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ATTENDANCE TO FOCUS ANTENATAL CARE CLINIC AND PLACE OF DELIVERY AT NANKESE IN SUHUM MUNICIPALITY

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DECLARATION

I, SENYO GLORIA AKORFA hereby declare that apart from peoples work which have been duly cited and acknowledged, this work is entirely my personal work done strictly under supervision. This dissertation has neither in part nor whole been presented elsewhere for another degree.

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DEDICATION

I dedicate this work to the Glory of God and My entire family.
ACKNOWLEDGEMENT

I owe it all to the Most High God who granted me wisdom, knowledge and Grace to bring this study to being. May His name be glorified. I also acknowledge the superseding work of my supervisors for their tired less effort in guiding and impacting knowledge into me for the success of this work. Not exempting the entire health staff of Nankese sub municipality for their unique support and allowing me use their facility to undertake this project successfully. To my family, friends and colleagues, I say God richly bless you all for your encouragement.
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LIST OF ABBREVIATIONS

ANC: Antenatal Care
FANC: Focused Antenatal Care
GDHS: Ghana Demographic Health Survey
GHS: Ghana Health Service
GPS: Global positioning system
HDSS: Health and Demographic Surveillance System
HIV: Human Immunodeficiency Virus
ICDDR, B: International Centre for Diarrhea Disease Research, Bangladesh
JHPIEGO: John Hopkins Program for International Education in Gynecology and Obstetrics
MHA: Municipal Health Administration
MHMT: Municipal Health Management Team
MNCH: Maternal Neonatal and Child Health
PMTC: Prevention of Maternal To Child Transmission of HIV
RCH: Reproductive and Child Health
SBA: Skilled Birth Attendant
TTV: Tetanus Toxoid Vaccine
UNAIDS: United Nations Agency of International Development
UNICEF: United Nations Children’s Fund
WHO: World Health Organization
ABSTRACT

Introduction: Focus Antenatal Care (FANC) and health facility skilled delivery are very vital issues to consider when dealing with matters of maternal mortality. Therefore perceived quality of these services and their relatedness cannot be overlooked when assessing patronage levels of these services. Records of non-patronage among some individuals still remain high in some communities. It is in this direction that this study sought to identify the relationship between receiving FANC and preference of place of delivery among pregnant women in the Nankese Sub-Municipality of the Suhum municipality in the Eastern Region of Ghana.

Methods: The study employed both qualitative and quantitative research methods where interview guide and a semi-structured questionnaire were tools for data collection. Data were obtained from 340 respondents and five (5) key informantsof which four were health facility workers and one community member to ascertain institutional based factors that could contribute to FANC attendance and facility based delivery. Data were analyzed using SPSS version 16.0. Descriptive and inferential analyses were used to analyze quantitative data whereas thematic content analysis was employed for the qualitative findings.

Results: The study found that women in the municipality had positive perceptions about FANC as the majority (99.7%) indicated its importance in areas of maternal and child health. There was a significantrelationship between FANC attendance and place of delivery among mothers (p<0.0001). Further, FANC attendance influenced the choice of place of delivery due to the quality of care they received at the facility in terms of medication, education and birth preparedness.

Conclusions: The majority of the mothers in this study had positive attitudes towards FANC. Employment status, distance to health facility and coverage under NHIS related with the attendance to FANC, and FANC attendance positively related with the place of delivery. These findings highlight the need for education on FANC services and the allocation of resources to enhance the delivery of effective FANC services to mothers.
CHAPTER ONE

INTRODUCTION

1.1 Background of Focus Antenatal Care

Focus Antenatal Care (FANC) is a systematic assessment and follow up of pregnant women that include education, counseling, screening and treatment to ensure the best possible health of the mother and fetus. This was designed with the objective of improving maternal and prenatal outcome (Basevi *et al.* 2005).

Historically, the traditional antenatal service model was developed in the early 1900’s. This model assumes that frequent visit and classifying pregnant women into low and high risk by predicting the complications ahead of time, is the best way to care for the mother and fetus. 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 *et al.* 2005).

The principles of Focus Antenatal Care (FANC) for women are to provide advice, education, reassurance and support; to address and treat the minor problems of pregnancy and to provide effective screening during pregnancy (Dphang *et al.* 2013).

The concept of quality of care is increasingly recognized as a key element in the provision of health care and its association with outcomes of care in terms of effectiveness, compliance and continuity of care (Dphang *et al.* 2013).

The FANC requires that a pregnant woman makes at least four antenatal visits before birth. Each of the four main visits consists of a well-defined set of activities related to three equally important general areas namely screening for conditions likely to increase adverse outcome, providing therapeutic interventions known to be beneficial and
educating pregnant women about planning for a safe delivery, emergencies during pregnancy and how to deal with them (Al-Ateeq, & Al-Rusaiess, 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 safe place of delivery and relevance of skilled birth attendant with the client and partner (WHO, 2012).

According to GDHS 2014, FANC coverage has improved from 78% to 87.3% nationally. It is however identified that utilization of FANC reduce with increased births among women. The percentage of deliveries occurring in a health facility has increased from 42% to 73% in 2014. Although increment has been realized in health facility delivery, coverage has still not reached its maximum. The Suhum municipality health records presented in Table 1.1 indicating a decline of 5.9% comparing 2011 and 2012 registrants despite the population increase. Supervised delivery though appreciated did not show much significance. The records spell out the level of patronage of ANC and supervised deliveries in the Suhum Municipality.

This study therefore seeks to bridge the knowledge gap on reasons for the lack of choice of place of delivery among expectant women in the Nankese sub-municipality, as well as bring to light necessary measures to enhance and promote quality care for pregnant women.

Table 1.1: Trends in ANC and supervised delivery coverage

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC Registrants</td>
<td>6,817</td>
<td>7,350</td>
<td>6,914</td>
</tr>
<tr>
<td>Supervised deliveries</td>
<td>3,001</td>
<td>3,545</td>
<td>3,565</td>
</tr>
</tbody>
</table>

Source: DHA Annual Reports, 2012
1.2 Problem Statement

According to Akoto (2013), one of the key or critical elements in advancing maternal health is skilled supervised delivery provided by skilled professionals during pregnancy and childbirth. It is evident in Ghana that, three quarters of all maternal deaths occur during birth and the immediate post-partum period (Akoto, 2013).

Ghana has recorded declining trends in the maternal mortality rate by forty-nine percent between 1990 and 2013 but this significant decline is still behind the Millennium Development Goal five target of 185 deaths per 100,000 live births (UNFPA 2014). The report indicated that 3,100 women died from pregnancy related complications which to an extent, attendance of focus antenatal clinic will enhance early detection and prompt treatment. Reports also indicate that, approximately 53 million women worldwide give birth at home every year without the help of specially trained skilled attendant (UNICEF, 2009; Akoto, 2013). However, as the current rate of skilled birth attendance (SBA) or supervised delivery is 56.6% a significant equity gap exists across regions and within regions—urban and rural disparities (NDP & UNDP, GHANA, 2012).

Skilled birth attendant is essential for safe delivery because labor and delivery are the most crucial period of pregnancy-childbirth and most maternal deaths arise from complications during delivery (GDHS 2014).

In the 2014 GDHS, 90.2% of women in the urban setting delivered in health facilities as compared to 59% in rural areas. Eastern Region in general recorded 67.7% deliveries at health facilities with 32.1% home deliveries. Cutting this down to Nankese sub-municipality, the area under study, monthly report by the midwife in-charge of the health center indicates that averagely 40-45 pregnant women come for antenatal service but only
13.3% of these women deliver monthly at the health center. This study therefore sought to identify the relation between attendance of ANC service rendered, and the choice of delivery place in the municipality.

1.3 Research Questions

1. What are the perceptions of women about FANC and place of delivery?
2. What is the relationship between FANC and the place of delivery?
3. Would the attendance of a particular FANC clinic lead to delivery at the same clinic?

1.4 Objectives

1.4.1 Main Objective

The main objective of this study was to identify the relationship between receiving FANC and preferred place of delivery among pregnant women in the Nankese Sub-Municipality.

1.4.2 Specific Objectives

The specific objectives of the study were to;

1. Assess perceptions about FANC by pregnant women in the municipality
2. Determine the relationship between place of ANC attendance and preferred place of delivery
3. Ascertain how ANC clinic attendance influence the choice of place of delivery
1.5 Conceptual Framework

Figure 1 depicts the relationship between variables and dependency of the individual variables on the outcome variable. The variables in the conceptual framework were measured and accounted for in this study. The expected outcome which in this study was the choice of delivery place was being associated to a number of independent variables which are discussed below.

Socio-cultural factors involving cultural practices and social factors are said to have an outcome on the individual’s ability to make decisions such as choice of delivery place.
Social factors like family issues and cultural factors like perception about labour and delivery all count for a pregnant woman’s decision towards attendance of antenatal and the desired place of delivery.

What the pregnant woman perceives to be quality service can be derived from user satisfaction with service rendered, availability of amenities and equipment for enhancing quality care, as well as care provider attitude according to Ekott et al. 2012. Such that care rendered at a facility is altered by the service provider’s poor attitude, and the choice to continue attending that facility for FANC services or delivering at that facility is rare.

According to the GDHS 2014, demographic characteristics had a role to play in attendance of ANC and delivery under skilled birth attendance. Age, level of education, occupation among others had significant relationship with the two mentioned services. According to Aniebue and Aniebue (2010), the less educated did not support the use of FANC. To most pregnant women, the need to settle and begin something gainful was perceived as most important as compared to attending antenatal care (Carolan and Cassar, 2008).

Geographical accessibility of the FANC clinic and place of delivery can influence the individual’s choice of patronizing the facility. This includes the distance between the pregnant woman’s residence and the facility and the means by which an individual can access the facility. Antenatal clinics with 5km distance away from client residence were patronized more than those that were 10km away from the residence of pregnant women (Ewa et al. 2012).

With financial accessibility, the National Health Insurance Scheme and free maternal health policy makes it partially easy for the pregnant woman to access the health facility
for both ANC and delivery. However this does not cover the total care involved in seeking health care: for example transportation fare involved in arriving at the health facility is not taken care of (Ewa et al. (2012). This made financial accessibility a variable for measurement.

Finally, the attendance of focused antenatal clinic can lead to the choice place of delivery as the fourth visit to FANC requires that service provider assists the pregnant woman to draw a plan for birth preparedness. In this plan skilled birth delivery is emphasized. Adherence to such advice will determine the place of delivery.

1.6 Significance of the Study

This study is significant as it can help improve on maternal health. This is because it has been noted that although there are various causes of maternal mortality, unskilled birth attendant and outside health facility delivery could cause crucial consequences as far as maternal morbidity and mortality is concerned. Thus the ability to conduct Focus Antenatal Care and delivery by a health provider is an important skill for improving maternal health and preventing complications associated with pregnancy and delivery. This can be possible if the principle of FANC is well understood.

In view of this, the findings of this study would help in two dimensions; in the field of education, it will serve as a guide for health providers to enlighten mothers with specific health information that will be identified as a knowledge gap. This study again will be significant to new graduates who are learning the skills of conducting FANC and delivery by knowing factors that will promote patronage of the services involved. The second
dimension is that in the field of research, it can help by acting as a stepping stone for further studies in the field by future researchers in health care setting.

This study will also be helpful to the entire Suhum Municipality to draw regulations and develop policies which will make the services friendly and appealing to community members as well as beneficial to their health. Finally, the study can also help stakeholders including government agencies involved in maternal health to take key interest in developing strategies to minimize maternal morbidity and mortality.
CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Globally, approximately 515,000 women die each year from pregnancy related causes and almost all of these deaths occur in developing countries. It is also confirmed that less than one percent of these deaths occur in developed countries indicating that the deaths could be avoided if resources and services were available (WHO, 2013).

According to UNICEF (2016) antenatal care is known as care during pregnancy which is essential for diagnosing and treating complications that could endanger the lives of mother and child. Antenatal care also serves as a point of convergence of the pregnant woman and family with the medical care and attention encompassed in the focused antenatal care module. With the numerous merits of antenatal care to the pregnant women, the developing baby and the family as whole, some women in developing countries do not patronize it as expected (GDHS, 2014)

The problems of pregnant women before, during and after delivery led to the inception of antenatal care which dates as far as the early twentieth century. Due to the economic and cultural disposition of Africa, antenatal care is faced with some challenges that prevent it from attaining full potential of providing a complication free pregnancy. Preparing the pregnant women for a complication free birth and effective postnatal care is also a challenge. According to the WHO (2010) report, antenatal care has not yet attained its completeness when it comes to patronage. 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 envisioned by FANC (WHO, 2010).

Essential interventions enshrined in ANC include identification and management of obstetric complications such as pre-eclampsia, tetanus toxoid immunization, intermittent preventive treatment for malaria during pregnancy (IPT) and anemia and identification and management of sexually transmitted infections including HIV and syphilis. ANC is also an opportunity to promote the use of skilled attendance at birth and healthy behaviors such as breastfeeding, early postnatal care, and planning for optimal pregnancy spacing (UNICEF, 2016).

The effects of social, economic and cultural disposition are always in play in the African population of pregnant women. Patronage is therefore affected by a plethora of factors and its resultant hindrance to achieving the full potential of antenatal care. Lack of education has always been in the factors that steal the minds of individuals on the right things to be done and therefore presents a potential source of low patronage of antenatal service (WHO, 2010).

2.1 Focused Antenatal Care and its principles

The classification of pregnant women into low and high risk states becomes necessary since it serves as the cornerstone to predicting the complications that pregnant women could have and projects the best solutions to these possibilities. Faced with some challenges, the conventional antenatal care module evolved into the focused antenatal care. The new approach to antenatal care is a goal oriented approach that seeks to
promote the health of mothers and their unborn babies through target assessment. Practically, the new approach to antenatal care seeks to achieve its aims and objectives through the following principles (WHO 2002).

It is a recommended practice for antenatal care staged by health officials to take and document any personal or family history of any form of disease that the pregnant woman has. History taking then follows with the treatment of such diseases and a means of preventing any further complications that could ensue as the pregnancy progresses, during delivery or afterwards.

The time and ability to detect complications early enough is an indicator for the level of quality of antenatal care rendered by health care services. The earlier complications are detected, the best prognosis that a pregnant women could have. Focused antenatal care is therefore proactive in nature that seeks to detect pregnancy and birth complications and to get the pregnant woman also ready and fully prepared for such situations.

With the intention of preventing a disease from occurring in the newly born child, a prophylaxis is recommended. Treatment is recommended for all diseases that could be transmitted or have deleterious effects on the developing child. Such diseases have been identified as malaria, anemia, sexually transmitted infections, urinary tract infection and tetanus.

Aside the points elaborated on above, focused antenatal care also aims at rendering a holistic and an individualized care to each pregnant woman with the objective of aiding the maintenance of the expected progress of pregnancy. This is ensured by the pragmatic and timely management and information for pregnant women on issues of birth
preparedness and complication readiness. Also on nutrition, immunization, personal hygiene and family planning and counseling on danger symptoms that indicate the pregnant woman should get immediate help from a health professional (WHO 2002).

