

UNIVERSITY FOR DEVELOPMENT STUDIES

**DETERMINANTS OF ANTENATAL CARE SERVICE UTILIZATION AMONG
PRIMIGRAVIDAE IN GUSHEGU MUNICIPALITY IN NORTHERN REGION**

UNIVERSITY FOR DEVELOPMENT STUDIES



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**DETERMINANTS OF ANTENATAL CARE SERVICE UTILIZATION AMONG
PRIMIGRAVIDAE IN GUSHEGU MUNICIPALITY IN NORTHERN REGION**

BY

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IN COMMUNITY HEALTH AND DEVELOPMENT**

OCTOBER, 2019



DECLARATION

I hereby declare that except for references to other researcher's works which have been duly acknowledged, this dissertation is the result of my own research and it has neither in part nor in whole been presented to this institution or elsewhere for another degree.

.....

.....

YAKUBU ABASS

DATE

ACCEPTANCE

SUPERVISOR

I hereby declare that the preparation and presentation of the thesis was supervised in accordance with the guidelines on supervision of thesis laid down by the University for Development Studies.

DR. MICHAEL WOMBEOGO

(SUPERVISOR)

SIGNATURE

DATE



ABSTRACT

The significant of antenatal care and skilled-birth attendants at delivery in the reduction of maternal morbidity and mortality cannot be emphasized and are key components of the safe motherhood initiatives. Despite the introduction of certain strategies to promote early antenatal care utilization and delivery in health facilities by skilled attendants, most primigravidae in Gushegu municipality initiate antenatal care services late while others did not utilize the services at all. As a result, this study intended to explore the determinants of ANC service utilization among primigravidae in Gushegu municipality. A cross sectional study was conducted from August to October, among three hundred and eighty four primigravidae and primiparous who delivered for the past six months preceding the survey. A quantitative method of data collection was used. The collected information was analysed using SPSS software. Descriptive statistics such as frequencies, tables, percentages among others were used to analyse the quantitative data collected. The study found that 71.4% of the respondents mentioned that they knew about ANC and 60% of the respondents mentioned that, it is better for pregnant women to visit the hospital at least four times before delivery. Also, the results showed age, religion, occupation as well as possession of NHIS as determinants of antenatal care service utilization in Gushegu Municipality. Other factors such as fear of stigmatization (23.4%), delays in service delivery (22%), poor family support (20%) are among the factors influencing ANC service utilization among primigravidae. The strategies suggested by the respondents to improve ANC utilization are public education and sensitization (43%), change of health care provider's attitudes (26%), distance and delays associated with the delivery (22%) and establishment of adolescence ante-natal care service centers as strategies to enhance ANC utilization among primigravidae in Gushegu municipality. The study recommends that, the Gushegu Municipal Health Directorates should organize professional development workshop and services for all health care providers in the Municipality as well as request for more midwives and community health nurses to pave way for more health centers to be opened for easy accessibility by primigravidae during ANC services.



DEDICATION

This work is dedicated to my mother, Halimatu Abass, my late father as well as my children, Abass Nazeef Tipagya and Abass Muhibbah Nasara.



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LIST OF ABBREVIATIONS

- ANC- Antenatal Care
- CHPS –Community-Based Health Planning and Services
- DHS –District Health Service
- DRC -Democratic Republic Of Congo
- EIC –Education-Information –Communication
- FANC- Focused Antenatal Care
- GDHS – Ghana Demographic Health Survey
- GHC- Ghana Cedis
- GHS–Ghana Health Service
- GLSS–Ghana Living Standard Survey
- GMA –Gushegu Municipal Assembly
- GSS –Ghana Statistical Service
- HBM –Health Belief Model
- HC–Health Centers
- HCPs –Health Care Professionals
- HIV –Human Immunodeficiency Virus
- ICF –International Classification of Functioning
- IPT-Intermittent Presumptive Therapy
- LI –Legislative Instrument
- MDGs–Millennium Development Goals
- MHS–Maternal Health Service
- MMR – Maternal Mortality Ratio



MOH –Ministry Of Health

OPD –Outpatients Department

PHC –Population and Housing Census

PHD –Public Health Division

PMNCH- Partnership for Maternal Newborn and Child Health

PMTCT- Prevention of Mother to Child Transmission

RCH–Reproductive and Child Health

SDGs – Sustainable Development Goals

SP –Sulphadoxine-Pyrimethane

SSA- Sub-Saharan Africa

STIs –Sexual Transmitted Infection

TBAs –Traditional Birth Attendants

TT –Tetanus

UN –United Nations

UNFPA- United Nations Fund for Population Activities

UNICEF- United Nations International Children’s Emergency Fund

UNPF – United Nation Population Fund

WHO- World Health Organization



CHAPTER ONE

1.1 Background

Antenatal Care (ANC) is defined by Partnership for Maternal Newborn and Child Health (PMNCH) as a health plan that helps expected mothers to know and prepare for childbirth and parenthood (2006). It can also be defined as a usual nursing and medical care given to pregnant women in pregnancy. It is further referred to as preventive care with the aim of ensuring frequent checkups that helps doctors or midwives to prevent and treat detected potential complications that may arise during pregnancy for a pregnant woman (WHO, 2005). Antenatal care gives advice and other relevant information to pregnant women with regards to place of delivery, depending on the health condition and status of pregnant women. In addition, it provides opportunity for pregnant women to be informed on the danger signs and symptoms which needs urgent attention from a service provider or health care professional. Furthermore, ANC may help in reducing the impacts of pregnancy related complications through proper monitoring and prompt treatment of pregnancy related conditions, such as malaria, anemia and pregnancy induced hypertension that usually subject both the mother and unborn child life to serious risks, (Bloom et al,1999; Bhatia and Cleland,1995). For many decades, ANC has often been an integral part of reproductive health care program throughout the world (Shah and Say, 2007).

Ante-natal care utilization refers to the usage of ante-natal care services by pregnant women as reflected in the attendance of ANC seminars organized by health personals, the periodic visits to health centres for palpation and administration of advice and drugs when necessary and the subsequent delivery of babies under the supervision of





professional health personnels. An understanding of the individual determinants (patient-related factors) of antenatal care (ANC) utilisation may assist the pursuit of adequate levels of care recommended for every pregnancy. ANC is important because it enables early and continuing risk assessment, health promotion and medical and psychosocial follow-up. Despite its value, some women do not make proper use of ANC . The measurement of ANC utilisation varies across studies, therefore results must be interpreted cautiously. The initiation of care, the number of ante- natal visits and several indices based on the timing of initiation of ANC, the total number of antenatal visits and the gestational age at birth have been used previously to define ANC use. Since there is no consensus about the number of antenatal visits, it is preferable to take into account elements of the content and timing of care during the pregnancy.

Feijen-de Jong et al (2016) found out that in the Netherlands, most women with uncomplicated pregnancies receive ANC from primary care midwives who act as gatekeepers to secondary obstetric care. They receive fixed remunerations for follow-up during the full length or part of the pregnancy. Boeleider et al (2013) also found out that in Belgium, most women access an obstetrician directly for ANC as they do not need pre- authorisation to gain access to specialist care. The majority of general practitioners, specialists and independent midwives in Belgium are paid on a fee- for-service basis. They both concluded that the ease of accessibility combine with other factors like employability and social support to increase ANC utilization among primigravidae in Belgium and in the Netherlands. .

In Sub-Saharan Africa, Oguntunde et al (2010) found out that ante-natal utilization is still very poor because many women choose not to access the services due to various factors

ranging from economic to socio-cultural. Oladokun (2010) also found out that women in Tanzania and Kenya will prefer to seek the services of a traditional birth attendant than go to the health facilities to utilize ANC services. The direct consequence of poor ANC service utilization is high maternal mortality rate.

In Ghana antenatal care service is provided free of charge throughout the public hospitals, clinics and health centers with minimum cost at private hospitals in the country. Despite this effort to continue the promotion of improved maternal and neonatal health care in Ghana, there was an observed increase in the percentage of pregnant women utilizing ANC services in 2014. For instance, in Gushegu municipality out of 4530 ANC attendance in 2013, only 1030 pregnant women visited ANC within twelve weeks of their pregnancy, representing 22.7% late attendance of antenatal care among pregnant women in the municipality (MHS, 2014). Also according to global health observatory report (2016), ANC coverage in Ghana has dropped from 97.3% in 2008 to 87.3% in 2014 despite the percentage increase of ANC visits in 2014. In addition ANC service attendance has just dropped drastically from 15581, (2015) to 6868, (2016) in Gushegu district. The family, social and community beliefs either impact positively or negatively on the pregnant women health. It is quite interesting to know that, while some cultures are of the view that pregnant women should be given rest and special food, others had different opinion and considered it to be normal and should not be acknowledged at such. As a result, most pregnant women work hard and observed certain taboos which deprived them certain essential nutrients leading to nutritional deficiencies, most especially protein, iron, vitamins among others





From 1990 to 2005, maternal mortality ratios declined from 740 per 100,000 live birth to 563 per 100,000 in 2008. Although a lot of efforts have been put in place to realize the Millennium Development Goal (MDG5) on maternal health to minimize the maternal mortality ratio (MMR) by 3/4's by the year 2015 is yet to be realized or achieved due to the poor utilisation of ANC services.

Generally, a lot of progress has been made globally in improving access and usage of ANC service, we still experienced a lower number of pregnant women maximizing the minimum four visits recommended by (WHO, 2010 and Carroli, 2001). Besides, most of them made their first visits often late in pregnancy despite maximum benefits associated with early antenatal care initiation. Several researchers discovered certain factors responsible for late ANC patronage to include; residential location, planned pregnancy, education, ethnicity, employment status, health insurance status, distance to health centers among others (Trinh, 2006 and Adekenle, 2008). In developing countries like Ghana, men as decision-makers play a pivotal role in women choice to access or utilize ANC services. They also serve as custodians of the family resource and decide when a pregnant women should access health care services and at where and eventual leads to underutilization of ANC services among pregnant women more especially among primigravida.

Globally, different ANC models were developed and put into practice and these models led to historical economic, traditional and socio-cultural factors of a particular country. The traditional antenatal care service delivery is based on one-on-one visits between a health care provider and a pregnant woman, and focuses primarily on physical risks assessment to ensure optimal health within the allotted appointment time, the health care

provider communicates pertinent clinical and self-care information to the woman (Banda, 2003).

In contrast to the traditional model of ANC delivery, group ANC is an integrated approach that incorporates physical assessment, education and skilled development as well as peer support. As such, it takes a broader, more holistic, women centered approach to ANC. Women receiving ANC in a group model benefits from both the expertise of the HCP and knowledge, experience and support of their peers (Baldwin, 2006 and heberlein et al, 2016). Thus group ANC can be posited to fulfil key elements of a framework for women centered care, including the need for respect and safety; empowerment, involvement and participation of women; a collaborative inclusive approach to the provision of health care and an emphasis on share information and decision making.

