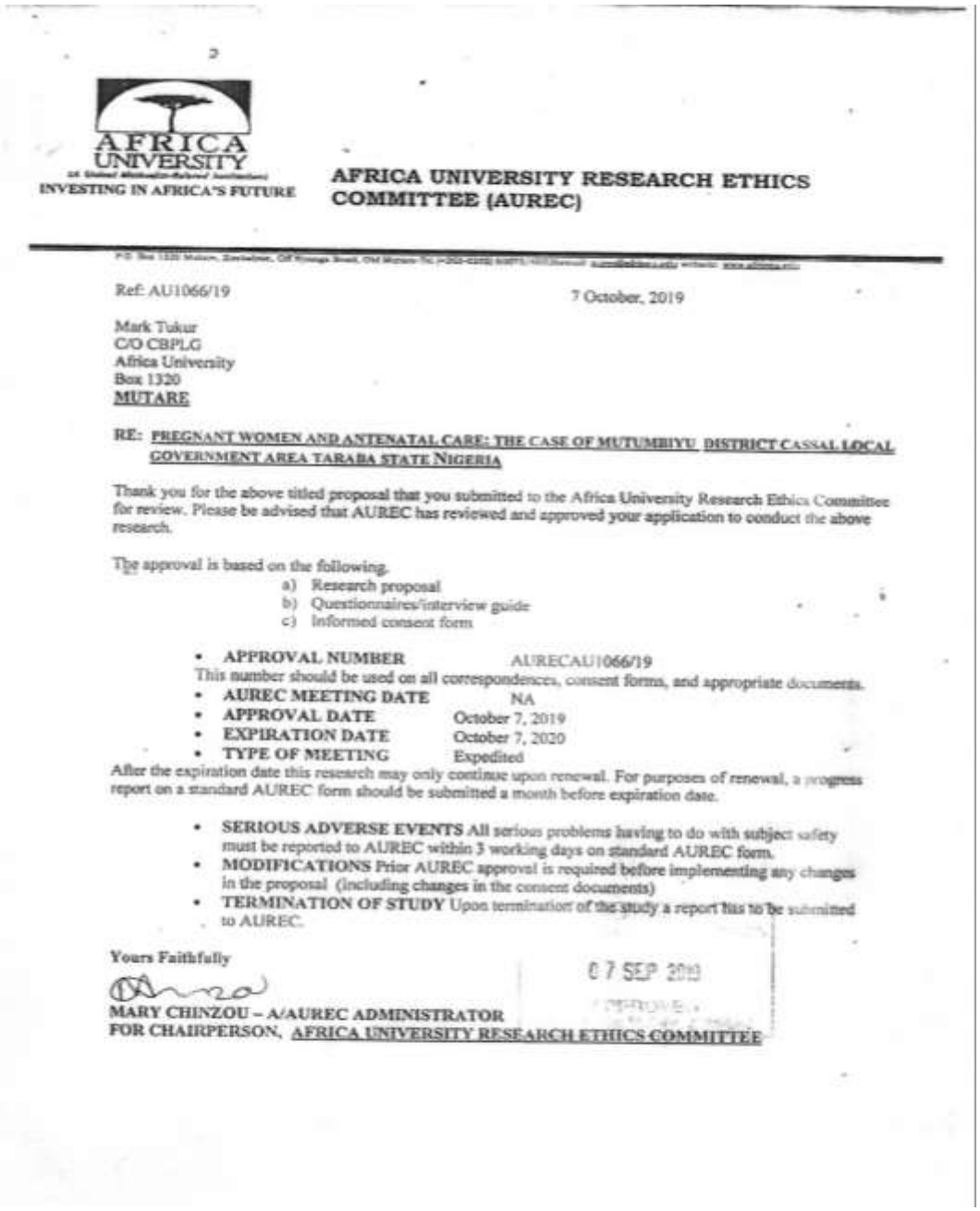
5). Kuna yarda da halin tattalin arziki na mata masu ciki za su iya shafar ayyukan kiwon lafiyar su?

6). Yaya kake zaton zai zama mafita don rashin kasancewa na srevices na kiwon lafiya na iyaye?

7).me yasa yawan mace-mace a cikin kasa yana cikin matsala?

8). Kuna iya bayar da shawarar mafita?