These are principles enshrined by WHO following recommendations of researches on the need for the right health care during pregnancy that prepares both the mother and child for birth. With the mother, they decide on to have the follow-up antenatal visit, how frequent the visit should be, where to give birth and whom to be involved in the pregnancy and postpartum care (Maternal and Neonatal Health, 2004). Provided that quality of care is given much emphasis during each visit, and couples are aware of the possible pregnancy risks, the majority of pregnancies progress without complication. However, no pregnancy is labeled as ‘risk-free’ till proved otherwise, because most pregnancy-related fatal and non-fatal complications are unpredictable and late pregnancy phenomena. Pregnant women and their husbands are seen as ‘risk identifiers’ after receiving counseling on danger signs and they are also ‘collaborators’ with the health service by accepting and practicing the recommendations.

2.3 Commencement and Implementation of Focused Antenatal Care

Studies established that effective utilization of antenatal care (ANC) is related to improved maternal and neonatal health outcome. Despite the reduction in maternal mortality, depending on access to adequate obstetric care and encouragement, the patronage of ANC could be instrumental in boosting the attitude of pregnant women to seeking skilled assistance at birth (Bullough et al., 2005; Darmstadt et al., 2005; WHO, 2005). The use of the skilled birth attendant has been proven to significantly reduce
maternal mortality (Campbell & Graham, 2006). Moreover, timely and appropriate ANC is important for the health of newborns (Halim et al. 2010). With regards to timing, international consensus favors commencement of care in the first trimester of pregnancy to ensure adequate antenatal follow-up, the early detection and management of complications, and the prevention of mother to child transmission of HIV and other infections in pregnancy. It is an established fact that most developing countries have adopted ANC programs to improve maternal and neonatal health outcomes (Adam et al. 2005). Nevertheless, within these countries, high rates of ANC coverage continue to co-exist with high maternal and neonatal mortality rates, prompting calls to advance the quality of implementation.

FANC is intended to reduce waiting times, increase the time spent educating women about pregnancy-related issues and stimulate the use of skilled assistance at birth (Babalola & Fatsui, 2009; Gabrysch & Campbell, 2009). As a result, even when the pregnant woman is not able to deliver at the main health facility, with the presence of a skilled assisted birth there, some kind of confidence that the right procedures are met. FANC is expected to reduce costs for both the service provider and households in developing countries, by recommending only four visits for women with uncomplicated pregnancies, with the first visit in the first trimester (ideally before 12 weeks, but not later than 16 weeks), at 24–28 weeks, 32 and 36 weeks gestation.

Since FANC is to ensure the quality of antenatal care rather than just the frequency, scheduled FANC visits should include the following: thorough evaluation (e.g. history taking and physical examination), intervention (e.g. prevention and treatment) and promotion (e.g. health education and counseling) (Gabrysch & Campbell, 2009).
In a study by the ministry of health in Zambia in 2005, it was recorded that 94% of women completed one antenatal visit in 2007, yet the maternal mortality rate was 591 deaths per 100,000 live births. This was projected to be possibly due to low first trimester ANC usage or incomplete ANC follow-through; 19% of ANC visits occur in the first trimester, whereas 60% complete the recommended minimum four antenatal visits during pregnancy. It was therefore recommended that there was a need that the old ANC module was repackaged into one which will be more qualitative and well positioned to give more attention to the pregnant women and also integrate the family as part of the care for the pregnant women. These are key components enshrined in the FANC module.

It is a fact that more studies have been conducted on factors associated with the use of ANC in sub-Saharan Africa and Asia, such as maternal education, cost, availability, household income, women’s employment and cultural beliefs and the outcome of such studies have been well documented (Simkhada et al., 2008). There is still limited evidence existing on individual- and community-level factors associated with ANC use after the adoption of FANC.

The few studies on FANC were conducted with smaller samples that holds back generalization to the population and may not be a good national representative (Nyarko et al., 2006), while little attention is given to community characteristics and supply-side factors that influence FANC utilization. Understanding both individual- and community-level factors related with FANC use is important, because individuals reside in communities and individual decisions can be influenced by their communities (Chama-Chiliba & Koch, 2015). Classifying these factors can further the development of all-
inclusive policies to improve ANC effectiveness in developing countries around the world. The FANC module still employs the four visits that were recommended in the traditional antenatal care module and in addition to that there was an emphasis on much more comprehensive activities that will enhance the safe pregnancy and healthy development of the developing baby. This module is also set to adequately prepare the pregnant women for an uncomplicated or a prepared delivery.

2.4 What FANC Seeks to achieve in developing countries

According to UNICEF (2016) FANC is essential in saving the life of baby and mother. This is evident by the contribution of the maternal service to the pregnant woman and the developing baby. A minimum of four (4) visits is recommended by WHO. The areas of care given are micronutrient supplementation, treatment of hypertension to prevent eclampsia, immunization against tetanus, HIV testing, in addition to medications to prevent mother-to-child transmission of HIV in cases of HIV-positive pregnant women. In addition to making available the health needs of the mother and developing baby, the services also affords women proper preparation for delivery and understand warning signs during pregnancy and childbirth. This adds to the safety off the pregnant woman. In areas where malaria is endemic, health personnel can also provide pregnant women with medications and insecticide-treated mosquito nets to help prevent this incapacitating disease.

The FANC encompasses the combined efforts of the doctor, nurse midwife and other health workers who make sure of monitoring the pregnant women and the babies, as well as provide health their care needs (UNICEF, 2016).
Economic activities of the mother, distance and other issues such as disapproval or lack of support from family negatively influence the patronage of FANC. In some areas, especially in the urban areas, there is a high rate of mothers making all four visits to the facility for FANC. The contrary occurs in the rural areas where FANC attendance is low. According to UNICEF (2016) South Asia and sub-Saharan Africa the urban-rural gap in coverage of four or more antenatal care visits exceeds 20 percentage points in favor of urban areas. Disparities have been identified in the utilization and coverage of FANC in urban and rural areas.

According to The Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO 2007), the main aim of FANC is to achieve a good mother and baby outcome during and after pregnancy, and prevent any complications that may occur in pregnancy, labour, delivery and postpartum. The following objectives were set to make this vision a reality.

Assessment and examination of a pregnant woman for chronic conditions and infectious diseases is a main objective. Circumstances that may threaten the life of the mother and baby when not treated are; HIV/AIDS, Syphilis, other sexually transmitted diseases, malnutrition, tuberculosis and malaria. Additionally, situations such as severe anemia (Hb<7g/dl), vaginal bleeding, eclampsia, fetal distress, fetal mal-presentation after 36 weeks, and chronic conditions such as kidney failure, diabetes and heart problems should also be taken into consideration if we are to save the life of the mother and unborn (JHPIEGO 2007).

A plan about place of delivery is provided, transportation, companionship, blood donor, items for clean and safe delivery are all inclusive in this plan. In addition, the woman is
given information on danger signs, and actions to take if they arise. Data from the JHPIEGO (2007) report indicates that 15% of women develop pregnancy related complications, and that these women could die if nobody was there to make timely decision at home and health facility, and also if no plans for transportation and finances are made.

Another objective was to embolden dialogue between the woman and the service provider. Issues affecting a woman’s health and that of the newborn are discussed at length to identify the right solutions for them. It includes dietary education, for example on foods that provide essential nutrients. In furtherance the pregnant woman is given information about risk of smoking, rest and relaxation, hygiene, use of herbs, safer sex, and medication all to enhance effective and safe pregnancy. Information regarding family planning, exclusive breast feeding as well as immunization and care of the newborn is included in counseling (JHIEGO 2007).

2.5 General knowledge on FANC/ANC

Knowledge on FANC and ANC among pregnant women is critical in determining the use of this service. Studies have shown that exposure to mass media particularly television and radio significantly predicts utilization of FANC (Simkhada et al. 2007). This is because individuals with access to the media benefit from education on the importance of the care and most often than not are convinced to take it up.

A similar study was conducted in Nigeria by Amosu et al. (2011) with findings indicating that health care providers and pregnant women are not enlightened about FANC and this lack of knowledge was one of the factors affecting utilization of FANC.
From the studies above, there is a clear indication that awareness and knowledge concerning FANC was very crucial in patronage among pregnant women. In areas where there is a continual lack of education on FANC, there is a projected and a persistent low utilization of FANC.

2.6 Health Care Workers Perspective

Health care workers compliance, perception and attitude play a crucial role as regards to utilization of any health related service and FANC is no exception. On a more serious note, attitude of health workers is very crucial in getting people on board for this very important service. It is explained that poor attitude of health care providers towards pregnant women contributes to low utilization of FANC service which confirms the assertion made above. It was further mentioned that many of these mothers prefer to deliver with unskilled birth attendants in the villages since they probably treated them better and they were much acclimatized with them and their environment (Mathole et al. 2004).

Conrad et al. (2011) substantiate this finding in a multi-center study conducted in Tanzania, Uganda and Burkina Faso where it was noted that health care workers did not comply with the procedures stipulated in FANC procedures and this had a remarkable effect on the use of FANC.

Contrariwise, Yengo (2007) refuted the claim that the perception of health workers (nurses) affected implementation and utilization of FANC. The argument presented indicates that health care workers perceived FANC as beneficial both to the pregnant
mother and the unborn baby, but shortage of human and material resources obstructed efficacious implementation of FANC.

2.7 Perception of Women on Antenatal Care

A study by Carolan and Cassar in 2008 was aimed at determining the experiences and concerns of an African-born sample of pregnant women receiving antenatal care in Melbourne, Australia. This study results proved that, these women had perceived ANC as a form of care received by pregnant women that covers education on pregnancy, medication and preparation for delivery.

Carolan and Cassar (2008) also showed from their study that African women receiving pregnancy care in Australia experienced a process of modification and adjustment as they transitioned from a view of pregnancy as not ‘special’ to appreciating continuous antenatal care.

The study was discussed under five themes that were identified along the course: pregnancy is not special; resettlement is a priority; childbearing is a normal process; coming to value continuous pregnancy care; and cultural sensitivity is important. Throughout each stage, valuing and acceptance of Australian pregnancy care were mediated by the women's cultural beliefs. The findings presented a situation that is affected negatively by prioritizing the needs of the pregnant women. To most pregnant women, the need to settle and begin something gainful was paramount as compared to attaining antenatal care. It is also identified that the cultural disposition of pregnant women, especially the study subjects had an impact on the health seeking behavior.
Carolan and Cassar (2008) therefore concluded that the African population that was used in this study showed heterogeneity in cultural background, residential status, prior experience and education which affected their perception of antenatal care. It was however identified that these attitude and perceptions changed upon adjustment to the new environment.

Another study by Ekott et al. (2013) delved into the perception of women about antenatal care. This study was 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 behavioral changes that are associated with pregnancy. It also sets the platform for healthy pregnancy as well as a healthy fetal development.

To determine the factors that affected the utilization of this all important health care service, the perception of pregnant women was necessary to be determined.

A finding on the overall satisfaction with care was 94 % and it was highest (95.8 %) with health talks and least with medical consultations (64 %) Ekott et al. (2013) Qualities valued at service points were educating nature of health talks, prompt attention, and friendly and polite staff. This finding clearly indicates that the care rendered was good since its components were well administered to the pregnant woman seeking the care. These components were mostly the education given and the health care component rendered by staff. However there were dissatisfaction among some of the study subjects and reasons given were that they were delayed at times and also some staff were unfriendly.
Nwaeze et al. (2013) also investigated the perception and satisfaction with the quality of antenatal care services among pregnant women attending the University College Hospital of Ibadan in Nigeria. They concluded that there is a high overall level of satisfaction with antenatal services among pregnant women and further recommended that policy makers and health providers should contributed to addressing the improvement of amenities, reduction of waiting time and ensure that health interventions were available for all clients.

Aniebue and Aniebue (2010) in a study on women’s perception as a barrier to focused antenatal care in Nigeria addressed the issue of fewer antenatal visits. The study found that as little as 20.3% advocated for a change to the new antenatal care approach which was Focus Antenatal Care (FANC). The study also found that those who defaulted from antenatal care were dissatisfied with the current antenatal care system. Among those who did not support the change in the system from ANC to FANC were those who worked as civil servants and pregnant women who were less educated or received education to the secondary level. This finding may be due to the fact that such individuals had little time to make four visits that is enshrined in recommendations of the FANC. In another school of thought, it could be coined that pregnant women who had minimal educational background were not enlightened on FANC and the importance it presents if adhered to.

Antenatal care has been identified as a wider view of medical and health promoting activities that are required to provide healthy and safe pregnancy according to Ekabua et al. (2015). This was made mention in a study that was mainly aimed at exploring the perceptions of midwives on focused antenatal care (FANC) at a large urban hospital in Tema, Ghana. Currently, there is a switch from the ANC that was observed to a more
individualized form of care namely FANC. In achieving this aim interpretive descriptive design was used to explore, interpret and describe the perceptions of midwives in the provision of focused antenatal services to pregnant women. Purposive sampling techniques were used to recruit participants (midwives). Data were collected by conducting individual semi-structured interviews. The documented interviews were transcribed verbatim. Data were manually coded using two methods described by Saldana (2009). Guba’s model of trustworthiness was also implemented. 

Ekabua et al (2015) identified from the study five themes emerged from the data analysis. It included midwives’ conceptualization of FANC and their perception of FANC processes/flow, quality of care, factors inhibiting the implementation of FANC, and strategies to enhance FANC interventions. The importance of the service was acknowledged as positive among the midwives who rendered the service. The quality of ANC was augmented by the FANC rendered since the pregnant women is met at the point of their need through privacy and a well committed health personnel devoted to render the service as prescribed.

2.8 Factors influencing ANC and the Place of Delivery

It is envisioned that FANC should have a positive influence on the place of delivery among mothers. In a study by Ewa et al. (2012) it was found that the decision on the attendance of ANC and the place of delivery depended on the preference of the husband and the level of perceived privacy. Another important finding that was attained in their study was the impact of distance on ANC and the delivery centers. It was found that ANC and place of delivery that were within 5km were patronized whilst the lowest
patronage was recorded for places more than 10km away from the residence of the pregnant woman. The need for husbands and other family members to give assistance to women of childbearing age in the choice of ANC and delivery place was recommended.

In another study (Kitui et al. 2013) on the factors that influenced place of delivery for women, it was mentioned that Kenya has suffered an increase in maternal mortality from 380/100000 live births to 530/100000 live births between 1990 and 2008. The essence of skilled assistance during childbirth is paramount to reducing maternal mortality. It was indicated that despite the education that is ongoing in the country, the proportion of childbirths that take place in the health facility where skilled birth attendants are available is below 50% since 1990s (Kitui et al. 2013). The researchers pointed out that residence in urban areas, being wealthy, educated, using ANC services to the optimal levels and lower parity where strong predictors of delivery in a particular place of health center. Ethnicity and type of facilities available in the health facility also affected the choice of place of delivery. The study also found that women most commonly cited distance and/or lack of transport as factors that do not influence delivering in a health facility but over 60% gave other reasons including 20.5% who considered health facility delivery unnecessary, 18% who cited abrupt delivery as the main reason and 11% who cited high cost. The level of enlightenment through educational background and access to ANC education even before pregnancy also affected the choice of place of delivery. They recommend that access to appropriate transport for mothers in labour and improving the experiences and outcomes for mothers using health facilities at childbirth augmented by health education may increase uptake of health facility delivery in Kenya.
Pervin et al. (2012) investigated into the association between antenatal care, facility delivery and perinatal survival and found that ANC patronage is associated with increase in the uptake of health facility based delivery and improved perinatal survival and concluded that the choice of delivery place vary among individuals and is based on factors that are measurable.