Besides the group model is the focused antenatal care (FANC) which was developed to replace the traditional ANC model and it is also known as goal-oriented ANC approach, which was recommended by the researchers in 2001 and adopted by WHO in 2002. FANC is accepted as a policy in Ghana. The objective of the FANC model is to promote the health of the mother and their babies through targeted assessments of pregnant women to facilitate; identification and treatment of already established disease, early detection of complications and other potential problems that can affect the outcome of pregnancy. FANC also aim to give holistic individualized care to each woman to help maintain the normal progress of her pregnancy, through timely guidance and advice on; birth, preparedness, nutrition, immunization, personal hygiene and family planning. The latest model of ANC is the 2016 WHO antenatal care model, this model recommends a minimum of eight ANC contacts, with the first contact scheduled to take place within the





first trimester, two contacts scheduled in the second trimester that is at 20 and 26 weeks respectively and the other five contacts scheduled in the third trimester, that is ranging from 30, 34, 36, 38, and 40 weeks. Here the word “contact” is used instead of the word “visit” and it means an active connection of a pregnant woman and a health care provider that is not implicit with the word “visit”. It should be noted that the list of interventions to be delivered at each contact and details about where they are delivered and by whom are not meant to be prescriptive but, rather meant to be adaptable to the individual woman and the local context, to allow flexibility in the delivery of the recommended interventions. At the third trimester contacts, ANC provider should aim to reduce preventable morbidity and mortality through systematic monitoring of maternal and fetal wellbeing, particularly in relation to hypertensive disorders and other complications that may be asymptomatic but detectable during this critical period.

ANC in Ghana comprises provision of effective therapeutic interventions, screening, sensitizing primigravidas on safe motherhood or birth planning, emergencies and complications and how to attend to such situations and other socio-economic conditions that are likely to pose serious adverse effects on pregnancy outcomes (WHO, 2009). Strategies that proved to be of relevance to the unborn child and the mother are serological screening and syphilis treatment, routine obstetric checkup, supplementation of iron and folate in areas with high risks of anemia, immunization against tetanus and intermittent presumptive therapy (IPT) (Van Eijk, 2006). Other relevant interventions or strategies that can be helpful during ANC are information on family planning, breast feeding, good nutrition as well as information on the need to deliver at the hospital or health center where she will be attended to by professional health care providers (WHO, 1999).



Of late antenatal care service program has received a boost by the incorporation of prevention of mother to child transmission (PMTCT) of HIV to prevent unborn child from being infected. All these strategies or interventions will be of great benefits to pregnant women if they start ANC early in pregnancy more especially during first trimester.

1.2 Problem Statement

Maternal mortality is one of the greatest development and health concerns facing developing countries (WHO, 2003). It is estimated that, about 800 women die every day from complications resulting from pregnancy and child birth (WHO, 2016). Despite the reduction of proportion of women dying due to complications during pregnancy and child birth, as well as bleeding after child birth globally by 50% from an estimated 523,000 in 1990 to 210,000 in 2014. About 99% of these deaths occur in developing countries (WHO, 2016). Deaths related to pregnancy complications in Africa is 1 in 40 compared to 1 in 3300 in Europe and 1 in 190 worldwide (WHO, 2014). Maternal mortality in Ghana has appreciated from 173 in 2011 (GHS, 2011) to 319 in 2015 (WHO, 2016). As a result Ghana missed the millennium development goal (MDG5).

ANC happened to be one of the most important care given to pregnant women WHO (2016) and as one of the indicators of (SDG3). The essence of ANC is to facilitate pregnant women birth and motherhood preparation as well as manage, check, identify and alleviate the three types of health problems associated with pregnancy that affects mothers and the unborn babies. It was estimated in 2014 that six out of ten pregnant women made at least four ANC visits, nine out of ten in Latin America as compared to four out of ten in Sub-Saharan Africa. In spite of the fact that ANC coverage in Ghana is

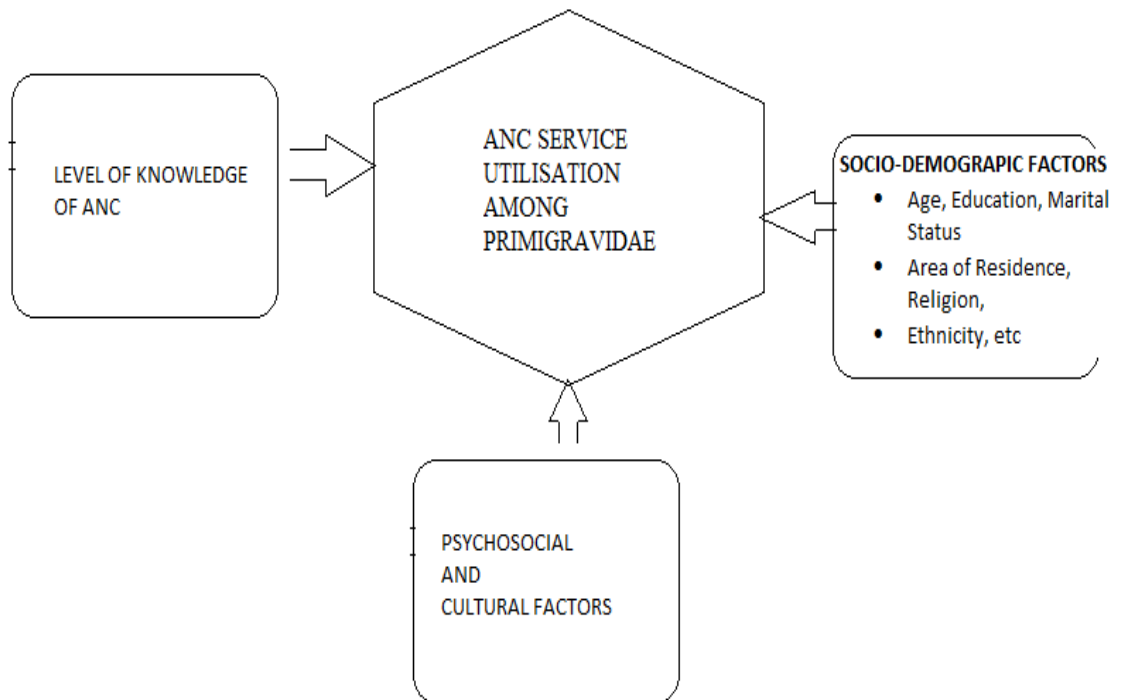
above the global average of 64% WHO (2016) and WHO (2002.), there are still in existence urban-rural differentials and regional disparities among the providers of ANC services (Aryeetey et al, 2015).

It is important to know that ANC coverage is about access and utilization of care during pregnancy. This helps to indicate the number of women who utilize ANC services at least once within a given year in a pregnancy. Also, it is interesting to know that ANC coverage in Ghana declined from 98.2% in 2011 to 92, 2% in 2012 and 90% in 2013 (GHS, 2013). Similarly, 2016 global observatory report indicated a reduction of ANC coverage in Ghana from 97.3% in 1990 to 87.3% in 2014 despite the percentage increase of ANC visits in the same year. In addition ANC service attendance has just dropped drastically from 15581 in 2015 to 6868 in 2016 representing 44% reduction of ANC service utilization in the municipality. This data failed to establish the percentage increased in the first trimester since this is the critical stage as far as ANC service is concern. For instance, in Gushegu Municipality out of 4530 ANC attendance in 2013, only 1030 pregnant women visits ANC within twelve weeks of their pregnancy, representing 22.7% late antenatal care attendance among pregnant women in the municipality (MHS, 2014)

Attempts were made by many researchers to ascertain what real accounted for such decreasing trend in ANC coverage by examining factors influencing ANC attendance (Arthur, 2012; Pell et al, 2014 and Campbell et al, 2006). But little has been done with regard to the phenomenon of ANC service utilization among (primagravidae) which are vulnerable as a result of having pregnancy for the first time in their life time in the Municipality. This is the gap the researcher seeks to fill.



Figure1.1: CONCEPTUAL FRAMEWORK/THEORETICAL FRAMEWORK



Source: Author's Concept

1.3 Research Questions

- 1.3.1 What is the knowledge level of primigravida on the significance of ANC service utilization?
- 1.3.2 What are the socio-demographic factors that determine primigravida ANC service utilization?
- 1.3.3 What are the psycho-social and cultural factors that determine ANC service utilization among primigravida?



1.3.4 What are the strategies that could promote primigravida antenatal care service utilization in Gushegu municipality?

1.4 Research Objectives

1.4.1 Main Objective

To investigate factors that determined the utilization of ANC service among first time pregnant women (primigravida) in Gushegu municipality.

1.4.2 Specific Objectives

1. To assess the level of knowledge of primigravida, on the importance of ANC service utilization.
2. To identify the socio-demographic factors that determined ANC service utilization among primigravidae.
3. To determine psycho-social and cultural factors that determined ANC service utilization among primigravidae.
4. To identify strategies to promote primigravida antenatal care service utilization in Gushegu municipality.

1.5 Justification

Generally, the significance of antenatal care is well known to most women in Ghana despite the fact that most pregnant women initiate ANC late in some parts of the country. Hence there is the need for a research to be conducted to know the determinants of ANC utilization among primigravida. Based on this, the research intends to focus on why first time pregnant women or primigravida are not accessing ANC service by concentrating



on the socio-demographic, psycho-social and cultural factors and primigravidas knowledge of ANC services that contribute to the phenomenon as well as strategies to be employed in order to improve access and utilization of antenatal care service among primigravida in Gushegu municipality.

It is hoped that the outcome of this study will be of relevant and useful to the existing knowledge in the field of reproductive health. Also, it will assist stakeholders and policy makers to develop public health policies in maternal and child health in Ghana. Lastly the findings could contribute to the promotion of social and family support mechanisms among primigravida in our societies.



CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter contains a review of related literature by different authors and identifies the gaps that are to be filled by the current study. The chapter takes a look at the various theories that seeks to explain ante-natal care utilization among primigravidae and ANC utilization among women in general and indicates how the theories provide a framework for deductive analysis and throws more light for an easy understanding of the entire study. The chapter further provides an empirical review where the works of experts in the field of reproductive health was thoroughly reviewed to offer a deeper understanding of the study particularly on issues that throws more light on the objectives of the study and the research questions the study seeks to answer. The empirical review centers on the issues of ANC utilization, economic, socio-cultural and psycho-social factors that prevent primigravidae from accessing ante-natal care services in Africa. The chapter ends with a demonstration on how the various concepts that are used in the study are linked with behavioral theories such as the Bandura's cognitive theory to provide a succinct understanding of the entire study.

2.1 Pregnancy and ANC service

Pregnancy is a condition and not a disease and comprises social and economic dimensions such as spiritual, psychological, physiological as well as socio-cultural (WHO, 2013). Also, it is a period in which good health behaviors are promoted, still birth are prevented and other major new borne illnesses are brought under control or avoided. ANC packages which are relevant interventions are provided during pregnancy. Such



interventions packages include; Sexual Transmitted Infections (STIs), detection and management, Tetanus (TT) immunization, Human Immunodeficiency Virus (HIV), syphilis and other management interventions such as counseling, preparedness, and nutrition as well as danger signs associated in maternal and child birth. ANC is defined by WHO (2010) as “care before birth”, and comprises screening, counseling, education among others in order to monitor the mothers and unborn baby welfare and to promote their general wellbeing. The annual report of RCH/PHD-GHS, (2007) also refers ANC as “the health care and education given during pregnancy”. Similarly the MOH (2007) reports also explains that “ the objective is to ensure regular contact with the pregnant women as well as early detection and management of health problems. This makes it possible for delivery plans to be developed by primigravida and their families depending on the circumstances, needs and the availability of resources. It is significant to know that, the identification and mitigation of the risks factors associated with pregnancy can only be achieved under complete ANC service utilization.