Appendix 5: AUREC Approval Letter



AFRICA UNIVERSITY
INVESTING IN AFRICA'S FUTURE

AFRICA UNIVERSITY RESEARCH ETHICS COMMITTEE (AUREC)

Ref: AU1066/19

7 October, 2019

Mark Tukur
C/O CBPLG
Africa University
Box 1320
MUTARE

RE: PREGNANT WOMEN AND ANTENATAL CARE: THE CASE OF MUTUMBIYU DISTRICT CASSAL LOCAL GOVERNMENT AREA TARABA STATE NIGERIA

Thank you for the above titled proposal that you submitted to the Africa University Research Ethics Committee for review. Please be advised that AUREC has reviewed and approved your application to conduct the above research.

The approval is based on the following.

a) Research proposal
b) Questionnaires/interview guide
c) Informed consent form

- **APPROVAL NUMBER** AURECAU1066/19

This number should be used on all correspondences, consent forms, and appropriate documents.

- **AUREC MEETING DATE** NA
- **APPROVAL DATE** October 7, 2019
- **EXPIRATION DATE** October 7, 2020
- **TYPE OF MEETING** Expedited

After the expiration date this research may only continue upon renewal. For purposes of renewal, a progress report on a standard AUREC form should be submitted a month before expiration date.

- **SERIOUS ADVERSE EVENTS** All serious problems having to do with subject safety must be reported to AUREC within 3 working days on standard AUREC form.
- **MODIFICATIONS** Prior AUREC approval is required before implementing any changes in the proposal (including changes in the consent documents)
- **TERMINATION OF STUDY** Upon termination of the study a report has to be submitted to AUREC.

Yours Faithfully

07 SEP 2020

MARY CHINZOU – A/AUREC ADMINISTRATOR
FOR CHAIRPERSON, AFRICA UNIVERSITY RESEARCH ETHICS COMMITTEE

Appendix 6: College letter of permission to undertake research

AFRICA UNIVERSITY

COLLEGE OF BUSINESS, PEACE, LEADERSHIP & GOVERNANCE

A UNITED METHODIST –RELATED INSTITUTION

P O BOX 1320, MUTARE, ZIMBABWE • TEL: (263-20) 60075/60026/61611/61618 • FAX: (263-20) 61785/63284 • EMAIL: cbplgdean@africau.edu cbplgsec@africau.edu cbplgadmin@africau.edu

9 October 2019

TO WHOM IT MAY CONCERN

Re: Permission to Undertake Research for Dissertation August - December 2019

Mark Abdullahi Tukur student registration number **181905** is a student at Africa University. He is enrolled in the Masters in Public Policy and Governance and is currently conducting research for his dissertation, which is required for completion of the programme in December 2019. The research topic is **"PREGNANT WOMEN AND ANTENATAL CARE A CASE OF MUTUMBIYU DISTRICT GASSOL LOCAL GOVERNMENT AREA TARABA STATE NIGERIA."**

Mark is expected to undertake his data collection from August – December 2019 before the dissertation can be submitted to the College in December 2019. The student will share with you the results of this research after its approval by the College.

We thank you for your support and cooperation regarding this research.

Yours sincerely

AFRICA UNIVERSITY
COLLEGE OF BUSINESS, PEACE, LEADERSHIP AND GOVERNANCE
03 OCT 2019
BOX 1320 MUTARE
MAIL RECEIVED

Ms. B. Dodzo
CBPLG Administrator

Appendix 7: Acceptance letter from Gassol Local Government Area to undertake research

SECRET

GASSOL LOCAL GOVERNMENT COUNCIL

MUTUM - BIYU

Telegram:.....

Telephone:.....

Ref No:.....
Local Government Secretariat
Mutum - Biyu,
Taraba State.

Ref. No. GLG/S.311/VOL I /XXX

Date.....16th octeber 2019.

The registrar,
African University College,
Of Business, Peace,
Leadership and Governance,
P.O Box Mutare Zimbabwe.

RE-PERMISSION TO UNDER TAKE RESEARCH FOR DISSERTATION From AUGUST TO DECEMBER (IN- RESPECT OF) (TUKUR MARK ABDULLAHI)

With reference to your letter, dated 9th October 2019, I am directed to write and inform you, that, the above named student (**Mark Tukur Abdullahi**) with registration number **181905** has been accepted to carry out his research work and data collection in Gassol local Government area of Taraba State as contained in your letter.

Yours faithfully

YAKUBU HARUNA MANJI
P.A.O.I
For:- Chairman

Appendix 8: Pictures

The researcher interviewing the Director of Health, Gassol Local Government and the Sectional Heads

The researcher receiving letter of acceptance from the Director of Health to carry out data collection

The researcher with the staff of Primary Health Care Mutum Biyu

A.

B.

C.

D.

A. The Interpreter assisting the researcher in language translation and data collection

C. & D. The Researcher receiving responses from the respondents during an interview session at Gunduma Primary Health Care Centre.