This study will therefore assess and measure the variables and relations between the dependent variables (Attendance of FANC and choice of place of delivery) and independent variables (demographic characteristics of respondents).

2.9. Determinants of FANC Utilization

A number of studies have found that access to health insurance plays a critical role in women’s decision to utilize antenatal care services. However, little is known about the role that social forces play in this decision. This study uses village-level data from the 2008 Ghana Demographic and Health Survey to investigate the effects of health insurance and social influences on the intensity of antenatal care utilization by Ghanaian women. Using GIS information at the village level, we employ a spatial lag regression model in this study.

A study by Owoo and Lambon-Quayefio (2013) explored the importance of social influence and the availability of health insurance on maternal care utilization in Ghana through the use of antenatal care services.

In their results Owoo and Lambon-Quayefio (2013) found that controlling for a host of socioeconomic and geographical factors, women who had health insurance appear to use
more antenatal services than women who did not. In addition, the intensity of antenatal 
visits appeared to be spatially correlated among the survey villages, implying that there 
may be some social influences that affect a woman’s decision to utilize antenatal care. A 
reason for this may be that women who benefit from antenatal care through positive 
pregnancy outcomes may pass this information along to their peers who also increase 
their use of these services in response. Traditional/Cultural leaders as “gate-keepers” may 
be useful in the dissemination of maternal health care information. Public health officials 
may also explore the possibility of disseminating information relating to maternal care 
services via the mass media.

In another study by Pell et al. (2013) it was mentioned that Focused Antenatal care 
(ANC) was a key strategy to improve maternal and infant health. However, survey data 
from sub-Saharan Africa indicate that women often only initiate ANC after the first 
trimester and do not achieve the recommended number of ANC visits. Drawing on 
qualitative data, this article comparatively explored the factors that influence ANC 
attendance across four sub-Saharan African sites in three countries (Ghana, Kenya and 
Malawi) with varying levels of ANC attendance.

Data were collected as part of a programme of qualitative research investigating the 
social and cultural context of malaria in pregnancy. A range of methods was employed 
interviews, focus groups with diverse respondents and observations in local communities 
and health facilities.

Pell et al. (2013) found that women attended ANC at least once. However, their 
descriptions of ANC were often vague. General ideas about pregnancy care – checking
the foetus’ position or monitoring its progress – motivated women to attend ANC; as did, especially in Kenya, obtaining the FANC card to avoid reprimands from health workers. Women’s timing of ANC initiation was influenced by reproductive concerns and pregnancy uncertainties, particularly during the first trimester, and how ANC services responded to this uncertainty; age, parity and the associated implications for pregnancy disclosure; interactions with healthcare workers, particularly messages about timing of ANC; and the cost of ANC, including charges levied for ANC procedures – in spite of policies of free ANC – combined with ideas about the compulsory nature of follow-up appointments. In these socially and culturally diverse sites, the findings suggest that ‘supply’ side factors have an important influence on ANC attendance: the design of ANC and particularly how ANC deals with the needs and concerns of women during the first trimester has implications for timing of initiation.

Asundep et al. (2013) investigated the determinants of access to antenatal care and birth outcomes in Kumasi. Specifically, they determined the factors that influence antenatal care utilization and their association with adverse pregnancy outcomes (defined as low birth weight, stillbirth, preterm delivery or small for gestational age) among pregnant women in Kumasi. A quantitative cross-sectional study was conducted of 643 women aged 19–48 years who presented for delivery at selected public hospitals and private traditional birth attendants from July–November 2011. Participants’ information and factors influencing antenatal attendance were collected using a structured questionnaire and antenatal records. Associations between these factors and adverse pregnancy outcomes were assessed using chi-square and logistic regression.
According to Asundep et al. (2013) nineteen percent of the women experienced an adverse pregnancy outcome. For 49% of the women, cost influenced their antenatal attendance. Cost was associated with increased likelihood of a woman experiencing an adverse outcome. Also, women with >5 births had an increased likelihood of an adverse outcome compared with women with single deliveries. The prevalence of adverse outcomes was lower than previously reported (44.6 versus 19%. Cost and distance were associated with adverse outcomes after adjusting for confounders. They recommended that the cost and distance could be minimized through a wider application of the Ghana National Health Insurance Scheme.

Abosse, Woldie and Ololo in 2010 researched into the Factors Influencing Antenatal Care Service Utilization in Hadiya Zone in Ethiopia. From their study it was identified that the levels of maternal and infant morbidity and mortality in Ethiopia was among the highest in the world considering Ethiopia. This is attributed to, among other factors, none use of modern health care services by women in Ethiopia. Abosse, Woldie and Ololo (2010) found that antenatal care service utilization in the study area was 86.3%. However, out of those who attended antenatal care service, 68.2% started antenatal care visit during the second trimester of pregnancy and a significant proportion 250 (42%) had less than four visits. Maternal age, husband attitude, family size, maternal education, and perceived morbidity were major predictors of antenatal care service utilization. The study concluded that though the antenatal care service utilization is high in the study population, four in ten of the mothers did not have the minimum number of visits recommended by World Health Organization. Promoting information, education and
communication in the community is recommended to favorably affect the major predictors of antenatal care service utilization.

Bbaale (2011) also conducted a study using the Uganda Demographic and Health Survey (2006) in Uganda on the factors influencing the utilisation of antenatal care content. He indicated that Uganda records an inadequate utilisation of antenatal care programmes. The study set out to investigate the factors associated with the use of antenatal care content to inform policy makers of the pertinent factors that need to be influenced by policy.

Bbaale (2011) found that on average, only 16% of women used the full content of antenatal care. Only 12% of women had a urine sample taken, 28% a blood sample taken, and 53% their blood pressure measured. Almost two-thirds of women (63%) took iron supplements, 77% had their weight measured, and 27% were given drugs for intestinal parasites. The utilisation of the content of care was significantly associated with education of the mother and her partner, wealth status, location disparities, timing and frequency of antenatal visits, nature of facility visited, access to media, family planning, and utilisation of professional care. The study recommended that efforts are needed to educate girls beyond secondary level, establish village outreach clinics with qualified staff to attract the hard to reach women in the rural areas, and facilitate antenatal care utilisation irrespective of the ability to pay.

Emelumadu et al (2014) in a study titled Socio-Demographic Determinants of Maternal Health-Care Service Utilization Among Rural Women in Anambra State, South East Nigeria aimed at exploring pattern of maternal health (MH) services utilization and the
socio-demographic factors influencing it in Anambra State, South East Nigeria. In the study, a total of 310 women of reproductive age with a previous history of gestation attending ANC services between September, 2007 and August, 2008 in selected Primary Health Centers in Anambra State were studied.

Emelumadu et al. (2014) found that use of health facility during delivery was 293 (97.0%) and 277 (92.7%) out of 302 women for ANC and delivery services respectively. Most women attended their first ANC consultation during the preceding pregnancy was after the first trimester and about 31% (94/298) of them had <4 ANC visits prior to delivery. Socio-demographic factors were found to be significantly associated with places where MH care services are accessed. Parity was found to be associated with timing of ANC booking and number of ANC attendance. The odds of utilizing formal health facility for MH services were found to be significantly associated with increasing age and educational status of mothers.

Agus and Horiuchi (2012) indicated that every year, nearly half a million women and girls needlessly die as a result of complications during pregnancy, childbirth or the 6 weeks following delivery. Almost all (99%) of these deaths occur in developing countries. Their study was aimed at describing the factors related to low visits for ANC services among pregnant women in Indonesia. A total of 145 of 200 married women of reproductive age who were pregnant or had experienced birth responded to the questionnaire about their ANC visits.

The results indicated that three-quarter of respondents received ANC more than four times. The others received ANC less than four times. About 59.4% attended ANC during
pregnancy, which was statistically significant. Women who were encouraged by their family to receive ANC had statistically significant higher traditional belief scores compared to those who encouraged themselves. Preference for TBAs was strongly associated with traditional beliefs. On the contrary, preference for midwives was negatively correlated with traditional beliefs.
CHAPTER THREE

METHODS

3.0 Introduction

This section outlines the methods, tools and techniques that were used to gather data on the research study. It presents the research design, population, sample and sampling technique and data collection technique. This section again describes the analysis procedure used, the ethical considerations employed and justification for choosing Nankese sub municipality as the study area.

3.1 Study Design

A descriptive cross sectional approach was adopted in this study. This study looked out for the attendance of focus antenatal care and delivery place. The study blended both qualitative and quantitative approach of analysis in order to attain the opinions of participants that could not be obtained with the questionnaire. The dependent variables that were considered in this study were; the attendance and patronage of FANC and the choice of place of delivery. These variables were ascertained as to whether they were affected by the independent variables being the socio-demographic characteristics such as age, employment status and educational background of mothers; geographical accessibility of the health facility; financial accessibility; perceived quality of FANC services and socio-cultural influences like family support.

This study type enabled me look out for perceived quality of focus antenatal care, geographical and financial accessibility of the facility and service, institutional based
issues, socio-cultural perception about delivery and place of delivery, and family members influence on expectant mothers decision on delivery place.

3.2 Study Area / Context

Suhum Municipal is located in the southern part of Eastern Region of Ghana and covers a land area of 940 square kilometers with a population size of 101,324 in 2015 projected from 2010 population and housing census. There are three main ethnic groups - Akans, Krobo/ Dangbe and Ewe. The Suhum Municipality is bounded by the New Juaben Municipality to the north east, Kwaebibirem and East Akim Municipal to the north, West Akim Municipal to the west, Akwapim South and Akwapim North Municipal to the south and east respectively.

The municipality consist of three zones namely Suhum, Akorabo and Nankese. For health administrative purposes these three major zones has been demarcated into nine sub municipalities. According to the Suhum Municipality Population Projection 2015, Nankese has a population of 12,361 involving 18 communities (Asumah, 2015)

Agriculture is the predominant occupation for about 70% of the people in the Municipality.

Trade and commerce employs about 7%, service 4.2% and public servants 4.2%. Major crops cultivated are cocoa, oil palm, citrus, maize, cassava, plantain and cocoyam.

The main mode of transport is by road. Conditions of some roads are very deplorable, hindering economic activities. There are telephone facilities with all the six network services available in Ghana (MTN, Vodaphone, Tigo, Airtel, Expresso and Glo).
Accessible radio stations are Adom, Peace, Eastern, Unique and the main one located in the municipality known as Thank U FM (Asumah, 2015).

Health delivery is the direct responsibility of the Municipal Health Administration (MHA), a decentralized agency under the Municipal Assembly. The nine sub municipalities including Nankese is headed by sub municipality team leader who attends monthly and quarterly Municipal Health Management Team (MHMT) meetings to give report on their activities and level of implementation of their action plan.

The MHMT draws an action plan at the beginning of each year within the broad framework of national and regional goals. This guides and facilitates service delivery and the overall administration of the municipality. It serves as a tool for evaluation of the municipality performance.

Private health facilities, chemical seller’s spiritual and herbal centers in Nankese include J. A. Arthur Atwaken prayer camp, Kwayisi Christian herbal center, Benjamin Opoku, Juliana Abena, Daniel K. Agbedanu, Alexander Ayerenkwa and Danso Atimoa Addo chemical shops. The Municipal health administration in collaboration with these private health practitioners see to the health of the populace (Asumah, 2015).

A league table is drawn on monitoring exercise and feedback is given on their strength and weakness. Nankese sub municipality was chosen for this research because it is one of the three major zones with 18 communities making its population large for the study. Nankese has a projected 494 expected pregnancies out of a total of 4053 in the nine sub municipalities in 2015. The above information indicates that Nankese Health Antenatal Clinic and delivery expectation for the year should increase.
Fig 3.1: Map of Suhum Sub-Municipalities
Source: Health Profile 2015, Suhum Municipality Health Administration compiled by Gabriel LansahAsumah (MHIO).

3.3 Data Collection Technique

3.3.1 Instrument/Tool for quantitative data collection

The quantitative data was collected by aid of a structured questionnaire which was issued to women with babies under five years in Nankese sub municipality. These women were selected at the postnatal clinic conducted at the health facility and the CHPs zone. The questionnaire was sectioned into five and designated as A, B, C, D and E. The first section covered demographic data of respondents, sections B, C and D captured the three specific objectives that were set in the order they appear in the objectives section and
section E sought recommendations from respondents on how situations can be improved pertaining to patronage of FANC and delivery services. The researcher employed the Likert scale of measurement at certain sections of the questionnaire. This scale is used to determine the opinions of attitude or subject and contains a number of declarative statements with a scale after each statement. The original version of the scale consisted of five categories. A scale of five (5) points was used to measure importance and quality of service using ranking technique. The measure of importance had five points being excellent, very good, good, poor and very poor and designated 1, 2, 3, 4, and 5.

3.3.2 Qualitative data collection

Qualitative data was collected at the facility level (health center and CHPs zone) through a key informant interview of one midwife, two other health workers, one service personnel at the health facility and one community member. The health workers were employed in other to elicit answers pertaining to institutional based challenges that contributed to patronage of both services. An audio recorder was used to record proceedings and discussion to ensure that all data and information was accurately captured during the interview.

3.4 Sample size calculation

The sample size of a study is a section of the population that is drawn to make inference or projections to the general population.

The size was calculated using the Cochran (1963); using the formula:

$$n = \frac{z^2pq}{d^2}$$
Z being the confidence limits which in this study was 95% level of confidence and 1.96 as critical value.

p as the assumed prevalence of the dependent variable; the proportion of pregnant women who delivered at a health facility in the Suhum municipality (66.7%=0.67).

q as the acceptable deviation from the assumed proportion (1-0.67=0.33).

d as the margin of error around p estimated as 0.05 in this study.

Therefore, \[ n = (1.96)^2 (0.67) (0.33) ÷ (0.05)^2 \]

\[ n = 339.8 = 340 \]

Questionnaires were issued out to a total of 340 women attending postnatal clinic.

3.5 Sampling Method and Population

The study population is the set of all individuals or units who are prospective respondents for a study. It is from this population that a sample is selected to represent the whole and also serve as the source of data collection. The study population is dependent on the inclusion criterion that has been set which in this study was; women who have delivered not more than five year ago in the Nankese sub-municipality.

The inclusion criterion was set based on the fact that women who had not delivered yet might be bias in answering some questions such as “where do you intend having your unborn baby”. Woman who had already delivered were therefore in a better position to answer a question on the factors that contributed to their decision on place of delivery.

The study adopted simple random sampling method, which is a probability sampling technique for its quantitative data collection. With this technique each unit in the target population has an equal chance of being selected, and has the advantage of reducing the
error margin of results. Sampling of respondents was based on the schedule and attendance of postnatal attendance and schedules at both the health center and CHPs zone to select participants. This sampling method concentrated on participants of particular characteristic (inclusion criterion) who were better able to assist with information relevant to the study. The Tuesdays in the second and third weeks of every month were noted for heavy attendance of postnatal clinic by mothers and data collection took place on those designated days.

On the field, simple random sampling technique was achieved by the balloting. In the process, prospective respondents balloted for paper cuts labeled ‘yes’ among those labeled ‘no’. A total of four hundred labeled paper cuts were folded and placed in a basket from which postnatal mothers picked. Mothers who picked paper cuts labeled ‘yes’ were sampled whereas those who picked ‘no’ were not recruited for the sampling process.