It is important to know that, good neonatal and maternal health outcomes can only be realized if primigravidas are able to use antenatal care service adequately (Onosoga et al, 2012). Similarly Conrad et al (2012) was of the view that, countries with maternal mortality has realized because of accessibility of quality maternal health care services which is critical in terms of maternal and child health improvement. It also serves as a platform through which there will be interaction between health personnel and primigravidas. This interaction emanates from the socio-cultural definitions, beliefs and other value systems of the pregnant women location.



According to United Nations (2010), ANC coverage is explained as the percentage of primigravidas who patronized ANC services offered by professional health care personnel, as percentage of live births in a given period at least once in pregnancy. The main aim of antenatal care is to ensure that pregnant women deliver safely without causing any harm to the mother and the baby. ANC have major goals to achieve and such goals are include; educating the mothers on personal hygiene, good nutrition, birthing process, early detection and management of pregnancy complications and early development of birth plan to ensure successful delivery and good care of both the child and mother physical, mental and socially wellbeing (WHO, 2012).

Also WHO (2012) traditionally expected primigravidas (pregnant women) to start ANC visits in the first three months and this gives the pregnant women the opportunity to witness 12-13 antenatal care visits in a pregnancy. Over 90% of pregnant women in Ghana is reported to have access to health professionals at least once in a pregnancy, prior to recent births for the past five years before 2008 Ghana Demographic Health Survey (GSS, 2009). It is important to know that, the world health organization recommends that a pregnant woman can only be adjudged to achieved a completed ANC, if only pregnant women is able to realize four minimum visits or more in a pregnancy. The suggested schedule visits in a pregnancy include; the end of sixteen weeks, between 24 and 28 weeks should be the second visits, the third visits shnould be at 32 weeks and last and fourth visits should be at 36 weeks till delivery (ICF Macro, 2013). However, further visits might require if there are complications.

2.2 Pregnancy Complications and Deaths

Globally, it is reported by WHO (2007) that 1500 die every day from complications associated with pregnancy and child birth as well as 536,000 maternal deaths worldwide in 2005 resulting from pregnancy related complications, despite the fact that, there was 47% reduction of maternal death annually in 2012 by UNFP/UNICEF/WHO/WORLD BANK, (2007). Many of these death occurred in developing countries as a result of complications in pregnancy (WHO, 2014). Complications in pregnancy in developing countries are the major causes of death among women of reproductive age bracket or group.

Though, there are a lot efforts put in place globally to ensure maternal mortality improvement , deaths related to pregnancy complications in Africa is 1 in 40 compared to 1 in 3300 in Europe and 1 in 190 worldwide (WHO, 2014). As the efforts to promote maternal and child birth continues, there was an increased in percentage of pregnant women realizing 4 minimum antenatal visits in 2014. It is estimated that 76.1% of women attained 4 minimum ANC visits in 2014 relative to 66.3% in 2013. Delivery being supervised by professional health care providers has increased from 55.3% in 2013 to 56.7% in 2014. Similarly, there was also an increase of family planning coverage from 24.7% in 2013 to 29.1% in 2014.

Despite the improvement of reproductive health care for the past two decades with a low pace, and the importance placed on free maternal care services in Ghana by pregnant women, we still witnessed late registration of ANC services as well as low skilled delivery in health facilities in northern parts of Ghana. Adanu (2010), reported that it was not uncommon to find close half (49%) of pregnant women in Ghana delivery without



skilled health provider at home. Furthermore, unlike their counter parts in the Southern parts of the country, pregnant women in northern Ghana were less likely to receive neither ANC nor delivering at the health center. Akazili et al (2011) and that of Adanu findings reported that in northern Ghana only 44% of pregnant women registered for ANC within the first trimester and 29% of them delivered in the health facilities. Additionally, Ghana Demographic Health Survey (2014) reported that in northern region of Ghana, 36% of pregnant women delivered in health facilities with skilled attendants ,Ghana Statiscal Service, Ghana Health Service and ICF international (2015). Also 41% of pregnant women in upper east region start ANC within the first trimester in 2014 (Awornor- Williams, 2015). Despite all the efforts put in place to ensure the achievement of millennium development goals (MGDs) and sustainable development goals (SDGs) on maternal health in order to guarantee the reduction of maternal mortality ratio by $\frac{3}{4}$ in 2015. This goal is yet to be realized or achieved

2.3 Theoretical Framework

The Cognitive Theory of Behaviour

This theory of behavior beliefs that, an individual behavior depends largely on the value he/she attach to the expected outcome and the belief that such a behavior will meet the expected outcome if only it is well performed (Bandura,1974). The model is also predicted that, an individual (primigravida) health behavior is likely to be influenced by the determinants such as perceived severity, susceptibility, benefits, barriers and cues to action or other associated modifying factors. Below is how the model could be applied in this study.





Perceived susceptibility; this refers to a situation where an individual decides to seek medical care if he/ she is at risk of getting certain health problem or contracting certain diseases. This implies that whenever there is an increased of perceived susceptibility, there will be a resultant increased in seeking health care or intervention and vice versa (Rosenstock, 1974). For example, primigravidas will like to seek more ANC services if their perceived susceptibility to develop pregnancy complications is too high. The subjective perception being held by an individual (primigravida) is that, if a health problem or disease is not treated will have serious health implications such as pain, reduced quality of life or death will play a major role in taking decision to either seek for medical health support or not (Becker and Maiman,1977). Primigravida's ability to access and seek ANC services will largely be depended on self-evaluation of the severity of perceived risks associated with the complications of the pregnancy such as the mother's death and the unborn baby.

Perceived barriers and benefits; perceived benefits are the beliefs primigravida has with regard to taking effective actions to minimize risks, whereas perceived barriers are the materials and psychological cost of seeking action/ care. This is more or less a cost benefits analysis that helps primigravida to properly evaluate expected outcome and subject it to expected perceived income to incur to see which one is more advantageous or outweighs the other (Rosenstock, 1974). This implies that, primigravida compliance with the world health recommended health seeking behavior is likely to be impeded if perceived barriers are more than perceived benefits (Rosenstock, 1974). For instance, primigravida may decides not to visits any clinic or hospital for antenatal care service if she felt that, she might not benefits from doing so, also distance to health could not act as

an impediment to primigravida intervention of ANC service utilization. In addition, health care provider's attitudes and knowledge about ANC can contribute either negatively or positively towards the utilization of ANC service.

Modifying factors or cues to action; these may include socio-cultural and demographic factors such as social values, religion, age, educational level as well as beliefs and practices of primigravida when it comes to antenatal care service utilization in the municipality.

2.4 Knowledge about the Importance of ANC Service

Knowledge is one of the variables that determining the decision of primigravidas to either use ANC service or not. Information about pregnancy and ANC is relevant to women in the preconception stage to enable them make informed decision on ANC services. Knowledge on the time to start antenatal care services, the customization of benefits and risks are low among pregnant women as demonstrated in most studies in Africa, thus prefiguring awareness where the development and delivery of specific messages about the early antenatal care service utilization. Existing tools are not updated and many of them are inappropriate for the education of pregnant women according to WHO recommendations. According to WHO recommendation (2009), the various education-information-communications (EIC) have specific messages. Thus the first visit or service is to confirm the pregnancy, calculate the probable term, detect, treat and administer preventive, make an emergency plan and prepare the birth plan, while the other three visits are assigned to tasks such as evaluation of maternal and faetal wellbeing, exchanging gestational hypertension and anaemia, taking preventive measures, revision and modification of the emergency plan and preparation for birth.





An inadequate knowledge a pregnant woman may have with regard to antenatal care service is a determinant of ANC service utilization in Ghana. For instance, a study conducted by Sumankuuro et al (2017) discovered that negative perceptions about medications such as; folic acid, fesoate, multivariates, calcium and sulphadoxine-pyrimethane (SP) etc which are provided during antenatal care demotivates pregnant women ANC service utilization in Ghana. These perceptions led to speculations that it results to fetal macrosomia and subsequent caesarian section. Despite the fact that antenatal care service utilization in Ghana has increased to about 96% for those who had ANC service for at least once and above 80% for those who attended at least four times or more, some pregnant women still lacks the awareness and knowledge about the significance of ANC services for the mother and unborn baby, most especially in northern part of Ghana where illiteracy rate among some pregnant women and their families are high. Most of them lack the knowledge on antenatal care services. Some of them even visits antenatal services once and even decides not to receive further care until delivery at home. While others will registered for the card and refused to maximize regular attendants for the medicines (Sunmakuuro, 2017).

Also, as reported by Gross et al (2012) in Tanzania, more than half of the pregnant women attend ANC because other women also attended or they are told by health workers to attend. This implies that maternal health service usage may be regarded as a norm and not for the benefits the women will derive from the health behavior (Gross et al, 2012).

In Nepal, women who were fortunate to have or be exposed to health information through mass media would be more likely to maximize four and more recommended ANC visits



(Deo et al, 2015). In a similar study in Ethiopia, women who were exposed to maternal health information were over eight times likely to utilize ANC service and give birth in health centers relative to those who did not receive information on maternal health (Hailu and Berthe, 2014). In Ghana women who are exposed to radio, Television and newspapers were likely to use antenatal services during pregnancy and even deliver at health center relative to unexposed women (Mills et al, 2007). Also, Indonesian women with less exposure to mass media or information about obstetric complications were more likely to maximize ANC services (Titaley et al, 2010). In another study by Amosu et al, (2011) have shown that inadequate knowledge about FANC by pregnant women and services provided was one of the factors determining ANC service usage.

The awareness of the risks of not utilizing ANC by primigravidas is likely to affect their behaviors to change if benefits associate with the preventive care outweighs the dangers. That is to say, pregnant women will maximize ANC services if the benefits women will get through ANC visits is perceived to be more advantageous than the risks associated with its usage. Primigravidas need to know the benefits of accessing ANC as well as the risks of not utilizing the service. Similarly, primigravidas might appreciate the significance of ANC service if they felt that, utilizing the service will benefits them and their babies. This implies that adequate utilization of ANC services should take place within the gestational period or within 16 weeks in first trimester with minimum four (4) visits in mind in a pregnancy.

2.5 Socio-Demographic Determinants of ANC Utilization

There are several research conducted to establish the socio-demographic determinants of ANC services in both the developed and developing countries. Such factors include age,

ethnicity, education, residence, plan pregnancy, health insurance, religion and occupation (Gurmesa, 2009 and Kawungezi et al, 2015).

2.5. 1 Age

Maternal age could be considered as an index for measurement of women's knowledge on the use of health care services and this could influence maternal health care services positively, more especially antenatal care services (Abor and Abekah-Nkrumah, 2011). According to Chaibva (2008), age is a factor that influences the decision of a woman to initiate ANC late or not to use it completely at all. She was of the view that, adolescent's pregnant women could hide their pregnancy if they are not married, attending school, afraid of health care providers insults or if they are too young and lack the knowledge to appreciate ANC services (Chaibva, 2008). Another study revealed that adolescents girls initiate ANC services earlier as compared to older women (Gross et al, 2012). Similar results were found in Ethiopia about the effects of unintended pregnancy with regards to the use of antenatal care and maternal health services in general (Wado et al, 2013). However, in Nigeria age is not a significant determinant on the time of initiating ANC services (Oguntunda et al, 2010).