Qualitative data was also obtained using purposive sampling method. Purposive sampling was employed as the researcher deemed it necessary to sample only individuals who could give necessary information needed for the study. Participants were selected based on their contribution to health care in the health facility at the study settings and an opinion leader in the community. This was done with the purpose of obtaining on-the-ground information on the issue under study.
3.6 Data Processing and Analysis

3.6.1 Quantitative data analysis

Data analysis is the process of making meaning out of any data set and drawing conclusions from them. The quantitative data were analyzed using Statistical Package of Social Sciences (SPSS) Version 20.0. Using the chi-square test of association, the relationship between the dependent and independent variables was measured.

3.6.2 Qualitative data analysis.

The aim of this analysis was to understand more of the experiences reported by the participants (Knudson, & Coyle, 2002) by the following methods: reading and rereading descriptions, extracting significant statements, formulating meanings, and categorizing into clusters of themes and validating to identify experiences common to all informants with original text. According to Cohen et al. (2003) the data analyses is involved with transcribing the recorded data, coding and organizing the data under themes in the case of the qualitative data. In this study the key informant interview data was analyzed by the thematic approach. The responses were transcribed verbatim, themes and sub themes formulated and discussed accordingly.

3.7 Training of Research Assistants

The research team involved two research assistants and the researcher as the facilitator. A session of training of team members was organized for accurate collection of data from respondents. The training session covered a period of two days and this enhanced maximum understanding of the task at hand.
3.8 Quality Control

Standardized data were collected to gain a consistent and precise data through trained research assistants. This was done with the intention of meeting the objectives of the research. The researcher was present on the field to participate and supervise proceedings and to ensure accurate and quality collection of data.

3.9 Pilot Testing of Instrument

Awanta and Asiedu-Addo (2008) cautioned that it is possible to design a questionnaire that is reliable because the responses are considered, but may be invalid because it fails to reward the concept it intends to examine and fail to achieve the aims of the study. According to Cohen et al. (2003) citing Wilson and Maclean (1994), piloting is able to help in establishing the reliability, validity and practicability of the questionnaire because it serves among other things to check the clarity of the questions, give feedback to validity of text items and also to make sure that the data items answered the research questions.

With the above concern in mind, the questionnaire was evaluated for content as well as face validity. The research instruments were pilot tested, using ten women with babies less than five years in Koforidua Medical Village RCH. The rational for the pilot testing was to establish the reliability and validity of the questionnaire.

The process was conducted carefully and attention given to any comment that was given by respondents. The data collection instrument was then taken through a rigorous
evaluation and necessary amendments were made before the main data collection was conducted.

### 3.10 Measures for trustworthiness

With the intention of ensuring credibility, dependability, conformability and transferability, the following procedures were followed: To ensure credibility, the researcher employed the following measures: All participants were taken through the same main question, debriefing with informants, and any additional information was taken into consideration during analysis (member checks). The participants were interviewed to the point at which there was data saturation (prolonged engagement) and the interviews were audio-recorded and transcriptions were made of each interview (referral adequacy).

### 3.11 Dependability

This was achieved through a dense description of the methodology used to conduct the study, and a dense description of the data. The data was organized in themes and sub-themes. All interview materials, transcriptions, documents, findings, interpretations, and recommendations, were kept, to be available and accessible to the supervisor and any other researcher, for the purpose of conducting an audit trail.

The researcher ensured confirmability by audit trail of the verbatim descriptions, categories and subcategories. The researcher provided a dense description of the research methodology, the participants’ background, and the research context to enable
someone interested in making a transfer, to reach a conclusion about whether transfer could be possible or not.

3.12 Ethical Consideration

Ethical clearance was sought from the Ethical Review Board of Ghana Health Service. Permission to proceed with the study was obtained from School of Public Health, Legon and the health management team of Nankese sub-municipality. An informed consent from participants with clear explanation of procedure was sought. 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.
CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents quantitative results of the study from 340 women who reported for postnatal care. The descriptive part of the study deals with the demographic characteristics of the respondents, the perception towards focused antenatal care that is being rendered and the practices in relation to attending antenatal clinic sessions in the study setting. The second section of quantitative results covers inferential statistics from the data obtained.

A qualitative result obtained from 5 key informants from both the facility and community is also presented in this chapter to highlight the institutional based factors affecting patronage of delivery services in the study setting.

4.1 Quantitative Results

4.1.1 Socio-demographic characteristics

Table 4.1 gives a summary of the results on socio-demographic features of respondents who were captured in this study. It was observed that the mean age was 30.6 years, married (67%) and those with junior high educational level (64.4%) were in the majority.

From the table, Akans (41.5%) were the majority, followed by Krobos (33.8%). With regards to occupation, traders (46.5%) were the majority, and then came individuals involved in other forms of occupation such as apprenticeship, hairdressing and food vending. Since Nankese is a small town, most of the respondents (36.6%) lived around the health facility in about a kilometer radius. It was also identified that respondents
having one child were the majority (32%). It was observed that most of the respondents (63.1%) lived with their husbands.

**Table 4.2: Socio-Demographic Characteristics of Respondents**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency</th>
<th>Percent</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age distribution</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19 years</td>
<td>46</td>
<td>13.5</td>
<td>30.6</td>
<td>1.27</td>
</tr>
<tr>
<td>20-24 years</td>
<td>74</td>
<td>21.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-29 years</td>
<td>83</td>
<td>24.4</td>
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<tr>
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<td>Senior high /vocational/technical school level</td>
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<td>Larteh</td>
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<td></td>
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<td>Northern tribes</td>
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<td>11.2</td>
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<td></td>
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<tr>
<td>Ga</td>
<td>9</td>
<td>2.6</td>
<td></td>
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<tr>
<td>Total</td>
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<td></td>
</tr>
<tr>
<td>Housewife/unemployed</td>
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<td>18.8</td>
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<tr>
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<tr>
<td><strong>Distance of residence from health facility</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 kilometer</td>
<td>124</td>
<td>36.5</td>
<td>2.29</td>
<td>1.294</td>
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<tr>
<td>1-2 kilometers</td>
<td>94</td>
<td>27.6</td>
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<tr>
<td>3-5 kilometers</td>
<td>47</td>
<td>13.8</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>More than 10 kilometers</td>
<td>25</td>
<td>7.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of children</td>
<td>1</td>
<td>108</td>
<td>32</td>
<td>2.5</td>
</tr>
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<td>-----</td>
</tr>
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<td></td>
<td>2</td>
<td>78</td>
<td>23.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>61</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>58</td>
<td>17.2</td>
<td></td>
</tr>
<tr>
<td>More than 4</td>
<td>33</td>
<td>9.8</td>
<td></td>
<td></td>
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</table>

<table>
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<tr>
<th>Person respondent lives with</th>
<th>Husband</th>
<th>214</th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In-laws</td>
<td>12</td>
<td>3.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents</td>
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<td>26</td>
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<td>Siblings</td>
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<td></td>
</tr>
<tr>
<td>Other</td>
<td>22</td>
<td>6.5</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Source: Survey Data, 2016

4.1.2 Perception of Importance of FANC among Women

Opinions of respondents with regards to the importance of FANC, rating of importance, rating of quality of delivery services, frequency of educating clients and the coverage of NHIS have been shown in Table 4.2. Almost all of the respondents indicated that FANC was important except one respondent who indicated that FANC was of no essence to pregnancy and birth. From the results obtained, it was mostly indicated by 51.1% of the women that it was a place where medication were given while checkups were done on the pregnant woman and the developing baby. This service also included giving pregnant women updates on the development and health of the baby (35.5%). They also brought to the light the fact that the service afforded them protection from complications and ailments during pregnancy, at delivery and post-pregnancy (13.4%).

Ratings of respondents with respect to how they perceived the quality of FANC services showed that majority (67.9%) agreed that the service was excellent whereas very few did not rate the service quality. More than half of the respondents, 175 (59.1%) perceived the delivery service as excellent; however very few of them, 7(2.4%) said it was poor.
The patronage of FANC has been presented as the frequency of utilization of FANC among respondents. Among the 338 respondents, the majority 207(61.2%) used the service always, while 3(0.9%) did not use the service at all. Others did not use the service frequently as was required (7.7%). It is observed that almost all (271, 95.1%) of the respondents who had NHIS coverage always used the FANC service. The results imply that NHIS affected the utilization of the service at the facility.
Table 4.3: Opinions and utilization of FANC

<table>
<thead>
<tr>
<th>FANC services</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Importance of FANC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>339</td>
<td>99.7</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Total</td>
<td>340</td>
<td>100</td>
</tr>
<tr>
<td><strong>Reasons for the importance of FANC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving medication and check-ups for pregnant women and developing babies</td>
<td>174</td>
<td>51.1%</td>
</tr>
<tr>
<td>giving pregnant women updates on the development and health of the baby</td>
<td>121</td>
<td>35.5%</td>
</tr>
<tr>
<td>protection from complications and ailments during pregnancy, at delivery and post-pregnancy</td>
<td>45</td>
<td>13.40%</td>
</tr>
<tr>
<td>Total</td>
<td>340</td>
<td>100</td>
</tr>
<tr>
<td><strong>Quality of FANC services provided</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>228</td>
<td>67.9</td>
</tr>
<tr>
<td>Very good</td>
<td>70</td>
<td>20.8</td>
</tr>
<tr>
<td>Good</td>
<td>34</td>
<td>10.1</td>
</tr>
<tr>
<td>No response</td>
<td>4</td>
<td>1.2</td>
</tr>
<tr>
<td>Total</td>
<td>336</td>
<td>100</td>
</tr>
<tr>
<td><strong>Quality of delivery services provided</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>175</td>
<td>59.1</td>
</tr>
<tr>
<td>Very good</td>
<td>75</td>
<td>25.3</td>
</tr>
<tr>
<td>Good</td>
<td>15</td>
<td>5.1</td>
</tr>
<tr>
<td>Poor</td>
<td>7</td>
<td>2.4</td>
</tr>
<tr>
<td>No response</td>
<td>24</td>
<td>8.1</td>
</tr>
<tr>
<td>Total</td>
<td>336</td>
<td>100</td>
</tr>
<tr>
<td><strong>Frequency of attendance of FANC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>207</td>
<td>61.2</td>
</tr>
<tr>
<td>Very often</td>
<td>84</td>
<td>24.9</td>
</tr>
<tr>
<td>Often</td>
<td>21</td>
<td>6.2</td>
</tr>
<tr>
<td>Not often</td>
<td>23</td>
<td>6.8</td>
</tr>
<tr>
<td>Never</td>
<td>3</td>
<td>0.9</td>
</tr>
<tr>
<td>Total</td>
<td>338</td>
<td>100</td>
</tr>
<tr>
<td><strong>Frequency of health education at FANC clinics</strong></td>
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</tr>
<tr>
<td>Always</td>
<td>182</td>
<td>53.5</td>
</tr>
<tr>
<td>Very often</td>
<td>103</td>
<td>30.3</td>
</tr>
<tr>
<td>Often</td>
<td>36</td>
<td>10.6</td>
</tr>
<tr>
<td>Seldom</td>
<td>10</td>
<td>2.9</td>
</tr>
<tr>
<td>Never</td>
<td>9</td>
<td>2.6</td>
</tr>
<tr>
<td>Total</td>
<td>340</td>
<td>100</td>
</tr>
<tr>
<td>NHIS coverage</td>
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<td>-----</td>
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</tr>
<tr>
<td>Total</td>
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<td>334</td>
</tr>
</tbody>
</table>

Source: Survey Data, 2016

4.1.3 Expectations and support

The support expected and received during FANC and delivery has been shown on Table 4.3. The table depicts that more than half of the women expected to receive medical support before the commenced antenatal clinic sessions. This was evident by as many as 195 (57.7%). Thirty-five (10.4%) of the respondents also mentioned they expected to be given emotional support during pregnancy. Thirty-two (9.5%) also stressed they expected social and medical support. These expectations might have propelled them to use the service. Medical support was mostly received by respondents as evident by more than half (58.5%), emotional support (11.5%) and a combination of financial and social support was stressed to have been attained by 39 (11.5%) of them. It was also recorded that some of the respondents had other forms of support which included nutritional support at times. Finally, the table illustrates that more than half 172 (55.3%) of the respondents in this study indicated that they had only medical support followed by 57 (18.3%) attained emotional support from health care providers whereas a handful, 16 (5.1%) had social support. 35 (11.3%) of the respondents mentioned they received both medical and emotional support.

The table also presents the level of support by the family of respondents when they were pregnant and the difficulty in obtaining this support. The table indicates that almost half
(153, 45.4%) had excellent support; 146(43%) said it was very good whereas 3(0.9%) indicated that their families gave them very poor support when they were pregnant.

It is also presented that almost half of the sample of respondents (146, 43.1%) confirmed that attaining support from their families was very easy, 120(35.4%) added it was easy. On the contrary 8(2.4%) mentioned they had a very difficult time getting help from their families. Health education during FANC visits was received always by more than half, 182(53.5%) of respondents in this study, 103(30.3%) had education very often while 9(2.6%) reported of not getting any education during FANC visits.
Table 4.4: Supports expectations and actual outcome of FANC and delivery

<table>
<thead>
<tr>
<th>Expected support during FANC</th>
<th>Frequency</th>
<th>Percent</th>
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</thead>
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<td>Financial</td>
<td>4</td>
<td>1.2</td>
</tr>
<tr>
<td>Social</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Medical support</td>
<td>195</td>
<td>57.7</td>
</tr>
<tr>
<td>Emotional</td>
<td>35</td>
<td>10.4</td>
</tr>
<tr>
<td>Financial and social</td>
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<td>0.6</td>
</tr>
<tr>
<td>Financial and medical</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td>Social and medical</td>
<td>32</td>
<td>9.5</td>
</tr>
<tr>
<td>Social and emotional</td>
<td>3</td>
<td>0.9</td>
</tr>
<tr>
<td>Medical and emotional</td>
<td>8</td>
<td>2.4</td>
</tr>
<tr>
<td>Social medical and emotional</td>
<td>28</td>
<td>8.3</td>
</tr>
<tr>
<td>Other</td>
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<td>3</td>
</tr>
<tr>
<td>All options</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td>Total</td>
<td>338</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actual support during FANC</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Social</td>
<td>19</td>
<td>5.6</td>
</tr>
<tr>
<td>Medical support</td>
<td>199</td>
<td>58.5</td>
</tr>
<tr>
<td>Emotional</td>
<td>39</td>
<td>11.5</td>
</tr>
<tr>
<td>Financial and social</td>
<td>39</td>
<td>11.5</td>
</tr>
<tr>
<td>Social and emotional</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td>Medical and emotional</td>
<td>9</td>
<td>2.6</td>
</tr>
<tr>
<td>Social, medical and emotional</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>3.2</td>
</tr>
<tr>
<td>No response</td>
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<td>0.3</td>
</tr>
<tr>
<td>Total</td>
<td>340</td>
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</table>

<table>
<thead>
<tr>
<th>Actual support during delivery</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
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<td>Social support</td>
<td>16</td>
<td>5.1</td>
</tr>
<tr>
<td>Medical support</td>
<td>172</td>
<td>55.3</td>
</tr>
<tr>
<td>Emotional</td>
<td>57</td>
<td>18.3</td>
</tr>
<tr>
<td>Social and medical</td>
<td>5</td>
<td>1.6</td>
</tr>
<tr>
<td>Social and emotional</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Medical and emotional</td>
<td>35</td>
<td>11.3</td>
</tr>
<tr>
<td>Medical and social</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Social, medical and emotional</td>
<td>11</td>
<td>3.5</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>2.6</td>
</tr>
<tr>
<td>Total</td>
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<td>100</td>
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</table>

<table>
<thead>
<tr>
<th>Family support attained</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
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<tr>
<td>Excellent</td>
<td>153</td>
<td>45.4</td>
</tr>
<tr>
<td>Very good</td>
<td>146</td>
<td>43</td>
</tr>
<tr>
<td>Good</td>
<td>18</td>
<td>5.3</td>
</tr>
</tbody>
</table>
### Difficulty when accessing family support

<p>| | | |</p>
<table>
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<th></th>
<th></th>
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</tr>
</thead>
<tbody>
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<td>Very easy</td>
<td>146</td>
<td>43.1</td>
</tr>
<tr>
<td>Easy</td>
<td>120</td>
<td>35.4</td>
</tr>
<tr>
<td>Somehow easy</td>
<td>41</td>
<td>12.1</td>
</tr>
<tr>
<td>Difficult</td>
<td>24</td>
<td>7.1</td>
</tr>
<tr>
<td>Very difficult</td>
<td>8</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>339</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Survey Data, 2016

#### 4.1.4 Preferred place of delivery

Respondents were also assessed on their preference of delivery place, motivation on choice and assistance in deliveries. The results are shown on Table 4.8. The health facility is the preference for the majority (284, 83.8%) of respondents in this study. Delivery at home was also preferred by 38(11.2%). The results clearly showed that respondents were more enthused with delivering at the health facility as compared with home and other places such as the prayer camp and locations managed by traditional birth attendants.

Decisions for preferred place of delivery have also been shown on Table 4.8. Majority (72.4%) of the respondents in this study made a personal decision on their choice of place of delivery. Husbands also participated in decision making with regards to choice of place of delivery among the pregnant women as was indicated by 62(18.2%) of them. Some of the respondents (5.9%) stated they were motivated by their parents. Finally, very few (3.5%) were motivated by their peers with regards to choice of place of delivery.

From Table 4.4 the majority of the respondents (278, 83.5%) agreed that there was a relationship between place of FANC attendance and the preferred place of delivery. It
was however found that a considerable section, 55(16.5%) did not admit that there could be any connection. According to the respondents, the prime reason for place of FANC impacting on the delivery place was that the facility was easy to reach; they always had access to the facility and for continuity of care rendered by the midwife who initiated service during pregnancy. Some also indicated that the cost of transportation was a contributing issue to patronage of the same facility for delivery.

It is also indicated that almost all of the respondents (95.2%) agreed to the important for a midwife to see pregnant women through FANC. The reasons for its relevance were; most of the respondents indicated that they gave an affirmative response since the midwife was specially trained, well vested and experienced in issues of pregnancy, delivery and postnatal period. They were skilled in determining the right position of child, ensuring maternal health and could check the uterus opening. Others indicated that the midwife tells with much accuracy the time delivery could occur (expected date of delivery). From some of the respondents, they mentioned that the midwife knew much about them and knew how best to handle them during pregnancy and delivery. Despite the positive statements made, a handful of the respondents stated that the midwives did not have much time for them as a result it was probably not important to have the midwife taking pregnant women through the FANC period.
Table 4.5: Preferred of place of delivery

<table>
<thead>
<tr>
<th>Delivery place</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred delivery places</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>38</td>
<td>11.2</td>
</tr>
<tr>
<td>Health facility</td>
<td>284</td>
<td>83.8</td>
</tr>
<tr>
<td>Prayer camp</td>
<td>6</td>
<td>1.8</td>
</tr>
<tr>
<td>With TBA</td>
<td>6</td>
<td>1.8</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>339</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activates on choice of delivery place</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own decision</td>
<td>246</td>
<td>72.4</td>
</tr>
<tr>
<td>Husband</td>
<td>62</td>
<td>18.2</td>
</tr>
<tr>
<td>Parents` decision</td>
<td>20</td>
<td>5.9</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>3.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>340</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Delivery assistant</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>37</td>
<td>11</td>
</tr>
<tr>
<td>Midwife</td>
<td>256</td>
<td>76</td>
</tr>
<tr>
<td>TBA</td>
<td>33</td>
<td>9.8</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>337</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perceived link between FANC and delivery place</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>278</td>
<td>83.5</td>
</tr>
<tr>
<td>No</td>
<td>55</td>
<td>16.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>333</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relevance of midwife in FANC</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>314</td>
<td>95.2</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>4.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>330</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Survey Data, 2016
4.1.5 Frequency of visits and motivation for FANC attendance

The results indicate that majority of the respondents, 235 representing 70.1% were able to make at least four (4) visits or more to the clinic for FANC. On the other hand, 57 (17%) respondents were able to make one (1) visit during pregnancy. The other details have been shown in the table 4.14. Motivating for FANC attendance were provided which covered satisfaction with the care, demands by schedule, time availability, waiting time and midwives promptings. Almost half of the respondents 164(48.2%) indicated their satisfaction with care rendered as the motivating factor, 194(57.1%) of them said they were made to report for the service by the demands made by schedules for FANC. Other factors were time availability, waiting time and midwives` promptings.

The contribution of FANC attendance was confirmed to positively affect birth preparedness among the respondents as indicated by majority, 285(88.2%) respondent. Reason for this response were that FANC attendance afforded an avenue to attain information on the items needed for birth, about the period to expect labour and general medical preparation and cautions to be taken. For other respondents (38, 11.8%) it was indicated that FANC attendance did not lead to any preparedness in birth since they perceived labour and delivery had a separate pattern and requirement. Based on the response on the reasons for importance of FANC attendance in birth preparedness, most of them stated that they were informed on the list of items needed during pregnancy and right afterwards. To others, this was of great importance since it informed them of the health status of child and expectant mother and they had the chance to know the month or week their delivery was most probably. Family planning services were also made available to them in terms of education and practice.
The majority of the respondents 266 (82.9%) affirmed that utilization of FANC services contributed to healthy pregnancy and building of self-confidence. On the contrary 41(13.1%) indicated it did not make any contribution to healthy pregnancy.

Table 4.6: Frequency and motivation for FANC and connection with birth preparedness

<table>
<thead>
<tr>
<th>FANC uses and links</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of visits to FANC clinic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>57</td>
<td>17</td>
</tr>
<tr>
<td>2</td>
<td>28</td>
<td>8.4</td>
</tr>
<tr>
<td>3</td>
<td>15</td>
<td>4.5</td>
</tr>
<tr>
<td>4 or more</td>
<td>235</td>
<td>70.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>335</td>
<td>100</td>
</tr>
<tr>
<td><strong>Motivation for number of visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with care rendered</td>
<td>164</td>
<td>48.2</td>
</tr>
<tr>
<td>Demands made by schedule</td>
<td>194</td>
<td>57.1</td>
</tr>
<tr>
<td>Time availability</td>
<td>41</td>
<td>12.1</td>
</tr>
<tr>
<td>Long waiting time</td>
<td>38</td>
<td>11.2</td>
</tr>
<tr>
<td>Compelled by midwife</td>
<td>24</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Evident link for FANC attendance and birth preparedness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>285</td>
<td>88.2</td>
</tr>
<tr>
<td>No</td>
<td>38</td>
<td>11.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>323</td>
<td>100</td>
</tr>
<tr>
<td><strong>Degree of linkage between FANC attendance and birth preparedness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very important</td>
<td>211</td>
<td>64.7</td>
</tr>
<tr>
<td>Important</td>
<td>112</td>
<td>34.4</td>
</tr>
<tr>
<td>Somehow important</td>
<td>3</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>326</td>
<td>100</td>
</tr>
<tr>
<td><strong>Evident link for FANC, healthy pregnancy and confidence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>266</td>
<td>82.9</td>
</tr>
<tr>
<td>No</td>
<td>42</td>
<td>13.1</td>
</tr>
<tr>
<td>Cannot tell</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>321</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Survey Data, 2016
4.1.6 Factors contributing to patronage of FANC and place of delivery

Table 4.6 is a composite tabulation of responses on the factors that contribute to patronage of FANC and the preferred place of delivery. The factors have been categorized into personal and institutional factors against patronage of FANC. Details of the results have been shown on Table 4.24 where only the positive responses were recorded in frequency and percentages. The results indicated that majority (15.6%) mentioned previous experience under personal factors, whereas waiting time (12.9%) and lack of facilities (15.9%) were the main institutional contributors to patronage of FANC services.

With regards to personal factors affecting place of delivery majority, 97 (28.5%) mentioned financial constraints while 49 (14.4%) indicated lack of facilities as hindering delivery at the institutional level. The table also presents responses indicating that Lack of time, busy work schedule, mistrust in system/service and lack of family support were not strong influence on the use of delivery services at the health facility. Mistrust in the service rendered at the health facility was observed with regards to referral system in cases of complications. Very few of the respondents indicated there was no means of transportation such as a functional ambulance to the main health facility.
Table 4.7: Factors contributing to Patronage of FANC and facility delivery

<table>
<thead>
<tr>
<th>Contributing factors</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of time</td>
<td>33</td>
<td>9.7</td>
</tr>
<tr>
<td>Busy work schedule</td>
<td>33</td>
<td>9.7</td>
</tr>
<tr>
<td>Mistrust in system/service</td>
<td>26</td>
<td>7.6</td>
</tr>
<tr>
<td>Positive previous experience</td>
<td>53</td>
<td>15.6</td>
</tr>
<tr>
<td><strong>Institutional factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting time at facility</td>
<td>44</td>
<td>12.9</td>
</tr>
<tr>
<td>Lack of facilities</td>
<td>54</td>
<td>15.9</td>
</tr>
<tr>
<td>Availability of resources</td>
<td>25</td>
<td>7.4</td>
</tr>
<tr>
<td><strong>Personal factors influencing place of delivery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of time</td>
<td>23</td>
<td>6.8</td>
</tr>
<tr>
<td>Busy work schedule</td>
<td>18</td>
<td>5.3</td>
</tr>
<tr>
<td>Mistrust in system/service</td>
<td>16</td>
<td>4.7</td>
</tr>
<tr>
<td>Previous experience</td>
<td>30</td>
<td>8.8</td>
</tr>
<tr>
<td>Lack of family support</td>
<td>10</td>
<td>2.9</td>
</tr>
<tr>
<td>Financial constraints</td>
<td>97</td>
<td>28.5</td>
</tr>
<tr>
<td>Lack of time</td>
<td>16</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Institutional factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting time at facility</td>
<td>37</td>
<td>10.9</td>
</tr>
<tr>
<td>Lack of facilities</td>
<td>49</td>
<td>14.4</td>
</tr>
<tr>
<td>Availability</td>
<td>26</td>
<td>7.6</td>
</tr>
</tbody>
</table>

Source: Survey Data, 2016

4.1.7 Chi-square test of association between dependent and independent variables

This section of the results and data analysis gives inferential account of the data obtained from respondents. The researcher deemed it necessary to test the relationship between the socio-demographics and attendance to FANC among respondents. The tests for
significant relationship between variables were done at 95% confidence interval and an alpha of 0.05. Both chi-square values and p-values have been presented. Cross comparison between demographic characteristics and utilization of ANC among pregnant women shows the relationship between the two variables and was to determine if a significance relationship occurred. The findings on the following have been tabulated on Table 4.7.

4.1.7.1 Age distribution and Utilization of FANC

Age could have affected the patronage of FANC among respondents as majority (66.4%) of them who used the service always were aged 25 years or older. It was however discovered that a smaller difference occurred between those who did not attend always with regards to the age groupings made. With respect to a statistical analysis of the extent of relationship ($x^2=3.047$, $p=0.081$) indication that age did not have any statistical significance to utilization of FANC among pregnant women sampled.

4.1.7.2 Marital status and Utilization of FANC

From the table above, more than half of the respondents who always used the service measuring 196 (67.6%) out of 290 respondents had married. A similar trend was recorded for those who did not use the service always.

It was however found that statistically there was no relationship between marital status and utilization of FANC implying that being married did not determine whether pregnant women will patronize FANC service ($x^2=0.631$, $p=0.427$).
4.1.7.3 Educational background status and Utilization of ANC

With the demarcations made on the educational background, majority (81.8%) of the respondents who always used the services had educational levels above junior high school level whereas a smaller percentage 18.2% had lower educational levels. Similar trend was observed for those who did not always utilize FANC. Despite the clear trend, it is seen that there is no statistically significant relationship between educational background and the utilization of FANC as a p-value obtained from the chi-square computation ($\chi^2=1.395$, $p=0.237$).

4.1.7.4 Employment status and Utilization of ANC

Constant visitation to the facility for FANC was mostly done by the employed (83.1%) whereas 16.9% of this group. Also majority of them 68.0% who did not always use the service were employed. Statistically there was a significant relationship between the trends of utilization and employment ($\chi^2=5.992$, $p=0.014$). By implication, it can be stated that utilization of FANC was not by chance with respect to employment statuses of respondents.

4.1.7.5 Geographical location of health facility from residence and Utilization of ANC

Respondents who resided within a 2 kilometer radius and always used the service were majority measuring 188(64.6%) out of 291 and those who lived farther were 103(35.4%) of the sample. Further details on those who did not always patronize FANC are shown on Table 4.24. There was not statistical significance ($\chi^2=0.011$, $p=0.918$) between the distance from health facility and the utilization of FANC among respondents.
4.1.7.6 Parity and Utilization of FANC

The table also indicates that there is no statistically significant relationship between parity and utilization of FANC ($x^2=4.06^a$, $p=0.524$). It is implied that the number of children did not have any effect on whether respondents will attend FANC more or less during their pregnancies.