According to Chaibva (2008) adolescent pregnant women might refused to utilize ANC services for fear to be labelled as "promiscuous". However, older women previous uneventful pregnancies and deliveries might see ANC to be irrelevant and no need to utilize. Also a study in Nigeria by Omanade (2014) confirmed that there is positive influence age exhibit in terms of antenatal care utilization or general health care services. Similarly Awusi et al (2009) in Ghana confirmed age as a determinant of ANC service among pregnant women most especially among primigravidas. Also, Doku's (2012)





study revealed that adolescent's girls are more likely to make a minimum of (4) ANC visits as compared to those above 35 years and above. This indicates that, an increase in women's age equally leads to reduction of ANC services utilization (Asiimwe, 2010). It is important to know that, most primigravidas are young and lack child bearing skills and once it is her first pregnant, put fears on them which compelled them to often visit medical personnel (Aderonke, 2014).

2.5.2 Education Status

“Education is a powerful weapon which can use to change the world”. It is the key in eliminating gender inequalities in reducing poverty, in preventing needles death as well as fostering peace (Nelson Mandela, 2013). Higher education assist pregnant women to develop a positive attitudes towards receiving information on maternal care which increases their knowledge on the benefits of seeking health services more especially ANC services. In Nigeria higher education was found to be a strong determinant in ANC service initiation within the first trimester relative to those with no or less education (Oludu, 2010). In a similar study in Ethiopia maternal education was a determinant of ANC service utilization as well as delivery in health facility (Wado et al, 2013). In another study in Ghana, Kenya and Malawi reported women with higher education to be using ANC services more often relative to those with lower education (Stephenson et al, 2006).

Anita (2012) found that, educated mothers tend to have some degree of autonomy, participate in decision making regarding reproductive health, home and family business and becomes more informed and resourced to face the vicissitudes of life. Education therefore stand out clearly as the most single important determinant of ANC utilization



even if other economic factors are taken into account. Pandey et al (2014) revealed that women with less education usually had irregular ANC services relative to those with high education. Moreover Celestin et al (2014) confirmed that pregnant women level of education determine their decisions to take part in early antenatal care service than those with less education

In Afulani (2015) in Ghana stated that uneducated women utilize less antenatal care services relative to educated women. Also, wealthier women with no education utilize antenatal care service than poor women with no education; hence wealth is a significant predictor of antenatal care service among pregnant women in Ghana. Edward et al (2013) also found out that pregnant women educational attainment is a significant predictor or determinant of ANC services. This finding is supported by Austin et al (2017) which revealed that pregnant women with educated partners tend to utilize ANC services at least four (4) times relative to uneducated. Awusi et al (2009) confirmed that high education is a significant determinant of antenatal care services and other relevant health services in general. This resulted from the fact that most women who are educated might have gotten better education and income, which improve their economic status as well as influence their information accessibility.

Similar study in Ghana by Appiah -Kubi (2004) and Awusi et al (2009) postulated positive impact education had on the utilization of health care and the rationale is that , those who are uneducated could easily be influenced by other significant factors such as traditional birth attendants, in-laws, grandmothers among others not to utilize ANC services or have delivery at the hospitals. Again inadequate education can worsen the abilities of women to take responsibilities of their own health by making informed

decisions. In another study by Ngatho et al (2015) in South Sudan revealed that, mothers who are uneducated had serious maternal health problems relative to their educated counterparts in terms of making the recommended number of visits during pregnancy to improve maternal health care services (Yared and Anaskedy, 2002). In the same study pregnant women educational level is said to be a determinant for non-utilization of antenatal care services with greater use of services as likely increase with educated women. Molla (2011) also found that educational status of a pregnant women was an essential determinant on the usage of antenatal care service among pregnant women including primigravidas. This implies that higher educational status had a stronger relationship with antenatal care uptake. Additionally, Zeine (2010) confirmed that mother's with second circle education had the potentials to receive professional health care services relative to those with primary education.

In contrast, a study in Senegal found that educational level of a woman did not determines ANC service utilization as well as place of delivery (Faye et al, 2011).

2.5.3 Marital Status

The marital status of a woman could influence the health seeking behaviors. WHO (2003) and Chaibva (2008) reported that pregnant women who are not married seek ANC less as a result of poor economic and social support from spouse, guardians among others. Adolescent primigravidas who are not married also lack the power to make an independent decision to visit antenatal care services. A study in Ghana by Yaboah (2012) reported unmarried women to have a higher chance of not utilizing ANC service relative to married women. Also Daniels et al (2013) found marital status as a determinant of





maternal health outcomes. It was of the view that single women tend to use maternal health services often than married women. This study revealed that 52.6% of single mothers were teenagers and 54% of them live without their parents or relatives, which might have determine the usage of maternal health services (MHS), since most of them might have lack the decision making power to make an informed decision on ANC services but rather force to accept decisions made on their behalf. This confirmed to the situation where some respondents claimed to be using the service because of the advice given to them by their mothers and other relatives (Daniels et al, 2013). However, Gross et al (2012) found no association between marital status and maternal health services. Another study by Walker et al (2010)and Blank et al (2010) reported that, the decision making power of married women is limited in terms of sexuality and reproduction and requires husband permission sometimes or the family head approval before seeking health care services which influence ANC service utilization among primigravidas and pregnant women in general. Similarly Austin et al (2017) found single divorce women and widowed not to maximize the minimum four (4) antenatal care visits relative to those who are married. Also, a Ghanaian woman in a society is supposed to be a chaste till marriage, therefore for fear of public stigmatization primigravidas who are unmarried tend not to utilize antenatal care services. Besides, those without partners could encounter certain financial challenges that might limit their chances of attending regular antenatal care. The findings of Celestin et al (2016) corroborated this, which indicated that premigravidas or pregnant women who married or co-habituating with a male partner usual initiate antenatal service earlier than those living alone, single, divorce among others. In a similar study in Nigeria by Molla (2011) revealed marital status as a



significant variable in antenatal care service utilization. For instance, married women were more likely to utilize the services than other categories. Thus single, divorced, or widowed mothers might be faced unwanted pregnancy and may seem to hide their pregnancy from their parents and the community instead of receiving antenatal care services. Besides that, Ngatho et al (2015) found that pregnant women whose husbands had more than one wife is more unlikely to attend ANC service than those in monogamous marriage. This emanated from the fact that most women in a polygamous marriage had their husbands attention divided between their wives and hence, their inabilities to pay maximum attention to each of their wives.

2.5.4 Residence of Location

The geographical location of a pregnant woman is an important determinant of maternal health care service utilization. According to Sinkhada et al, (2007) residence location is a significant determinant of health facility accessibility since distance and transport could be barriers in terms of seeking antenatal care services. In remote communities, physical access to health facilities is a major factor which determines how people seek health care (Crissman et al, 2013; Gabrysch et al, 2011 and Sychareun et al., 2015). In another study by Babinard & Roberts (2006), women are more likely to begin ANC after twelve weeks, attain less than four visits or deliver outside the health facility due to challenges resulting from long walking distances to health facilities and absence of transportation to ease travelling to seek care from trained personnel. In Ghana for instance, there are villages in some regions which are already prone to default in the use of ANC, simply because of their location. There are far to reach hinterlands across most of the regions in Ghana which are hardly accessible by road. These villages lack most, if not all, of the basic

necessities in life. Their roads are not passable especially in the rainy season, place of abode is a problem, what to eat is not guaranteed, no viable source of income, malnourished and no better source of drinking water. Even the water sources they have are the ones they share with their livestock. Some of these villages are scattered around the country, in most of the regions-the three Northern Regions (the hardest hit), the northern Volta, hinterlands in the cocoa growing areas in the Brong Ahafo, Eastern, Western and Ashanti Regions, as well as coastal villages who are even poorer than those having fertile lands. Urban poor communities in Central and the Greater Accra regions are no exception. Also, the distance of one location to the health center and the transportation challenges associated with distance impedes accessibility to health care more especially antenatal care services, since the mother to be needs to endure the bad roads or travel long distance before having access to health center for antenatal care services. Sometimes the mother does well by visiting the health center or hospital for first time but the subsequent visits become a problem, thereby leading to inadequate utilization of antenatal care services.

A study in Ghana by Edward (2013) revealed residence of pregnant women as important determinant of antenatal care services. This findings corroborated Celestin et al, (2016) which also found distance as a significant determinant of ANC service utilization among pregnant women. It is stated that, pregnant women living far away from the health centers were found mainly in the rural and mixed urban areas which eventual limit health care usage in many parts of Africa including Ghana. Also Sumunkuuro et al, (2017) in Ghana disclosed distance and transportation challenges as some of the determinants of antenatal services in. For instance, antenatal care service registration in Ghana is done at health



centers and most pregnant women referred for laboratory investigations at the district or municipal hospitals and this causes a lot of inconvenience to them and thereby demotivates them not to utilize antenatal care service because of distance and bad road networks in northern part of Ghana. Also, a study conducted by Afulani (2015) indicated travel barriers as one of the obstacles of antenatal care service utilization as more geographical location tends to dictate women's ability to access care. This is similar to Overbosch et al (2004) findings which reported that, 1/3 of the rural folks travel long distance to access antenatal care and it is characterized with transportation difficulties and hence, limit access to antenatal care services in rural Ghana and most African countries. Also, in terms of rural- urban differentials Doku's (2012) study indicated that women in urban areas make at least four (4) antenatal care attendants than their counterparts in the rural areas. This result supported the findings of Tawiah (2011), where women in rural areas are 7.7 times unlikely to seek ANC services relative to their counterpart in urban areas. These rural-urban disparities are peculiar in Ghana than other African countries. Another study by Molla, (2011) stated that residence of location is a determinant of antenatal care in Nigeria that, women in urban areas had more chances of utilizing antenatal care service than those in the rural areas.

2.5.5 Employment Status

Studies in Africa have reported a positive relationship between ANC utilization and maternal employment as well as health facility delivery (Chama-Chailiba and Koch, 2013 and Dixon et al, 2014). A similar study in central Nepal revealed a significant difference between women in service sector and those with agricultural sector with regard to antenatal care utilization. It is reported that 35% of women in agricultural sector received



ANC service relative to 81% engaged in the service sector. Employment is considered to have a strong relationship with antenatal care services since transportation, consultations and purchases of recommended drugs or medications cannot be disassociated from its usage. This implies that women in employment had a greater chance to utilize ANC service as compared to those who are unemployed and very poor in the society (Arthur, 2012). A study by Asundep et al, (2013) also suggested cost or wealth as a determinant of antenatal care services or attendance with associated adverse outcomes. Hence, the decision of most pregnant women who are unemployed and cannot afford the transportation, drugs and other services cost not to attend or make good use of antenatal care services. Though the introduction of national health insurance scheme was meant to reduce the burden of pregnant women and ease accessibility challenges, travelling cost and other unofficial fees are still serving as barriers to antenatal care service in Ghana. Other expenses such as feeding, drugs and supplies not covered by the NHIS as well as enrolment in to the scheme cannot be underestimated (Mensah et al, 2010). Sometimes due to long queues in public hospitals or health centers, others resulted to private maternity homes which charged high fees and these eventual limits the number of time they utilized antenatal care service in Ghana. Also Okutu (2011) found that women in clerical, technical and professional occupation were in good position to received care in pregnancy under skilled attendant than those in agricultural sector. This calls for more efforts to economically empower women to enable them have access to antenatal care services and positive maternal and child health.