4.1.7.7 Coverage by NHIS and Utilization of FANC

It is observed that a very strong relationship occurred between coverage under NHIS and utilization of the FANC service ($x^2=23.766^a$, $p=0.000$). It is observed that almost all (271, 95.1%) of the respondents who had NHIS coverage always used the FANC service. The results imply that NHIS affected the utilization of the service at the facility.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Utilization of ANC</th>
<th>Total</th>
<th>X² value</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age distribution</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24years</td>
<td>98(33.6%)</td>
<td>22(46.8%)</td>
<td>120</td>
<td>3.047a</td>
</tr>
<tr>
<td>25 years or older</td>
<td>193(66.4%)</td>
<td>25(53.2%)</td>
<td>218</td>
<td></td>
</tr>
<tr>
<td></td>
<td>291(100%)</td>
<td>47(100%)</td>
<td>338</td>
<td></td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>196(67.6%)</td>
<td>29(61.7%)</td>
<td>225</td>
<td>0.631a</td>
</tr>
<tr>
<td>Single</td>
<td>94(32.4%)</td>
<td>18(38.3%)</td>
<td>112</td>
<td></td>
</tr>
<tr>
<td></td>
<td>290(100%)</td>
<td>47(100%)</td>
<td>337</td>
<td></td>
</tr>
<tr>
<td><strong>Highest educational level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below junior high school</td>
<td>53(18.2%)</td>
<td>12(25.6%)</td>
<td>65</td>
<td>1.395a</td>
</tr>
<tr>
<td>Above junior high school</td>
<td>238(81.8%)</td>
<td>35(74.4%)</td>
<td>273</td>
<td></td>
</tr>
<tr>
<td></td>
<td>291(100%)</td>
<td>47(100%)</td>
<td>338</td>
<td></td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>242(83.1%)</td>
<td>32(68.0%)</td>
<td>274</td>
<td>5.992a</td>
</tr>
<tr>
<td>Unemployed</td>
<td>49(16.9%)</td>
<td>15(32.0%)</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td></td>
<td>291(100%)</td>
<td>47(100%)</td>
<td>338</td>
<td></td>
</tr>
<tr>
<td><strong>Distance of residence from health facility</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 2 kilometers</td>
<td>188(64.6%)</td>
<td>30(63.8%)</td>
<td>218</td>
<td>0.011a</td>
</tr>
<tr>
<td>More than 2 kilometers</td>
<td>103(35.4%)</td>
<td>17(36.2%)</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td></td>
<td>291(100%)</td>
<td>47(100%)</td>
<td>338</td>
<td></td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 child</td>
<td>91(31.5%)</td>
<td>17(36.2%)</td>
<td>108</td>
<td>.406a</td>
</tr>
<tr>
<td>More than 1 child</td>
<td>198(68.5%)</td>
<td>30(63.8%)</td>
<td>228</td>
<td></td>
</tr>
<tr>
<td></td>
<td>289(100%)</td>
<td>47(100%)</td>
<td>336</td>
<td></td>
</tr>
<tr>
<td><strong>NHIS coverage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHIS coverage</td>
<td>271(95.1%)</td>
<td>35(74.5%)</td>
<td>306</td>
<td>23.766a</td>
</tr>
<tr>
<td>No NHIS coverage</td>
<td>14(4.9%)</td>
<td>12(25.5%)</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td></td>
<td>285(100%)</td>
<td>47(100%)</td>
<td>332</td>
<td></td>
</tr>
</tbody>
</table>

Source: Survey Data, 2016
4.1.3.3 Association between FANC attendance and Place of delivery

A significant correlation between the place of FANC attendance and the preferred place of delivery was observed (p<0.001). This implied that place of FANC influenced the choice of delivery place.

Table 4.9: One-Sample Test for FANC attendance influencing place of delivery

<table>
<thead>
<tr>
<th></th>
<th>T</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
<th>Mean Difference</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>FANC attendance</td>
<td>54.66</td>
<td>334</td>
<td>&lt;.0001</td>
<td>1.203</td>
<td>1.16 to 1.25</td>
</tr>
<tr>
<td>contributing to place of delivery</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.2 Qualitative Data Analysis

According to the methodology of this study data collection was to cover both quantitative and qualitative methods. This was aimed at covering the opinions of health workers and community members on the institutional based factor that contribute to utilization of FANC and delivery services. The qualitative results seek to compensate results obtained from the questionnaire (quantitative data). Five key informants were interviewed of which four were workers in the health facility and one community member. The interview covered demographic characteristics and four main themes namely; attitude of health workers, Institutional challenges, relative distance to health facility and lack of education among nursing mothers. Designation of key informants was done with alphabets F and M for female and male genders respectively. CN, CM, SP and HW stood for community health nurse, community member, service personnel and health worker respectively. Ages were indicated in ranges for each informants.
4.2.1 Socio-demographic characteristic of participants

Table 4.9 presents summary of the socio-demographic characteristics of participants in this study. They were five (5) in numbers of which four were females and one was a male. Three were health workers in the facility; the male was service personnel whereas the remaining one was an opinion leader in the community. This variation was attained to arrive at diverse dimensions of view of how the FANC and delivery system was at the health facility and to assess the institutional factors that could impact on delivery of both services at Nankese.
Table 4.10: Demographic characteristics of participants

<table>
<thead>
<tr>
<th>Variables</th>
<th>Category</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age distribution</td>
<td>20-24years</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>25-29years</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>30-34years</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>35years or older</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5</td>
</tr>
<tr>
<td>Marital status</td>
<td>Married</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Single</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5</td>
</tr>
<tr>
<td>Highest educational level</td>
<td>Basic Certificate</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Diploma</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5</td>
</tr>
<tr>
<td>Religious affiliation</td>
<td>Christianity</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Islam</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5</td>
</tr>
<tr>
<td>Tribe</td>
<td>Krobo</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Akan</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Ewe</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5</td>
</tr>
<tr>
<td>Profession</td>
<td>Midwife</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Community health Nurse</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Health assistant</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Service personnel</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Non health worker</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: Field Data, 2016
Table 4.11: Summary of results into themes and subthemes

<table>
<thead>
<tr>
<th>MAIN THEMES</th>
<th>SUBTHEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTITUDE OF HEALTH WORKERS</td>
<td>Negative attitude of some health workers</td>
</tr>
<tr>
<td></td>
<td>Impatience among some health workers</td>
</tr>
<tr>
<td></td>
<td>Lack of provision of privacy for FANC patronisers</td>
</tr>
<tr>
<td>INSTITUTIONAL CHALLENGES</td>
<td>Lack of laboratory facility, rooms for individualized care</td>
</tr>
<tr>
<td></td>
<td>Lack of pharmacy</td>
</tr>
<tr>
<td></td>
<td>Lack of source of entertainment for clients</td>
</tr>
<tr>
<td></td>
<td>Lack of facilities and expertise in handling complications</td>
</tr>
<tr>
<td>RELATIVE DISTANCE TO HEALTH FACILITY</td>
<td>Distance to facility against ease in transportation to bigger health facilities.</td>
</tr>
<tr>
<td>LACK OF EDUCATION AMONG NURSING MOTHERS</td>
<td>Lack of education on service among the general public</td>
</tr>
<tr>
<td></td>
<td>Inadequate education on importance of FANC and facility delivery.</td>
</tr>
</tbody>
</table>

4.2.2 Attitude of Health Workers

The attitude of health workers has more to tell when it comes to the patronage of FANC services among pregnant women of most populations. In this study clear indication were made that point to the attitude of health workers impacting on patronage for FANC and delivery services.

4.2.2.1 Negative attitude of some health workers towards clients

The attitude of health staff has a direct influence on satisfaction of clients and is a measure of the quality of health care. Instances of inappropriate attitude of health personnel were identified under this subtheme. Patients seek some level of respect from
health workers and will not attend FANC if they are not treated with the respect they deserve.

Participants indicated that;

‘They do not know that the pregnant women should be pampered during delivery but shout at them sometimes’ (F2, HW, A<30).

4.2.2.2 Impatience among some health workers

According to some of the participants in the study, some health personnel do not exercise patience in handling clients. It is clear that patients visiting the facility present with ailments that render them depressed or agitated, as such there is a pressing need for health personnel to be extra careful and extremely tolerant with patients. Participants indicated that;

‘Some nurses do not exercise patience when handling clients at the facility. I even interviewed some pregnant women in the community on why they do not turn up for FANC and delivery at the facility. They said they could not bear the negative attitude of some staff at the facility’ (F1, HW, A>35)

‘Some of the nurses do not have patience for pregnant women’ (F2, CN, <30)

4.2.2.3 Lack of privacy

FANC involves an individualized care for pregnant women where personal issues are addressed in the holistic manner. The need for privacy can therefore never be over emphasized. In this study it was identified that some pregnant women did not received the privacy they deserved as stated by one participant that;
“The nurses do not ensure privacy for patients, for instance a pregnant woman had to partially undress at the OPD place for her temperature to be checked” (F4, CM, <24)

4.2.3 Institutional Challenges for both FANC and facility base delivery.

4.2.3.1 Lack of facilities

Any health facility should have the necessary facilities to be fully functional. In facilities where there are no laboratories, pharmacies and adequate space leads to poor patronage by clients. Clients fear that their lives can be at risk if they delay where they are aware there are inadequate facilities to care for their needs. The laboratory facility is an integral part of a health setup. This is justified by the fact that most health professional rely on the laboratory for effective diagnoses. Participants in this study therefore identified the loophole in the facilities as it was stated by a participant that;

‘We have just one delivery bed and if about three deliveries come at a go it gives problems since the midwife is only one and delivery bed is also one and we need more facilities but we don’t have much space for facilities we need’ (F2, HW, >30)

‘We need more facilities, scans, laboratory to make the care complete, increase consulting rooms, beds and counseling should be done to enlighten the public to patronize. We need rooms and the whole hospital should be completed as soon as possible and we need uniforms and raincoats so we can be mobile even when it rains’ (F1, HW, A>35)
4.2.3.2 Lack of source of entertainment for clients

Clients’ especially pregnant women who use the health facility expressed their boredom when they had to wait till it gets to their turn for medical attention. The need for a source of entertainment was stressed by one participant who mentioned that;

‘The pregnant women also have been stating that there is no source of entertainment like TV in the facility so they get bored when they attend’

(M1, SP, 23).

4.2.3.3 Inadequate personnel and expertise in handling complications

Staff strength of any institution should be adequate to handle the services rendered by the institution. The need for adequate health personnel is very important in the delivery of quality health care as it ensures a proper division of labour and enhances expertise and the best outcomes of care. In this study, inadequate personnel were expressed as a participant stated that;

‘Staff strength is six and is not adequate since most of the time if only one midwifes and there are three deliveries it could be a problem’ (M1, SP, 25-29).

4.2.4 Distance to facility against ease in transportation to bigger health facilities

4.2.4.1 Distance limitations

Distance had been noted to have a direct influence on health seeking behaviors in most studies. The study identified that the location of the health facility where FANC and
delivery services were available was a bit far from the inhabitants of Nankese. The problem of distance which influenced their utilization of the health facility was made prominent when there was easy access to transportation to the Koforidua or Suhum Township where there are bigger hospitals. The issue of distances and its effect on patronage of FANC and delivery at the health facility was indicated as;

‘The distance is halfway between Koforidua and Suhum, as such the pregnant women prefer boarding a bus at a cost of 2 cedis to these hospitals rather than walking all the way up the hill to the facility during delivery’ (F4, CM, 27)

‘Distance is another challenge so they prefer going to the main hospitals where they could get transportation in and out easily’ (N2, HW, 29)

4.2.5 Lack of Education

4.2.5.1 Inadequate education on importance of FANC and health facility delivery

The need for education on the importance of FANC and delivery at the facility and by a skilled person was stressed. It is observed that some pregnant women need to be made aware of the necessity to make attendance of FANC a priority. The general public should be disabused on their negative perception of FANC and delivery at the facility. In adequate education on FANC and importance of facility delivery were depicted in the following statements,
‘Durbars will help and encourage pregnant women. Also immunization, keeping surroundings clean and preventing diseases can be preached’

(M1, SP, 25-29)

‘Durbars have been organized for Presby and Pentecost churches, Other churches and the Muslim community will also need to be educated, even the others who used the facility will benefit from the education given in the facility’ (M1, SP, 25-29).
CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter presents a thorough evaluation of the results obtained from both the questionnaires and interviews. In all, three hundred and forty respondents and five key informants served as participants in the quantitative and qualitative data collection with the aid of a questionnaire and interview guide. The discussion below has been done by rationalizing results that have been obtained and compared with the existing literature in terms of deviations or conformities with other related studies. This is necessary to determine which areas need further investigation and the recommendations that are appropriate.

This study assessed the perception of FANC among women of Nankese concerning FANC attendance and choice of place of delivery. Demographic characteristics as age, gender, educational background, tribe, occupational/profession, and marital statuses were been investigated into and how they contributed to the utilization of FANC and delivery services at the health facility.

5.2 Perception of FANC among Women

The study found that most of the women know FANC to be the care given to women during their pregnancy period and it covered education, checkups on the health of the baby and expectant mother, medications and others. Others also indicated that the service was a very important one due to what is seeks to achieve. According to UNICEF (2004) antenatal care is the care giving during pregnancy and is essential for diagnosing and
treating complications that could endanger the lives of the mother and child. In this study, the responses given concerning perception of FANC resonated with that of the definition of UNICEF (2016). This finding showed the quality of education given to pregnant women who visit the facility for FANC.

From the finding in this study, it is indicated that the quality of FANC was very good or excellent as majority affirmed the quality of care received during FANC. Despite the quality of FANC portrayed through the rating, there were some few women who expressed their disapproval about the service, though the percentage was small (2.4%) compared to women who indicated it had high quality. The finding here points out how important the services are to most of the women in the township and presents that the service is achieving its aim and gaining much popularity among the women in the town. By standard, FANC is aimed at giving a more individualized care to pregnant women where they will be educated on how best to handle their pregnancy and their health as well. Education is given by well experienced health personnel who have the knowledge to impact needed information for a well-controlled pregnancy that ensures the health of the expectant mother and developing child. The Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO 2007) presents that the main purpose of FANC is to achieve a good mother and baby outcome during and after pregnancy, and prevent any complications that may occur in pregnancy, labour, delivery and postpartum. This is reflected in this study’s finding where most respondents indicated that FANC was aimed at caring for pregnant women by giving them the necessary medical attention and support at pregnancy, birth and right after birth.
Ekabua et al (2015) stressed that the quality of care of pregnant women was made better with FANC since it is constituted to ensure a better antenatal care that gives an individualized care and attention medically and gives support to cope better. In this form of care, each pregnant woman is given thorough evaluation intervention and promotion in the form of health education and counseling. Similarly, these points were identified in this study as mentioned by mothers who were sampled.

Findings here separated into positive reasons were centered on the fact that the health workers were devoted to them in terms of health care, education, and they established a good rapport and level of communication with them. In effect, they made them to feel well at home when they visited the facility for FANC. On the other hand, the negative attitude of nurses began to show up among those who indicated poor rating of their FANC service. The study identified poor communication, disrespectful attitude and lack of patience in handling pregnant women at times. Another issue that has the potential to ward off pregnant women from using the FANC service was the fact that some women indicated they had money taken from them unnecessarily. The Nankese community has inhabitants who are mostly petty traders and may not be much well to do in handling much payment. This could be a discouraging factor to the patronage of the services and even affect delivery at the facility.

Ekabua et al. (2015) mentions the need to adhere to the right practices and attitude of health worker for the best FANC outcomes. In this study it was noted that the majority of mothers experienced the right attitude towards them hence were encouraged to participate in the service.
On the contrary it was stressed by the mothers that in a situation where staff attitude was reproachable there is a high likelihood that patronage for the service will be poor. This present study’s findings is in line with the argument by Ekabua et al. (2015).

A similar trend was observed with the delivery at the facility. The finding on delivery quality was high as the majority of the participants indicated the health staff gave the needed attention, care, emotional support and other mothers had some social support. From the finding in this study, the health of the mother and baby were being catered for. It was brought to light again that some women were faced with poor attitude of health workers during delivery. This stresses the fact that health personnel still had room to perform better and encourage the patronage of delivery by skilled health personnel.

Conrad et al. (2011) points out that, health care workers played a critical role in advertising FANC to the general public by how they handle the service. In the service, it is required that they support the pregnant women with medical, emotional, social and other forms of support the pregnant woman required. Findings in this study affirm the level of quality of support that health workers provided even though some women had reservation concerning how they were treated at the facility.

The observed quality of FANC was asserted by the fact that the majority of women in this study (61.2%) used the service always. From the women, visits were attended based on their scheduled dates and were not missed by the pregnant women. This situation could be attributed to the education given to women who started FANC attendance early in pregnancy. According to Ekabua et al. (2015) education is one of the pillars of FANC as such with the right education and treatment given to pregnant women, there is a high
probability that pregnant women will continue the service and end up delivering at the facility where the service is rendered.

For any individual to venture into an enterprise there should be a motivation. Quality of care can therefore be evaluated based on the perception before service and afterwards. Expectations of women before initiating FANC at the facility found that more than half (57.7%) of them were expecting medical care though emotional, social and very few indicated financial support upon receiving FANC care. There were individuals who mentioned envisioning medical and social support from the service. There is a clear indication that pregnant women had in mind receiving various forms of support that they believed were necessary for their well-being. The diversity in responses is also an indication that the pregnant women had different needs peculiar to them despite their prime aim of receiving medical support from the facility.

To confirm the quality of care received by pregnant women who attended FANC services, study participants were asked to report the support they received after going through the service. It was found that service received corresponded with their expectation as more than half (55.3%) received medical support, others also received emotional (18.3%) and social (5.1%). It can be confidently mentioned that averagely, the quality of FANC care is adequately high as expectation mostly met performance of the service. Basically, medical support is the main provision made by the health personnel in the past with ANC; FANC however comes with the need for an individualized care as an integral part of the service. With this form of care, other support areas should also be fulfilled. The need to give emotional support as well as social support should go hand in hand with medical provisions. It was also identified that some pregnant women needed
financial support in the form of incentives that could encourage them to attend FANC as scheduled. A presentation of their economic status is presented here since those study subjects would not have mentioned expectation for financial support if they had strong economic statuses.

In the study by Nwaeze et al. (2013) where there was a high overall level of satisfaction with antenatal services among pregnant women, there was a marked reduction of waiting time, proper health intervention and education given to pregnant women who registered for the FANC. In their study it is clear that the expectation of clients had the performance of health workers superseding it and this was observed as quality care.

The family plays an important role of ensuring that important schedules are met, provides financial support, emotional support and any kind of help possible to ensure the wellbeing of the expectant mothers. In this study, the majority of participants indicated that they did received family support (43.1%). It was also found that a marginal percentage (2.4%) did not received family support or had it very difficult attaining any support from their families. There is therefore a need to bridge this gap by educating the general public on the need for family support.

An integral part of FANC is the giving of health education. The service therefore will not thrive if there is no education on basic care during the pregnancy period. To ascertain the quality of the service in another dimension, the women reported on the frequency at which education was given during FANC services. The study found that more than half (53.5%) of the women received education concerning pregnancy, child birth preparedness and postnatal practices that could enhance their health and that of the developing or
newly born child. This situation could have arisen due to the fact that the education of pregnant women was paramount in the service and the only instances one does not get any information as education was when they do not visit frequently. Currently there is a drastic increase in patronage in the country due to the widespread education that is ongoing on media and from other sources. It is therefore expected that patronage of FANC should ascend with time and further enlightenment of the general public.

The essence of FANC as indicated in this study by women was highlighted by JHPIEGO (2007) where it was specified that women develop complications if they are not given close monitoring and education on the best way to manage themselves during their pregnancy. There is a confirmation of the findings of the study. Abosse et al. (2010) also mentions that maternal education including age and other demographic characteristics were major predictors of antenatal care service utilization. Mothers who are given proper education through FANC services have been noted to patronize the service than those who do not have much information on the service.

5.3 Relationship between Antenatal Care and Place of Delivery

Issues concerning delivery were another critical issue that could have been affected by attendance of FANC among mothers. In this study, the researcher sought to determine the place of preference for delivery among women in the Nankese Sub municipality when pregnant, who precipitates their choice and the reasons for their choice. Findings attained pointed out that the majority (83.8%) of mothers preferred delivery at the health facility whereas a handful preferred delivery at home. In a study by Kitui et al. (2013), it was
mentioned that despite the education on the need for delivery in the health facility, pregnant women still resorted to home births as they found that less than 50% of the participants in their study used the skilled labour.

Despite the high preference for the health facility delivery, it was noted that some of them were accustomed to births at home. The need for positive staff attitude was described by Ekabua et al. (2011) and the report by UNICEF (2016) who present the standards of FANC in terms practices and attitude of health workers. The researchers mentioned the need for health workers to exhibit the best attitude possible towards their clients. They go on to indicate that many of the mothers captured in their study preferred using unskilled birth attendants simply because they treated them better, and are more familiar with them than the health workers in the facility. Another advantage for using the TBA is that they can be paid by cash or kind as indicated in the same study.

Education on the importance of antenatal care was well widespread in the community as the majority (72.4%) of the mothers made a personal decision to register for the service. It can be mentioned that gradually, the general public are being enlightened on issues concerning health adequately though some of them are still not well informed. Aniebue and Aniebue (2010) argue that women patronized FANC more when they are satisfied with the service rendered by health workers whereas the reverse occurs with poor antenatal care. In this study most of the mothers continued to attend FANC since they achieved what they expected for registering for the service.

Among the mothers, preference for delivery in the health facility was further confirmed when the majority (76%) of the mothers indicated that their deliveries were assisted
mostly by skilled health workers such as the midwife or the nurse. However, there were few mothers who did not use the facility during birth and resorted to TBAs. From the finding it can be inferred that more mothers are getting interested in the patronage of FANC and births at the health facility since the services of the TBA is dwindling gradually.

A significant relation was observed between FANC services given at the health facility and the place of delivery. This result implied that attendance of FANC clearly contributed to expectant mothers deciding they will deliver at the same facility. This contributed to the trust and friendship they had built over the period of pregnancy and FANC visits. According to Pervin et al. (2012) in the study on the association between antenatal care, facility delivery and perinatal survival, they found that ANC patronage is associated with increase in the uptake of health facility based delivery and improved perinatal survival. In effect, the place of FANC could influence choice of place of delivery with the right education and care.

This study also identified that majority of the mothers (83.5%) were in favor of the point that the attendance of FANC led to preference for health facility delivery. This was because the majority affirmed accessibility and availability of health workers in the facility always. These were expectant mothers who had much trust in the facility with regards to handling of pregnancy, delivery and postpartum issues of women. They were also assured that the health facility had competent staff to handle any complication that came their way.
Some mothers on the other hand who responded to the questionnaire stated that they harbored some fear in them concerning complications of pregnancy that might not be well catered for in the facility at Nankese. They also expressed their fear about the referral system since the Nankese facility does not have any emergency transportation as in an ambulance that is ready to convey emergency cases to the main hospitals. Mothers therefore will naturally tend to avoid the situation where they have to be taken to the main hospitals in Koforidua or Suhum in complicated states. These mothers will resort to going to the main hospitals than opt to delivery at the available facility.

In evaluating the role played by midwives, it was made clear that the midwife held a major role in FANC. About 95.2% of the mothers mentioned the importance of midwife handling FANC. Reasons given showed clearly that the mothers had some expectation that could be achieved with the midwife. Furthermore, the midwife was perceived as the health worker who had the knowledge and skill to impart knowledge in the form of education on prenatal and postnatal health issues as well as skillfully handling the pregnant women with the needed care and compassion especially during delivery. The midwife is therefore the pivot of the FANC service. Some of the merits of having a midwife taking a pregnant woman through FANC were to give them correct updates on their health status and that of the developing child. The expertise that the midwife had to give could not be overstated as they really played a vital role in FANC. Conrad _et al._ (2011) indicated the essence of experts taking up roles in managing FANC. This mostly fell to the midwife who is trained to provide care in pregnancy, birth and post-delivery. It was therefore expected that mothers in this study acknowledge the fact that the midwife’s role was indispensable if the success of FANC was desired. The finding in this...
study adequately confirms the delivery by Conrad et al. and also implied that the services of midwives were much appreciated. Conrad et al. (2011) stresses on the fact that health workers should comply to the procedures specified by FANC to ensure patronage of the service. Expertise in FANC was adequately provided by the midwife and expresses the importance of the midwife in handling the service.

One of the specific objectives of this study was to determine the patronage of FANC among mothers in the Nankese community and the sub-communities under it. From the findings, it is clear that patronage was high as evidence by 70.1% of them confirming they visited at least 4 times. In a recommendation by WHO (2012) which was aimed at determining the frequency and month of initiating antenatal care, it was found that the median number of attendance was four. In this study, a similar finding was made where the majority of mothers visited four times or more. FANC should be done for at least four times. According to WHO (2012), it is prescribed that ANC visits should be at least four times before delivery. In this study majority of mothers reported that, they made at least four visits or more implying compliance with the prescribed number of visits.

Among this group of mothers, the majority further indicated that they visited anytime they were scheduled till they delivered. Among those who patronize the FANC service, it was also worth noting that almost half of them (48.2%) were satisfied with the services rendered concerning FANC. Health seeking behaviors is mostly affected with quality care and satisfaction. It was therefore expected that this satisfaction should translate into high attendance rate and delivery at the health facility. Ekottet al. (2013) added that almost all mothers in their study were highly satisfied with the care they were given. The satisfaction of mothers was deep rooted in the health talks and education and with the
medical consultations. The remainder of the mothers added that they were propelled to report for FANC as their schedules demanded. This probably did not attend FANC based on their personal satisfaction with the service but on compulsion of some sort. It can therefore be indicated that they attended FANC not willingly and this could lead to a low patronage of delivery services when they were due.

In the delivery by Simkhada et al. (2008) it was indicated that satisfaction had no influence on utilization service. Satisfaction did not affect utilization since they perceived the care as mandatory and therefore attended FANC based on schedule.

Contribution of FANC attendance to birth preparedness, health and confidence of the pregnant women was also evaluated. Mothers were asked questions that elicited responses on whether FANC contributed to birth preparedness, health and confidence during pregnancy and child birth.

The study revealed that FANC contributed to the birth preparedness of pregnant women in many studies. It was recorded that almost all (88.2%) participants confirmed being informed of their needs for birth especially the items needed for labour, signs of labour and any sign of complications. JHPIEGO (2007) presented that FANC provided a woman with a plan about place of delivery, companionship, transportation, blood donor, items for clean and safe delivery. In this study, FANC attendance contributed to birth preparedness among pregnant women. The findings are in line therefore with the delivery by JHPIEGO (2007).
5.4 Factors Contributing To Patronage of FANC and Place of Delivery

Determining the factors that contributed to patronage of FANC and the places of delivery, it was clearly noted that two main factors did contribute negatively to patronage of FANC. These were financial constraints (28.5%) and lack of equipment needed by the health facility for care of pregnant women and those in labour as indicated by 14.4%. It was also noted that family support, mistrust in system and service rendered by the facility did not inspire the attendance of FANC by pregnant women.

UNICEF (2016) also stresses on the need to provide support from family, health facility situated in a shorter distance from pregnant women and financial support for women to enhance their patronage of FANC. These factors were identified as potent influence on the utilization of FANC and eventually delivery at the health facility. In this study an assessment of relationship between demographic characteristics and utilization of FANC, there was no significant relationship observed for age marital status, educational background, parity. However, employment status was one socio-demographic characteristic that significantly correlated with utilization of FANC among mothers.

According to Emelumadu et al (2014) age influenced patronage of FANC as they found that the older mothers patronized the service better due to experience they had attained. Women with 1 child were observed to patronize the service less. In this study however age and parity did not have a significant relationship with utilization of FANC. In the study by Bbaale (2011) educational background of women influenced their utilization of FANC. This was because they had information on the service and perceived it as important for healthy pregnancy and childbirth. In this study’s findings points raised by UNICEF (2016) have been proven to influence FANC attendance. This implies that those
who had employment as against those without employment gave significant difference in relation to patronage of FANC. It can be deduced that women with poor finances were negatively influenced and could not attend FANC by not affording transportation to the facility (Simkhada et al. 2008) indicated in their study that employment had a direct effect on the utilization of FANC among pregnant women. This was because they observed that women who could not afford the means of transportation to the health facility could not attend antenatal care sessions. It was also found that coverage under NHIS had a strong relationship with the patronage of the service since almost all the mothers (92.2%) had health insurance coverage in a study by Owu and Lambon-Quayefio (2013), it was also found that mothers who had NHIS patronized the service more. This could have a connection to financial constraints limiting others form using the service. Findings by Asundep et al. (2013) pointed out that ANC attendance was influenced by financial limitations. They stated that the NHIS should be widely employed by pregnant women to cut down the cost of health seeking.

5.5 Attempts to Improve the Patronage of FANC

In an attempts to improve the problem of incomplete patronage of FANC among women of reproductive age staying in the Nankese Community and it neighboring villages, participants suggested possible solutions to the problem of not having all mothers patronizing the service, and the factors that could make the health facility well composed in handling any birth related issues such as complications or effective referrals.
Four major areas of consideration were suggested. These areas were communication between health worker and clients, upgrade of facilities in the health facility and an increase in staff strength and motivation of staff through increase in salaries and bonuses. These points were also mentioned by participants in the interviews.

Participants in this study also made mention of the need for facilities and space for them. The need for staff and health facilities cannot be overstated in any way since it forms the backbone of FANC as indicated by Yengo (2007) who argued that the health care workers perceived FANC as beneficial both to the pregnant mother and the unborn baby, however this benefit is not achieved with an incapable workforce and available material resource for the service.

A collection of problems leading to the low patronage of skilled birth attendants were identified as primarily caused by lack of education. It was therefore advised that education should be spearheaded by the health workers and carried on by peer education such that all women including their husbands can be abreast with the importance of FANC and skilled birth attendant to their wives.

Conrad et al. (2011) encouraged education for pregnant women as the mainstay of the FANC service. It is through education that the pregnant woman buys the idea of effective health seeking behavior and gets to know the services available that can enhance the health of the pregnant women and the developing child. In this study the recommendations mentioned above shows the need for education of women of reproductive age to enhance the health seeking behavior. These choices include the patronage of skilled birth care. The findings showed that education is the main driving
force that could be used to capture the interest of more women of reproductive age to utilize the service.

5.6 Discussion of results from key informant interview

Below is a discussion of the results from key informant interview captured in the interview. The study identified four main themes namely; attitude of health workers where it was further found that some health workers exhibited negative attitude. It was also observed that some key informants did not appreciate the impatience nature of some health workers. It was mentioned that some health workers did not provide the privacy mothers needed when taking to them during FANC. The study by Conrad et al. (2011) stated that health care workers had a vital role to play and should be professional in their duties during FANC. One area worth mentioning is to ensure privacy. This privacy was lacking according to the finding in this present study.

Some of the participants in the interview mentioned that some pregnant women are examined at the OPD where privacy cannot be ensured especially during the checking of vital signs such as temperature. The health facility has little space hence FANC cannot be well achieved in privacy. Quality of care from the facility was stressed by Ekott et al. (2012) as a factor that can influence patronage of FANC. Since privacy is an important facet of FANC, any dent on the privacy affects quality of care and FANC patronage.

The study also identified some institutional challenges as was captured as a main theme and under this it was found that the facility had lack of facilities such as laboratories, rooms for individualized care, lack of pharmacy and lack of entertainment for clients during their waiting time. The informants clearly identified that the facility was not well
equipped with regards to facilities to handle health problems and pregnancy related issues completely. The lack of a laboratory had an influence on the diagnostics of the facility. Patients with more complicated diseases have to go to the bigger hospitals where there are fully equipped laboratories. Ekott et al. (2012) identified a lack of amenities and facilities as influencing FANC patronage and health seeking behavior in general. In this study delivery is negatively affected in this present study.