Despite the fact that, the NHIS in Ghana is free and pregnant women are exempted from the premium payment, the program or policy is yet to realize its potentials in some

communities, since cost is still a determinant of antenatal care service especially in referral cases.

In contrast, women in low income status or families used maternal health services in towns or local private clinics, where as those from well to do families used hospitals with high quality of services. This gave birth to the fact that low income should be considered as “high risks factor” for maternal health care services (WHO, 2010).

2.5.6 Religion

Religion plays a critical role in determining how women use health care service including antenatal care services. According to Abor and Abekah-Nkrumah, (2011) Christian women used ANC services as compared to other religious denominations. A study in Ghana and Nigeria reported Muslims and traditionalists as those who starts ANC late and if possible have fewer visits or failed to utilize antenatal care service at all (Dixon et al, 2014). Also, in Kenya Muslim women used less maternal health services relative to Christians and Protestants (Kitui et al, 2013). Similar results from various studies indicated strong relationship between religion and maternal health care services (Pandey et al, 2014). Moreover, Celestin et al (2016) found religion as one of the most significant determinant of ANC services among pregnant women which includes primigravidas. Religious practices influence antenatal services because some religious sects recommend prophetic antenatal care consultations. This delays antenatal care utilization and eventually leads to unfortunate irrational practices such as “to seal or open the cervix through prayers”.





2.5.7 Ethnicity

Ethnicity is an inconsistent determinant of maternal health service utilization due to variations among various traditions (Moyer and Mustafa, 2013). In Upper west region of Ghana, a study revealed that Kasena women had the tendency to utilize ANC services relative to Nankana women (Sekeah et al, 2014). In another study in Ghana, it was revealed that women who are Akan by tribe uses maternal health services such as antenatal care more often than the other ethnic groups in Ghana (Abor and Abekah-Nkrumah, 2011). Despite the fact that the sample size is very representative nationally, the findings could be influenced by the multiple nature of ethnic groups in Ghana (GSS, 2013). A similar study in Ghana reported that, the percentage of women who received skilled ANC attendants and delivery service from 2003-2007 was 96% and 55% respectively. Though Ghana has made tremendous effort in improving maternal health care accessibility, there still exist disparities among ethnic groupings. Although ethnic differences in the usage of ANC was seen to be minimal, majority of women from the larger ethnic groups such as Akan experienced fewer birth at home than those from the minority ethnic groups such as the Mole-Dagbani (74.7%), Grusi (53.4%) among others. However, such differentials in all components of ANC services in Ghana were lower relative to delivery in health facilities and access to professional health care providers during ANC and at birth (Kuumuori, 2015).

2.5.8 Planned Pregnancy

Austin et al (2017) reported that, women with intended pregnancy had attended antenatal care services at least four (4) times than those with unintended pregnancy. This implies



that women with unintended pregnancy will not be willing to visit antenatal care services in Ghana. Also, women who had unplanned pregnancy will feel lazy to visit health facilities for antenatal services. Unwanted pregnancies often characterized with absence of “mind set” exerted negative influence of primigravidas decision to seek for antenatal care services in Ghana. A survey conducted by Exavery et al, (2013) among women of reproductive age groups (15-49) found women with planned pregnancy to initiate ANC service early relative to those with unplanned pregnancy. In Edward (2011), there is evident that women who were not practicing family planning and seek no care from skilled personnel were unlikely to utilize antenatal service than those with planned pregnancy and practice family planning.

2.5.9 National Health Insurance Status

The removal of maternal health care user fees or expenses has helped in contributing to improve access by reducing financial barriers to health seeking by women. Health insurance status has been reported in many studies in Ghana to have a strong relationship with health service utilization (Arthur, 2012 and Nketiah et al, 2013). This association is manifested in a woman’s ANC visits and attendants. A study in Kenya by Kitui et al, (2013) revealed that women with national insurance utilize maternal health and deliver in a health center. In another study by Dixon et al, (2014) reported that women with valid health insurance often seek antenatal care than those without valid health insurance. This finding corroborated Singn et al (2015), which stated further that pregnant women with valid insurance during pregnancy have 25% or more opportunity to use health centers for delivery or at the time of delivery. Wiley et al, (2013) conducted a research on the influence of NHIS on antenatal care utilization. They used 2008 GDHS data and the



findings were that irrespective of the social and economic status of pregnant women, those with valid national health insurance made maximum use of antenatal care than those with invalid or not enrolled into the system. It is important to know that until 2005 and early 2008, the government of Ghana in 2008 decided to improve maternal care through the NHIS by exempting pregnant women from the payment of premium or renewal before accessing maternal care services including antenatal care. This was an attempt to rekindle its commitment to meet or attain MDGs 4 and 5 respectively and those who enrolled into the NHIS are receiving complete benefits of maternal health care services in Ghana.

According to Witter and Garshong, (2013) the existence of NHIS has led to the removal of cash and carry system in Ghana, thereby increasing health care accessibility. This supported Sekyi and Demanban (2012) and that of Aboakye and Agyemang (2013) findings that members with health insurance made maximum use of health care services relative to those who are uninsured. A study by Pell et al, (2013) revealed that national health insurance can only impact on antenatal care if only pregnant women are aware of their pregnancies, since most of them in sub-Saharan Africa are unaware until the second trimester thereby affecting early antenatal care visits. Also Dixon et al, (2011) found the poor enrolment into the scheme to be less relative to those with higher socio-economic background, since most of them are already enrolled into the scheme, thus making antenatal care initiation very inconsistent to the poor. Other factors such as transportation fares, laboratory tests are still serving as hindrance to pregnant women early antenatal care service initiations. For instance, Pell et al (2013) found that before a woman is enrolled into the health insurance scheme for free such a woman must present a certified



laboratory test results to confirm her pregnancy. As a result most of them have to travel to health facility and back to health insurance office several times and this might influence early initiation of ANC services due to absence of NHIS officers and to receive her temporary card might have lasted beyond her first trimester (Wiley et al, 2013).

In a related research by Nketia et al (2013) stated that, in Ghana rural folks with insurance were over 22% likely to have increased maternal or antenatal care utilization as compared to rural women with no health insurance. Also, Ranji et al, and Nketia (cited in Dicknoo, 2011) reported a strong relationship between access to health insurance and prescription medicines through minimizing cash and carry, which undermines the significance of health insurance in antenatal care service utilization. This outcome supports the finding of Jowell, (2009) where ownership of valid insurance card is a significant determinant of antenatal care utilization in South America.

The enactment of fee exemption for primigravidas or pregnant women in antenatal care service and free delivery accessibility are supposed to contribute to increase in early antenatal care initiation as well as delivery in health center. Thus inclusion of health insurance status in the research is to contribute to existing literature on determinants of antenatal care service utilization among primigravidas.

2.6 Psychosocial and Cultural Factors Determining ANC Services Utilization

According to Cassel (1976), who happened to be the father of psycho-social health approach in health stated that an individual perception about his personal status have the potentials of causing stress and poor health condition. The psycho-social approach is of the view that, there is weak social cohesion due to differences leading to health status



variability. As a result, psycho-social challenges among first time pregnant women cause certain challenges in accessing ANC. Also, WHO (2003) stated that factors such as pregnancy, social position, cultural limitations, new relationship among others interfere or hinder basic ANC service accessibility. Most primigravidas need social support, since some of them may face social isolation leading to underutilization of antenatal care services and its adverse effects. Apart from these, other factors to review the literature on are; stigmatization, witchcraft, attitudes, family support, delays in access and many more.

2.6.1 Attitudes

According to Mutua, (2004) both society and care providers attitudes sometimes have psychological effects on the pregnant adolescent who might decides not to make good use of ANC services due to fear of harassment by care provider and older pregnant women. The “supply side” challenges such as health care provider’s attitudes and unfriendly nature of service provided to adolescent primigravidas determine their ability to utilize antenatal care services (Chaibva et al, 2010). Also, Gross et al (2013) found most women unable to seek ANC services due to the fact that, they were unable to leave routine daily activities which emanated from social norms and attitudes that makes it impossible for male partners to assist their wives in pregnancy. Culture as a way of life determines the people way of life and the way they act in terms of utilizing health care and ANC in particular. Culture as a determinant of ANC services can help primigravidas to seek out ANC services depending on the severity of the condition (Reynolds et al, 2006). Also, George (2002) reported the influence of culture and traditional beliefs on primigravidas or pregnant adolescents thoughts, behavior, decision making as well as actions to take towards certain conditions cannot be underestimated.

Similarly, some family member's attitudes could influence primigravidae not to seek ANC services and even motivates them to stay at home and deliver (Irinoyoye et al, 2001). In another study by Sialubanje et al, (2014) reported that both mother and health care providers attitude towards one another is predicting women's decision to use ANC services in pregnancy.

2.6.2 Decision making power

According to Pell et al, (2013) pregnancy in general among adolescent primigravidae tends to reduce the power and autonomy in accessing antenatal care services. The autonomy of first time pregnant women in terms of making decisions and use of financial resources are duly restricted in the society. These "demand -side" challenges can affect the desire of first time pregnant women to seek out antenatal care service. For instance, those who are married will depend largely on the willingness of their husbands to start ANC services. In a study by Sumankuuro et al (2017) demonstrated that, pregnant women cannot commence ANC services unless "cleansing rites" or an official announcement is made before a pregnant woman can starts antenatal care service more especially among married primigravidae. They are of the viewed that, it aids to prevent miscarriage and complications among pregnant women including premigravidas. Also, Lee et al (2009) found husbands and mother in-laws as pivot in determining decisions to be taken by primigravidae or pregnant women in terms of ANC service utilization. As a result male partners should be motivated to take part fully in their spouses antenatal care services.





Similarly Byamugisha et al, (2011) reported that involving male partners in FANC utilization would have minimized decisions that derail the efforts of pregnant women to access antenatal care services. Another study reported that mother in-laws play negative roles towards their daughter in- laws ANC visits. This is due to the inability of pregnant women to challenge decisions of mother in-laws (Simikhada et al, 2010). It is also reported the influence mother in-laws put to bear by persuading the daughter in-laws not to seek antenatal care but rather remains in the house to fulfill household activities at their own risks.

In a similar study by WHO, (2007) mentioned that young women including teens had a lack of authority for decision making or resources for using health services including antenatal care. It is also reported that most pregnant women only engage in behaviors that were approved by important members of the family and community and these beliefs influenced their use of health care including antenatal care (Sialubanje et al, 2014).

In some cultures, family members are the pivots when it comes to ANC service determination among pregnant women or primigravidas in the family. For instance, if family members realized that a primigravida who is young is pregnant, they need to delay the disclosure to other family members but rather encourage her to initiate antenatal care service earlier (pell et al, 2013). Alternatively, if older family members are not making good use of antenatal care services during pregnancy, they might feel reluctance to support her decision to utilize antenatal care services. According to Upadhyay et al (2014), gender plays a significant role in decision making towards ANC service utilization as most partners of women strongly influence their wives decision in terms of ANC service usage.



2.6.3 Stigmatization

For adolescent primigravidas, most of them decide to delay ANC initiation for fear of early disclosure and stigma associated with the pregnancy, more especially among unmarried women or students (Pell et al, 2013). Also, Sumankuuro et al (2017) found stigmatization such as “criticism and mockery” associated with pregnancy by members of the society sometimes deter primigravidae from ANC service attendance more especially among primigravidas who are not married. It is important to know that some of the mothers to be refused to seek ANC services deliberately and others do not want the public to know about the existence of her pregnancy, particularly when they are controversies surrounding her conceptions and hence her decision to delay or not to access antenatal care service at all in order to avoid being mockery or ridiculed. Adolescent females include primigravidas sometimes encounter certain challenges such as stigmatization in accessing ANC services and this leads to complications during pregnancy and sometimes at child birth (UN, 2003 and UNPF, 2012). Adolescent primigravidas are also bound to be ridiculed for early pregnancy and as a result likely to experience poor social and family support relative to older women.

2.6.4 Witchcraft

It is true that socio-cultural representations exist in our traditions and seems to influence the attitudes and practices of most pregnant women in our grassroots communities. The fear of wizards and witches clearly stand out as a determinant of ANC services among primigravidae. pregnancy as a condition in most societies is considered as an event that are associated with mystery and needs to be kept in secrecy within the first trimester and pregnant women convince of booking late beyond fifth and sixth months when the

secrete cannot be kept anymore and be sure she might not be suffered from evil spirits and curses (Celestin et al, 2016 and Birmeta et al, 2013). As a result most pregnant women registered ANC service beyond first trimester.

Similarly, cultural beliefs in our societies has made it possible for pregnant women to believe that pregnancy at early stage needs to be kept in secrecy to prevent it from being destroyed by mystical forces (Onoh et al, 2015 and Ouendo et al, 2012). Also, a study in Zimbabwe found most pregnant women not initiating ANC services within the first trimester for fear of witchcraft and its negative consequences (Mathole et al, 2004 and Mumtaz and Salway, 2005). In another study by Chaibva, (2010) revealed negative influence of cultural beliefs such as witchcraft on ANC service utilization among pregnant women in the societies. Similarly, the belief that pregnancy should not be exposed to non- family member for fear of witchcraft compelled most pregnant women to delay first ANC visits beyond first trimester or less likely to complete their ANC visits schedules (Sialubanje et al, 2014).

2.6.5 Delays in accessing services

Delays in accessing ANC are in three categories that is delays in taken decision to visits ANC services, delays in reaching care or health facility as well as delays involved in receiving adequate health care. There is a significant influence of distance and time involved in traveling to the health facility on at least four ANC visits and safe delivery utilization among adolescent women (Ziblim et al, 2018). In another study by Daniels et al, (2013) reported that many women who did not go for ANC during first trimester considered time spend on the journey to the health facility and the time to spend in



receiving ANC services as being too long. In another study by Brighton et al, (2013) and Gross et al, (2013) indicated that most pregnant women chose to delay their antenatal care service because they cannot openly acknowledge the existence of the pregnancy and hence the decision to delay in seeking ANC service.



CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This explains the research methods the researcher intended to use in the analysis and collection of data process for the study. This chapter is to define the study design, setting, and other techniques such as population, sample, sampling procedures, data collection, analysis, study variables, inclusion and exclusion procedures, pre-test, limitations and ethical clearance.

3.1 Study Setting

The Gushegu Municipal assembly is one of fifteen (15) administrative assemblies of the northern region of Ghana. The municipality is found in the north eastern corridors of Northern region. The legislative instrument that established the municipality was LI 1783. The municipality was initial part of the Eastern Dagomba district and curved out in 1988 and inaugurated to start operation as a district on 20th march, 1993 with Gushegu as the district capital. Based on the growing population of the District and the need to spread development to all parts of the area, it gave birth to the creation of Karaga District in August, 2004. In July, 2017 the district is elevated to municipal status by the president of the republic of Ghana in accordance with the power conferred on him by section (2) of section (1) of the local Government Act, 2016, Act (936) (GMA Second ordinary meeting, 2017). The municipality is officially inaugurated on 8th march, 2018 and the current population of the Municipality is 111,259 (GSS, PHC, 2010).





The municipality is found in the North Eastern corridor of Northern region and bordered by seven (7) districts and two municipalities in the region and it includes; Savelugu municipality, Nanton and Karaga district to the west, to the East is chereponi and Saboba districts, Binkpurugu, Yunyoo and East Mamprusi to the North and Yendi Municipality and Mion district to the South. The municipality has an estimated land area of 5,796 km² with 22 persons per km² Population density. The Gushegu Municipality is about 114 km away from the regional capital with 395 communities (GSS, PHC, 2010).

Islam constitutes the highest religious group (68,1%) and followed by (22.2%) as traditionalists, Christianity was (7.8%) where as those who profess no religion and other religions are 1.6% and 0.3% respectively. The sex composition was that, in both Islam and Christianity there were more females than males. However, in traditional religion the males population (22.8%) outweighs that of females (21.7%).

The predominant ethnic group in the municipality is Dagombas (57.43%), followed by Konkombas (33.05%) and (9.52%) of other settler ethnic groups (GSS, PHC, 2010).

These settlers can be located in the North Eastern part of the municipality and they are mostly farmers. The highest health facility is the Gushegu municipal hospital and supported by other health centers dotted around the Municipality in places such as Kpatinga, Gaa, Katani, Damankung, Zamashegu, Zinindo, Kpanashel, Galwei and Nabuli. It is important to know that the only referral facility for medical conditions these health centres could not handle is the Tamale teaching hospital. The introduction of national health insurance in 2003, has led to an increase in OPD attendance. However, there are other personals in the municipality who help in providing health services to the

population and they include; village health workers, traditional birth attendance among others.

On the economic status of the municipality, the active population is estimated to be (43%) and out of this population (80%) are into agriculture. Most of the economic ventures in the municipality are; farming, agro-processing and foodstuff trading. In the region, the municipality seems to be the largest producer of beans and groundnuts. Shea-butter extraction and rice processing are the only industrial activities in the municipality. Also, small-scale industries such as mechanics, welding shops and petty trading among women are excluded in the municipality.

3.2 Research Design

This study used cross sectional study to carry out the studies whiles employing a quantitative method of data collection approach in the research using questionnaire. A cross sectional study is a common research method used in social science (Frankfort-Machmias and Machmias, 2008). It is advantageous because it permits a large amount of data collection in order to increase statistically power and allows more complex analysis. It is also less costly as compared to cohort and experimental studies. However, its limitations include; its inability to allow the researcher to manipulate the independent variables or the sequence of events. It occasional introduces recall bias when one is recollecting from the past (Rossette, 2015).

A quantitative design involves using precise measurements to rigorously investigate a problem in a research (Polit and Beck, 2006). It is also defined as one in which the investigator primarily uses postpositive claims for developing knowledge (cause and



effect thinking, reductions to specific variables and hypothesis and questions, use of measurement and observations and the test of theories), and data collection instrument bound to yield statistical data (Creswell, 2007). The essence of research is to come out with a plan to administer research questions and control mechanisms specification.

This method was selected above the rest because; it enables data collection on both the dependent and the independent variables simultaneously by the researcher. It was comparable quicker and cheaper to carryout (Mann, 2003). The questionnaire was administrated by the research assistants in an interview manner since most of the primigravidas were illiterates and hence, it was impossible for the questionnaires to be self-administered. In this study, the questionnaire was meant to gather information on knowledge on ANC services, demographic characteristics and psychosocial and cultural factors that determined ANC service utilization among primigravidas

3.3 Study Population

According to Brink (1999) and Sakala (2011), a study population is supposed to involve complete persons, entities or groups which are relevance in the research. This means that, the study subjects in this study are primigravidas, primiparous with live infant of six (6) months and has been to the facilities for their babies immunization were recruited into the research in the selected centres the research were conducted. Convenience sample was used in the recruitment of participants since it makes it easier to interview any primigravida who came to the health facility and agrees to partake in the research process as well as primiparous who delivered for the first time in the research areas with live



infant of six months would be recruited as participants in the research if they agree to partake in the research.

The research assistants who were nurses themselves were asked to recruit potential participants for the study. The health passport or attendance register was used to confirm the gestation and potential primigravidas as well as primiparous. Those recruited were given information for the study and seek their opinion on the willingness to participate before commencing the administration of the questionnaire

3.4 Sample Size

In this study the sample size would be determined by the used of statistical formula below,

$$N = \frac{Z^2 pq}{d^2} \text{ (Cochran 1963)}$$

Where

Z = (accurate coefficient of 95% confidence level)

P = the prevalence of ANC attendance (50% if prevalence not known)

$$q = 1 - p = 1 - 0.5 = 0.5$$

d = degree of freedom (0.05)

$$N = \frac{1.96^2 \times 0.5 \times 0.5}{0.05^2}$$

$$N = \frac{3.84 \times 0.25}{0.0025}$$



$$N = \frac{0.96}{0.0025}$$

$$N = 384$$

Planning for lost to follow-up

N (number recruited) × % retained = desired sample size

$$N \text{ (number recruited)} = \frac{\text{desired sample size}}{\% \text{ retained}}$$

Where desired sample size = 384

% retained = 0.95

$$N \text{ (number recruited)} = \frac{384}{0.95}$$

$$N \text{ (number recruited)} = 404$$

3.5 Sampling Techniques

This study was making good use of simple random technique to select the number of health centres to collect the data from since all health centres in the municipality cannot be included in the study. It was selected because it ensures that each health centre has equal chance to be selected for the sample and generalization of the findings would be possible. This was done by numbering all the health centres in the district and asks an independent person to pick one after the other until the required numbers were reached.

The element of a population was determined by using consecutive sampling technique for most contacted and easily available to take part in the study. This was employed to administer questionnaire to eligible participants at the health centres (HC) who were



available and had an interest in partaking in such research or study. This was appropriate because, it was convenience to the researcher and less costly and time consuming.

3.6 Data Collection Tools

Quantitative data collection tool such as structured questionnaire was used. The questionnaire was interpreted in the local language (Dagbani) to any respondent who did not understand English or decides to communicate in the local language. Qualitative data relating to knowledge on, benefits of ANC services, and respondents socio-demographic features as well as cultural and psychosocial factors that determine ANC service utilization among primigravidas was gathered using interviews guide

3.7 Data Analysis

The quantitative data collected was suitable for statistical analysis (Dawson et al., 2006). The quantitative data collected was analyzed using the Statistical Package for Social Sciences (SPSS) Version 20 and Microsoft Excel software packages. Two levels of analysis were carried out; descriptive analysis and inferential analysis. The descriptive analysis described the data in terms of its mean, mode, median and frequencies and these were presented in tables, figures and percentages.

The inferential analysis was done using Relative Importance Index (RII) for ranking the benefits and factors militating against the implementation of IBM. The formula is given by:

$$\text{Relative Importance Index (RII)} = \frac{\sum W}{AN}$$

Where, W = the weights given to each variable by the respondents, ranging from 1 to 5;



A = the highest weight (i.e. 5 in the study)

N = the total number of samples (384).

3.8 Study Variables

3.8.1 Dependent Variables

ANC service utilization among first time pregnant women (primigravida)

3.8.2 Independent Variables

In dependable variables in the study are; socio-demographics of study variables, knowledge of ANC services as well as psychosocial and cultural factors. These variables are chosen based on findings from published literatures and field observations such as; Mawaku, (2015) , chaibva, (2007) and Ouendo et al, (2015).