According to one key informant, it was indicated that pregnant women or clients complain there is no source of entertainment at the facility. They indicated that a source of entertainment was necessary to while away time when they are in queues at the facility. The health facility also had inadequate expertise and health workers such as midwives. The need for more health workers was therefore stressed by some of the key informants. The finding on inadequate health workers was also stressed by Yengo (2007) who argues that shortage of human and material resources obstructed efficacious implementation of FANC.

Distance to the health facility was another issue that earned a place as a main theme. Here the key informants mentioned that the health facility is situated on a hilly position in the community and sometimes deterred pregnant women from using the place during delivery. It was identified that some women prefer picking a bus to the main cities for delivery to getting to the health facility in the community when they are due for delivery. Ewa et al. (2012) mentioned distance as a factor influencing patronage of FANC among mothers. It is noted in this study that distance did not significantly affect FANC attendance but influenced delivery at the facility.
Education of women of reproductive age especially on the importance of FANC during pregnancy was emphatically spelt out. This education was to capture all individuals who were within the reproductive age and not only pregnant women. To disabuse all negative ideologies concerning FANC attendance education should be well given to women in the community such that they can make personal choices to participate in the service. According to Carolan and Cassar (2008) the need for education on the African Population was of great essence if the perception of FANC is to be changed. They made this point when the factors’ affecting the utilization of FANC was assessed. This study’s findings therefore agree with that of Carolan and Cassar (2008).

Some limitations of the study are discussed. The study dealt with indigenes of Nankese from diverse tribes composed of Krobo, Akan, Ewe and Ga. Since the data collection tool was in English much time was spent translating the questions to respondents. Financial constraints also affected data collection process as the researcher self-funded the study. It is also worth mentioning that time limitations did not allow data gathering from a large number of key informants.
CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The majority of mothers in present study had positive attitudes towards FANC, employment status, distance to health facility and coverage under NHIS related with the attendance to FANC and FANC attendance positively related with the place of delivery. These findings highlight the need for education on FANC services and the allocation of resources to enhance the delivery of effective FANC services to mothers. The findings also identify some linkages with the conceptual framework presented in the first chapter. It was found that a strong relationship occurred between FANC attendance and preferred place of delivery among women. Occupation of pregnant women and NHIS coverage, all connected to affordability, had a direct influence on FANC attendance.

6.2 Recommendations

Recommendations given in this study covers the areas of provision of facilities, increase in staff strength and motivation of staff.

- It is recommended that the facility should acquire the needed facilities to serve the users of FANC services and provide adequate delivery services for those who patronize the facility for delivery. Items such as ultra sound scan machine, laboratory equipment and more delivery beds. This can be done by soliciting for funds through proposal writing to Non-Governmental Organizations, prominent opinion leaders and interested individuals to donate funds that can aid in
acquisition of the needed facilities. This will go a long way to enhance the quality of health care in terms of effectiveness and efficiency of care.

- The Suhum Municipal health directorate should advocate for more health personnel to be posted to the municipality in order to reduce the workload on health staff. By increasing the staff strength of the facility in Nankese sub municipality, the pressure and stress will be reduced. More personnel with antenatal, delivery and postnatal knowledge and skills could be appointed to aid with FANC and delivery services. This will enhance health workers to give out their best in service delivery to the sick and pregnant women who require attention in the administration of FANC.

- Health staff should be motivated and encouraged to keep up a good attitude towards their client in order to enhance optimal relationship with them. This can be in the form of incentives and bonuses. With this measure on board, delivery of health services to the pregnant woman during FANC and labor will be executed effectively.
REFERENCES


UNICEF, Progress for Children beyond Averages: Learning from the MDGs, New York, 2015

UNICEF, Progress for Children beyond Averages: Learning from the MDGs, New York, 2016


Yengo, M.L. (2009). Nurses’ perception about the implementation of focused antenatal care.
APPENDICES

Name of Researcher: Senyo Gloria Akorfa

Name of Institution: University of Ghana, Legon. School of Public Health

Proposal Topic: The attendance to Focus Antenatal Care Clinic and the Place of Delivery in Suhum Municipality.

This form is in two sessions:
- Information on the study
- Certificate of consent

Introduction

For academic purposes, this study seeks to address a number of issues pertaining to the attendance of antenatal and the choice of delivery place by pregnant women, and therefore Your full participation will be of great help to the success of this research. This research will go a long way to improve health service quality in the community and nation at large.

Purpose of Research

Focus Antenatal Care (FANC) is an approach designed to improve maternal health during, before and after pregnancy and delivery outcomes. We believe that You can help us by telling us what You know about both perception about FANC and factors influencing a pregnant woman’s choice of delivery place.

Type of research intervention

This research will involve your participation in an in-depth interview or questionnaire answering that will take forty-five minutes of your precious time.
For in-depth interview

During the interview, I or another interviewer will sit down with you in a comfortable place. If it is better for you, the interview can take place in your home or a friend's home.

If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but the interviewer will be present unless you would like someone else to be there. The information recorded is confidential, and no one else except the research team will access to the information documented during your interview. The entire interview will be tape-recorded, but no-one will be identified by name on the tape. The tape will be kept under lock at researchers home. The information recorded is confidential, and no one else except the research team will have access to the tapes. The tapes will be destroyed after data has been analyzed.

For questionnaire survey

You may answer the questionnaire yourself, or it can be read to you and you can say out loud the answer you want me to write down.

If you do not wish to answer any of the questions included in the survey, you may skip them and move on to the next question.

Information recorded is confidential, your name is will not be included on the forms, only a given number or code will identify you, and no one else except the research team will have access to your answers provided in the survey.

Participant selection

You are being selected to participate in this research because we feel that your experiences and responses as a mother residing in this community can contribute much to our understanding and knowledge on FANC practice and influences on choice of delivery
place.

**Voluntary Participation**

Your participation in this research is going to be entirely voluntary. It is your choice whether to participate or not. The choice you make will have no bearing on your private or personal life. You may change your mind later or stop participating even if you agreed earlier.

**Benefits**

There will be no direct benefit to you but your participation is likely to bring great improvement in health service delivery system and maternal health in this community and nation at large.

**Confidentiality**

The research being done in the community may draw attention and if you participate you may be asked questions by other people in the community. We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private. Any information about you will have your initials on it instead of your name. Only the researchers will know what your initials are and we will lock that information up with a lock and key. It will not be shared with or given to anyone except the research team who will have access to the information.
APPENDIX II

CERTIFICATE OF CONSENT

I have read the foregoing information or it has been read to me, I have had the opportunity to ask questions about it and have been answered satisfactorily. I consent to be a participant in this study.

Initials of Participant……………………………
Signature or thumb print……………………………..
Date…………………………………………………..

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following that will be done.

Name of Researcher………………………………………
Signature…………………………………………………
Date………………………………………………………

University of Ghana http://ugspace.ug.edu.gh
Dear Respondent,

The researcher is a student of University of Ghana and currently conducting a study on “The Attendance to Focus Antenatal Care Clinic and the Place of Delivery in Suhum Municipality” the study is means solely for academic purpose therefore any information provided by respondents would be treated with utmost confidentiality. In view of this you are encouraged to respond to each question with frankness.

APPENDIX III

SECTION A: DEMOGRAPHIC INFORMATION

A1. How old are you?
   a) 15-19 years
   b) 20-24 years
   c) 25-29 years
   d) 30-34 years
   e) 35+

A2. What is your marital status?
   a) Married
   b) Single
   c) Divorced
   d) Widowed

A3. What is your highest level of education?
   a) No formal education
   b) Primary school level
c) Junior high school level

d) Senior high/Vocational/ Technical School

e) Tertiary level

A4. Religious affiliation

a) Christianity

b) Moslem

c) Traditionalist

d) Other, please specify

A5. What tribe do you belong?

A6. What is your occupation?

A7. How far is your residence from the health facility?

a) Less than 1 kilometer

b) 1-2 kilometers

c) 3-5 kilometers

d) 6-10 kilometers

e) More than 10 kilometers

A8. How many children do you have?

A9. Who do you live with?

a) Husband

b) In-laws

c) Parents

d) Siblings

e) Other, please specify
SECTION B: PERCEPTION OF FANC AMONG WOMEN

B1. In your opinion what is your perception on antenatal care?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

B2. Do you think antenatal care is an important service to the pregnant woman?

a) Yes
b) No

B3. Please give reason for response in the question immediately above.................

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

On a scale of 1-5 with designations; 1- Excellent, 2- Very good, 3- Good, 4-Poor and 5-
Very poor, how will you rate the following:

B4. Antenatal service provided in your health facility.

a) 1
b) 2
c) 3
d) 4
e) 5

B5i. Give two reasons for response in the question immediately above

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

B6. Delivery services provided in your health facility.

a) 1
b) 2
c) 3

d) 4

e) 5

B6i. Give two reasons for response in the question immediately above.

........................................................................................................................................

B7. How often did you use the antenatal care service available at your health facility?

a) Always

b) Very often

c) Often

d) Not often

e) Never

B8. What kind of support do you expect when accessing the antenatal care at the facility.

a) Financial

b) Social

c) Medical support

d) Emotional

e) Others, please specify.................................................................

B9. What kind of support did you receive when accessing the ANC service at the facility?

a) Financial

b) Social

c) Medical support
d) Emotional

e) Others, please specify……………………………………………………………………

B10. What kind of support did you receive during delivery at the facility?

a) Social

b) Medical support

c) Emotional

d) Others, please specify……………………………………………………………………

B11. What is the rating for the family support received?

a) Excellent

b) Very good

c) Good

d) Poor

e) Very poor

B12. What is the level of difficulty you face when accessing family support mentioned above?

a) Very easy

b) Easy

c) Somehow easy

d) Difficult
B13. How often did you receive any health education or talk from health workers during your visit to the health facility for ANC?

a) Always
b) Very often
c) Often
d) Seldom
e) Never

SECTION C: RELATIONSHIP BETWEEN ANTENATAL CARE AND PLACE DELIVERY

C1. Given the opportunity, where will you prefer to deliver your baby when pregnant?

a) Home
b) Health center
c) Prayer camp
d) With TBA
e) Other, please specify..........................................................................................

C2. What inform your choice of delivery place as indicated above?

a) Owns decision
b) Husbands decision
c) Parents decision
d) Others, please specify..........................................................................................
C3. Who assists you in your delivery/deliveries?
   a) Doctor
   b) Midwife
   c) TBA
   d) Other, please specify…………………………………………………………………….

C4. Does the place of ANC have any connection with the place of delivery among pregnant women?
   a) Yes
   b) No

C4i. Please give reason for response in the question above.
………………………………………………………………………………………………
………………………………………………………………………………………………

C6. In your opinion, is it important to have a midwife seeing through ANC during pregnancy?
   a) Yes
   b) No

C6 i. Give reasons for response for question C6………………………………………………

C7. Are you covered under the health insurance scheme?
   a) Yes
   b) No

C8. How many visits do you make to the antenatal clinic when pregnant?
   a) 1
b) 2

c) 3

d) 4 or more

C9. What informs the number of visits you make to the antenatal clinic (tick as many as applicable?)

a) Satisfaction with care rendered
b) Demands made by schedule
c) Time availability
d) Long waiting time
e) Compelled by midwife
f) Other, please specify……………………………………………………………………

C10. Does ANC attendance contribute to the birth preparedness of pregnant women?

a) Yes  b) No

C11. How would you rate the contribution of ANC attendance to birth/delivery preparedness?

a) Very important
b) Important
c) Somehow important
d) Unimportant

C11i. Please give reason for response given in the question immediately above.

…………………………………………………………………………………………………………………………

C12. In your opinion, does the utilization of ANC service contribute to healthy pregnancy and confidence?
a) Yes  
b) No  
c) Cannot tell

**SECTION D: FACTORS CONTRIBUTING TO PATRONAGE OF FANC AND PLACE OF DELIVERY**

D1. Indicate the factors that could impact on the patronage of FANC

<table>
<thead>
<tr>
<th>A. Personal factors</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time</td>
<td>(   )</td>
<td>(   )</td>
</tr>
<tr>
<td>Busy work schedule</td>
<td>(   )</td>
<td>(   )</td>
</tr>
<tr>
<td>Mistrust in system/service</td>
<td>(   )</td>
<td>(   )</td>
</tr>
<tr>
<td>Previous experience</td>
<td>(   )</td>
<td>(   )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Institutional factors</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting time at facility</td>
<td>(   )</td>
<td>(   )</td>
</tr>
<tr>
<td>Lack of facilities</td>
<td>(   )</td>
<td>(   )</td>
</tr>
<tr>
<td>Availability</td>
<td>(   )</td>
<td>(   )</td>
</tr>
</tbody>
</table>

D2. Indicate the Factors affecting place of delivery

<table>
<thead>
<tr>
<th>A. Personal factors</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time</td>
<td>(   )</td>
<td>(   )</td>
</tr>
<tr>
<td>Busy work schedule</td>
<td>(   )</td>
<td>(   )</td>
</tr>
<tr>
<td>Mistrust in system/service</td>
<td>(   )</td>
<td>(   )</td>
</tr>
<tr>
<td>Previous experience</td>
<td>(   )</td>
<td>(   )</td>
</tr>
<tr>
<td>Lack of family</td>
<td>(   )</td>
<td>(   )</td>
</tr>
</tbody>
</table>
Financial constraints ( ) ( )
Cultural beliefs ( ) ( )

B. Institutional factors Yes No
Waiting time at facility ( ) ( )
Lack of facilities ( ) ( )
Availability ( ) ( )

D3. How would you rate the attitude of health workers in the health facility?

a) Very friendly
b) Friendly
c) Somehow friendly
d) Unfriendly
e) Very unfriendly
SECTION E: RECOMMENDATIONS FOR IMPROVING FANC

E1. What can be done to improve on antenatal services rendered at the health facility?

........................................................................................................................................
........................................................................................................................................

E2. What measures can be put in place to improve the patronage of skilled attendant for delivery among pregnant women?

........................................................................................................................................
........................................................................................................................................
APPENDIX III

IN-DEPTH INTERVIEW QUESTIONS

1. What challenges are encountered in the delivery of antenatal and delivery services?

2. What are the demands of clients on the facility?

3. What is the staff strengths and bed capacity of the facility?

4. Is the capacity above enough to serve the 18 communities in the sub-municipality?

5. Are there enough equipment for services that cater for a pregnant woman`s needs like ultra sound scan machine active laboratory services and pharmacy?

6. Are there available emergency readiness policy and equipment in use like ambulance services, emergency drugs etc.?

7. How far is the facility from the township?

8. Does free maternal delivery policy and NHIS policy hold in the health facility?

9. What do you think accounts for the low turn up for delivery at the facility?

10. Is FANC in full practice at the facility?

11. What can be done to improve on the service delivery system?

12. What measures can be put in place to improve on the health seeking behavior of women during pregnancy and childbirth?

13. Any general comment and suggestions are fully welcome?
Dear Gloria Akorfa Senyo,

Please find the review summary of the Protocol titled: “The Attendance of Focus Antenatal Care Clinic and the Place of Delivery in the Suhum Municipality” that was submitted to the ERC Secretariat for review.

We wish to inform you that the above-mentioned Protocol underwent full general meeting review and that approval has been granted for its implementation.

Your approval letter is being processed.

We wish you a successful project implementation.

Accept our congratulations.

Administrative Secretary, Ghana Health Service Ethics Review Committee
For: Chairman
Name: Hannah Frimpong