3.9 Inclusion and Exclusion

3.9.1 Inclusion.

This has to do with respondents to be involved in the study and they were first time pregnant women within the selected health centres in the district, residence in the area willing to be part in the study as well as first time nursing mothers (primiparous) who delivered for the past six month.

3.9.2 Exclusion

These were the respondents in the study who were not supposed to be included in the study and they includes; Non-residence in the district., Non-pregnant women, Pregnant



women not in the selected health centres, Non-first time pregnant women in the district, primigravidas who were unwilling to participate among others.

3.10 Pre-Test

A structure questionnaire was pre-test in non-participating health centres. This was done to ensure that the questionnaire met the stated objectives and helps to train further the interviewers. Also problems emanated from the questionnaire was identified and corrected to pave way for the commencement of the studies.

3.11 Ethical Consideration

Ethical clearance was sought from the Gushegu Municipal health directorates, chiefs and opinion leaders in the Municipality. The study objectives were explained to those agreed to take part in the studies. Voluntary informed consent was obtained from each primigravida and before the interview begins. The consent explains to the participants that, they were at liberty to be part of it or not and refusal to be part would not affect the services to be received at the facility and those opted to give consent were given assurance of good care and quality of services. The information collected were treated with maximum privacy and confidentiality.



CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION

This chapter analyses the information gathered in the field through survey and interview and the literature reviewed. It further discusses the results by relating responses of respondents to available literature for purposes of triangulation. The data was analyzed according to the four research objectives. Discussions were guided by the conceptual framework and research questions used in the study.

4.1 Knowledge about ante-natal Care.

Knowledge of ante-natal care (ANC) services is very important. Before women can access and utilize ante-natal care services, they need to have adequate knowledge about its importance, the need for it and the implications for not accessing ante-natal care in a pregnancy and the availability and accessibility of ante-natal care services at no cost at all hospitals and clinics in Ghana provided one has a valid health insurance card. WHO (2009) highlights the need to access ante-natal care. From the first trimester ANC is needed to confirm pregnancy, calculate the probable term, detect, treat and administer preventive services, make an emergency plan and prepare the birth plan.



Table 4.1 Respondents Knowledge about Ante-Natal Care

Variables	Frequency	Percentage
Knowledge of Ante-Natal Care Services		
Yes	274	71.4
No	110	28.6
Whether or not a healthy pregnant Women should Access ANC Service		
Yes	359	93.5
No	25	6.5
When pregnant Women Should Access the Service		
1st Trimester	294	76.6
Second trimester	58	15.1
Third Trimester	32	8.3
How many Visits a pregnant Woman should make to ANC clinics		
1	35	9
2	100	26
3	19	5
4	230	60

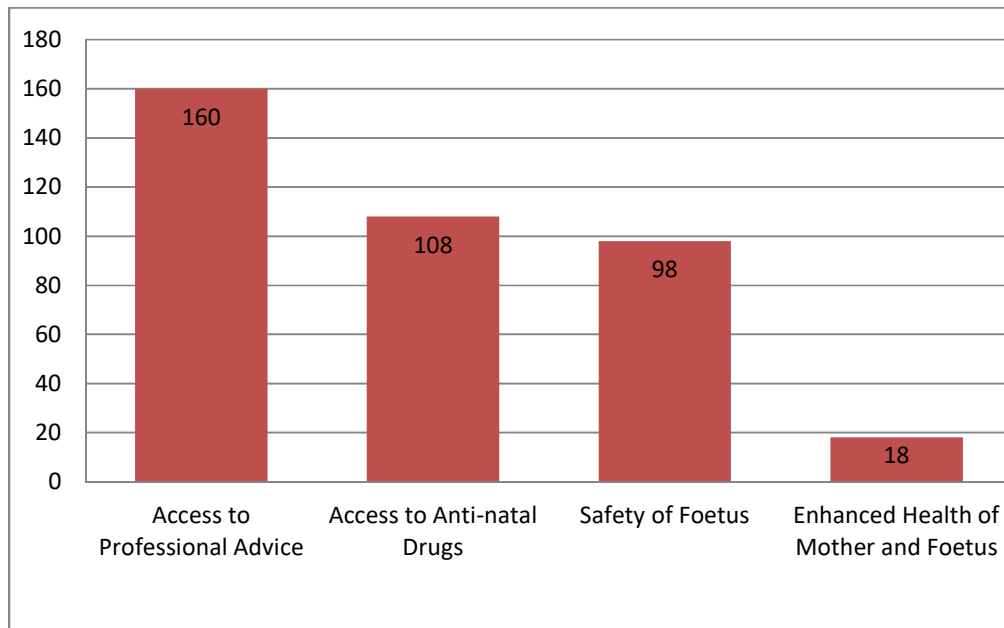
Source: Field Work, 2018

As indicated in the table above, respondents had fair knowledge about Ante- Natal Care (ANC) services. About 274 persons representing 71.4% of the total respondents mentioned that they knew about ante-natal care and about 359 of them representing 93.5% of the total respondents agreed that women need to access ante-natal care. 294 of the respondents, representing 76.6% of the respondents mentioned that such visits should be done during the first trimester of the pregnancy that is during the first three months. About 230 respondents, representing 60% of the total respondents mentioned that women



should visit the hospital at least four times before delivery. The researched further revealed that most of the respondents experienced dizziness, loss of appetite, nausea, body pains among others which determined antenatal care service utilization among primigravidae in Gushegu municipality.

Figure 4.1 Benefits of Accessing Ante-Natal Care Services



Source: Field Survey.2018

As indicated in figure 4.1, About 160 respondents, representing 41.6% of the total respondents mentioned that going to ante-natal clinics will give women access to professional advice about pregnancy and delivery from trained midwives. 108 persons, representing 28% of the total respondents mentioned access to ante-natal drugs as one of the benefits of going for ANC visits, other benefits mentioned by respondents included safety of foetus (7.3%), health of mother and foetus (41) and counseling on STIs, drug abuse and personal hygiene (4.7%).



4.2 Demographic features that determined primigravidas ANC service usage.

The researcher wanted to find out if socio-demographic factors like education, occupation, age, geographical location, planned pregnancy, possession of health insurance, religion and employment status affect ANC service utilization among primigravidae in Gushegu. The data gathered revealed the demographic characteristics of respondents as demonstrated below.

TABLE 4.2 DISTRIBUTION OF SOCIO-DEMOGRAPHIC CHARACTERISTICS OF STUDY PARTICIPANTS

VARIABLE	FREQUENCY	PERCENTAGE
AGE		
14-18	73	19
19-23	99	25.8
24-28	114	29.7
29-33	57	14.8
34+	41	10.6
MARITAL STATUS		
Single	79	21
Married	250	65
Divorces	35	9
Other	20	5
EDUCATIONAL STATUS		
Non formal	144	37.5
Primary	48	12.5
Middle/JHS	65	17
Secondary/SHS	79	20.5
Vocational/Technical	38	9.9
Tertiary	10	2.6
RELIGION		
Islam	215	56
Christianity	111	29
Traditional Religion	58	15
EMPLOYMENT		
Farming	230	60
Trading	92	23.9
Artisan	10	2.6
Student	52	13.5





ETHNICITY		
Dagomba	111	27.5
Konkomba	112	27.7
Chokosi	60	14.9
Bimoba	58	15
Grusi	70	17.3
SOURCE OF INCOME		
Salary	52	13.5
Profit from Sales	92	23.9
Transfers from Spouse/Relatives	10	2.6
Sales of Farm Produce	230	60
NHIS		
Beneficiary	307	80
Non-Beneficiary	77	20
Status of Card		
Active	215	56
Expired	169	44

Source: Field Work, 2018

As noted above socio-demographic factors such as ethnicity, employment status, age, geographical location, planned pregnancy, possession of health insurance, travel time, religious background and occupation sometimes affect the rate at which women are willing to access ante-natal services. The researcher also discovered that these factors interfered in primigravidas ante-natal care utilization in Gushegu Municipal.

4.2.1 Age

the respondents age in this study are above 18 years. About 114 respondents were aged between 24-28 years. Forty-one (41) of them representing 10.6% of the total respondents were aged above 34 years. Ninety-nine were aged between 19-23 years. Over all, respondents were still in their reproductive age. Of those who expressed willingness and

readiness to access ANC services, most of them were aged above twenty (20) years and were married.

4.2.2 Marital Status

Results from table 4.2 above indicated that, many of the participants were married. 250 of them, representing 65% of the total respondents were married, 79 were single, 35 of them were divorced and 20 others were either cohabitate or practicing different forms of marriage in the municipality.

4.2.3 Educational Status

The results from the above indicated that majority of the primigravidas are uneducated. About 144 persons, representing 37.5% of the total respondents had no formal education. Seventy-nine of them, representing 20.5% of the total respondents had attended senior high school. Sixty-five (65) representing 17% of the total respondents had completed Junior High School, another forty-eight (48) representing 12.5% had completed Primary school, thirty-eight (38) others went through vocational training and only ten (10) women had tertiary education.

4.2.4 Religion

Islam is the dominant religion in the Municipality. Most of the respondents were practicing Islam. About 215 persons, representing 56% of the women were Muslims as compared to 111 and 58 others who were Christians and traditionalists respectively.





4.2.5 Occupation

Many of the respondents were farmers. About 230 persons, representing 60% of the total respondents were farmers. 92 persons, representing about 23.9% of the respondents were traders, 52 others were students and just ten (10) persons were artisans.

4.2.6 Health Insurance Status

In Ghana, the insurance scheme covers the cost involve in accessing ANC services. The only cost women do incur is the cost of transportation and probably the opportunity cost associated with visiting the clinics. As shown in table 4.4 above, many of the women had enrolled into the health insurance scheme. About 307 respondents, representing 80% of total respondents confirmed to having been registered for the insurance card, Only 77 of the respondents were not beneficiaries of the scheme. However, of the 307 primigravidas that were enrolled into the Insurance Scheme, only 112 owned active cards and could access free ante-natal services, the rest were inactive and could not access ante-natal services.

4.2.7 Ethnicity

Varied ethnic groups participated in the research. These included Dagombas, Konombas, Bimobas, Chokosis and Gurusis. Dagombas and Konkombas constituted the majority. There were 112 Dagombas and 111 Konkombas. Gurusi were 70 in number while Chokosis and Bimobas were 60 and 58 respectively.

4.2.8 Employment Status

Results from the above indicated that majority of the respondents were farmers representing 60%, 23.9% of the respondents were traders, 2.6% were Artisans and the remaining 13.5% respondents were students

4.2.9 Sources of Income

From the table above, 60% of the respondents claimed to get their income through the sales of their farm products, 23.9% who were traders said through the profit of their sales, 13.5% said through their relatives and 2.6% said through their salaries.

Cross Tabulation of Demographic Characteristics And Number of Ante-Natal Visits To A Health Facility.

To ascertain if demographic factors influence the decisions of primigravidae to access ante-natal services in Gushegu Municipal, a cross tabulation analysis was carried out. All samples were captured with no missing number, this shows high validity and provided good analysis for the table to be used for analysis.



Table 4.3 Case Processing Summary

	Valid		Cases Missing		Total	
	N	Percent	N	Percent	N	Percent
age * Number of times visited hospital/clinic	384	100.0%	0	.0%	384	100.0%
Marital Staus * Number of times visited hospital/clinic	384	100.0%	0	.0%	384	100.0%
Religion * Number of times visited hospital/clinic	384	100.0%	0	.0%	384	100.0%
edstatus * Number of times visited hospital/clinic	384	100.0%	0	.0%	384	100.0%
occupation * Number of times visited hospital/clinic	384	100.0%	0	.0%	384	100.0%
Ethnicity* Number of times visited hospital/clinic	384	100.0%	0	.0%	384	100.0%
NHIA Card * Number of times visited hospital/clinic	384	100.0%	0	.0%	384	100.0%

Source: Field work, 2018

Table 4.3.1 Age * Number of Times Visited Hospital/Clinic ANC

x		Number of times Visited Health Facility			Total
		Non	1-3 times	4 +	
age	15-25	100	24	27	151
	16-35	62	24	25	111
	36-45	0	54	54	108
	46 and above	0	0	14	14
Total		162	102	120	384

Source: Field work, 2018

As shown in table 4.3.1 above, majority of those who did not visit hospital to access ANC services at all were within the ages of 15-25. Those who utilize the services most were aged between 36-45. For those aged between 15-25 had about 100 of them who never visited the hospital or clinic for even once, only 24 of them had visited it more than once and another 27 visited it more than four times.

Table 4.3.2. Marital Status * Number of times Visited Health Facility

x	Non	1-3 times	4+	Total
Single	61	24	2	87
Married	38	126	40	204
Divorced	45	21	27	93
Others	0	0	0	
Total	144	171	69	384

Source: field work, 2018

As indicated in table 4.3.2 above. Those who were single and did not visit the hospital were 61, those who were single and visited the hospital for more than once were 24 in number and only 2 persons who were single visited the hospital or clinic more than four times. 38 of those who were married did not visit the hospital or clinic to utilize ante-natal services. One hundred and twenty-six of them had visited the hospital or clinic for more than once and over forty of them visited the hospital over four times.

Forty-five of those who were divorced did not visit the hospital to access ante-natal services, twenty-one visited for at least once, and twenty-seven of them visited the clinic or hospital over four times to access ANC services.



Table 4.3.3. Religion * Number of time visited the Hospital

	Number of Times Visited			Total
	Non	1-3 times	4+	
Christian	18	90	70	178
Muslim	105	50	34	189
Traditionalist	09	5	3	17
Total	132	145	107	384

Source: field work, 2018

As indicated in table 4.3.3 above, one hundred and five individuals who were Muslims never visited the hospital or clinic for at least once to utilize ANC services. Fifty of them visited for at least once and thirty-four of them visited the hospital or clinic for over four times to access ANC services. Those who were Christian had a number of eighteen persons who never visited the hospital or clinic to access ante-natal services but had about 90 persons who visited more than once and thirty-four persons who visited over four times. Nine persons who were Traditionalists never visited any health facility to access ante-natal services, five of them visited for at least once and three persons visited the hospital for over four times.



Table 4.3.4. Educational Status * Number of times Visited

		Hospital/Clinic			Total
		Number of Times Visited			
X		Non	1-3 Times	4+	Total
	None	50	09	09	68
	Primary	42	75	13	130
	Secondary	18	33	31	82
	Tertiary	0	6	98	104
Total		110	123	151	384

Source: field work, 2018

As shown in table 4.3.4, fifty of those who never had any form of formal education at all never visited the hospital for even once to access ante-natal services, nine of them visited for at least once and nine visited over four times to access and utilize ante-natal services. Those who had no primary education were forty two persons and never visited the hospital to access and utilize ANC services while over seventy five of them visited for at least once and thirteen of them visited for over four times to access and utilize ANC services. Eighteen of those who had secondary school education never visited any health facility to access and utilize ANC services, thirtt-three of them visited for at least once while thirty-one of them visited a health facility for over four times to access and utilize ANC services. All those who had attended tertiary visited the hospital for at least once. Six persons visited the hospital or clinic for at least once while ninety-eight of them visited a health facility for over four times.



Table 4.3.5. Occupation * Number of Times Visited Hospital/Clinic

X	Number of Times Visited			Total
	Non	1-3 Times	4+	
Student	30	4	10	44
Trader	45	47	34	126
Farmer	25	13	10	48
Civil/Public Servant	0	40	62	102
Housewife	20	22	22	64
Total	120	126	138	384

Source:field work, 2018

As indicated in table 4.3.5 above, thirty persons who were students never accessed ante-natal services for at least once. Four of them attended ante-natal sessions at least once while ten attended it for over four times. Forty-five persons who were traders never attended ante-natal sessions even for once, forty-seven of this same group attended it for at least once and thirty-four persons attended it over four times. For the farmers category, twenty five of them did not visit any health facility to access and utilize ante-natal services at least once. Thirteen persons who were farmers visited a health facility at least once and ten of them visited for over four times to access ante-natal services. Everyone who was a public servant visited a health facility for at least once to access ante-natal services. Sixty-two persons visited for over four times to access and utilize ANC services. For those who were housewives, 20 of them never visited the hospital or clinic to access and utilize ANC services. Twenty-two of them visited the health facility for ANC service for at least once and another twenty-two visited the hospital or clinics to utilize services more than four times



Table 4.3.6 Ethnicity * Number of Times Visited Hospital/Clinic

X	Number of Times Visited				Total
	Non	1-3 Times	4+		
Dagomba	68	22	11	101	
Konkomba	23	37	57	117	
Chokosi	20	18	20	58	
Bimoba	12	25	21	58	
Gurusi	0	33	17	50	
Total	123	135	126	384	

Source:field work, 2018

As shown in figure 4.3.6 above, sixty-eight persons who were Dagombas never visited any health facility to access antenatal care services, twenty-two of them visited once while eleven persons who were Dagombas visited at least once and eleven of them visited over four times. Of those who were Konkombas, twenty-three of them did not visit any ante-natal facility to utilize the services, thirty-seven of them did visit a health facility for at least once to access and utilize ante-natal services, fifty seven of them did visit hospital Or clinics for at least once. Twenty of those who were Chokosis never visited any hospital or clinic to access and utilize ante-natal services, eighteen of them visited a health centre for at least once, and twenty of them visited for more than four times to access ante-natal services. Twelve persons who were Bimobas never visited any health facility to access ANC services, twenty-five did at least once and twenty-one of them visited a health centre for over four times. Thirty-three of those who were Gurusis visited

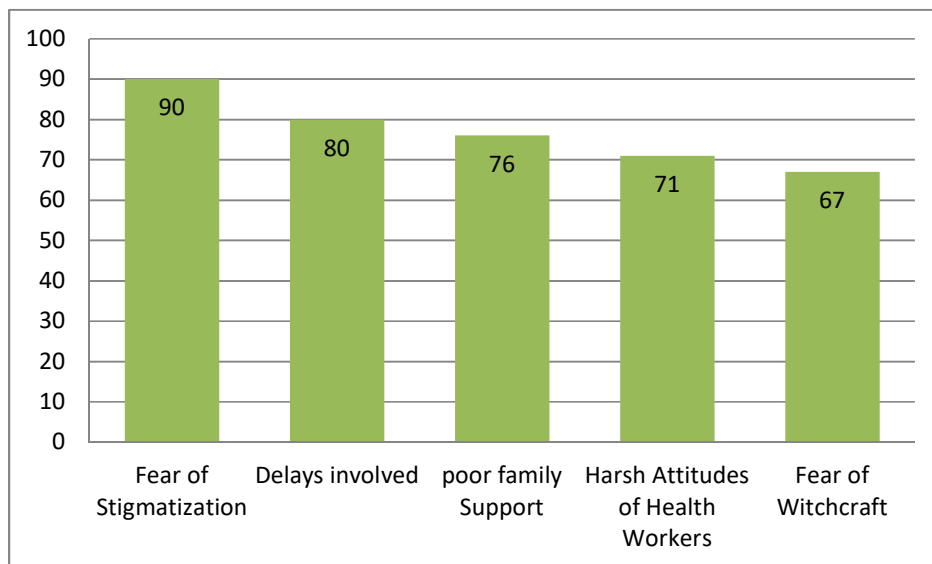


a health facility for at least once to access ANC services and seventeen of them visited for over four times.

4.3 Psycho-social and Cultural Factors that Determine Primigravidae ANC services Utilization

Psycho-social factors refer to variables such as stigmatization, attitudes. Social and family support, weak decision making power and peer pressure that when exposed to, may have some effects on the chances of primigravidae to utilize ANC services. Cultural factors are beliefs, norms and value systems that may hinder or promote ANC utilization among primigravidae. The researcher wanted to know if any of these factors affect ANC utilization among Primigravidae in Gushegu Municipal. When asked what situations may hinder primigravidae from accessing ANC services in Gushegu, respondents responses were varied as shown in the chart below.

Figure 4.3: Factors that Affect ANC utilization among Primigravidae in Gushegu Municipal



Source: Field Survey, 2018



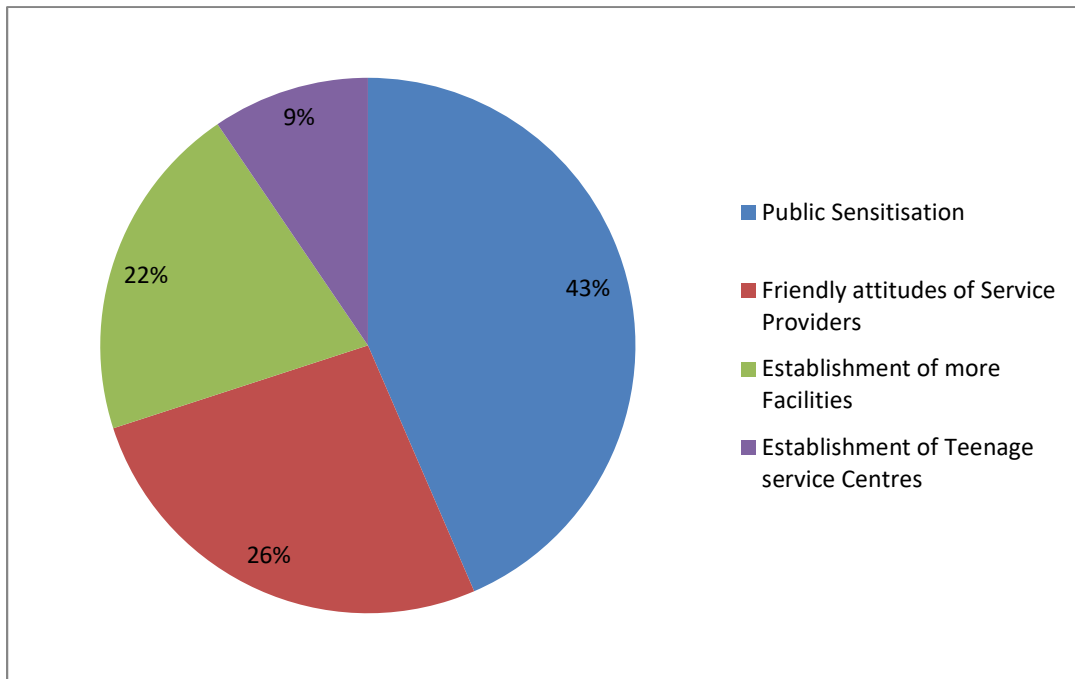
As shown above in figure 4.3, about ninety (90) respondents mentioned that primigravidae fear to access ANC services because of the fear of being stigmatized. Another eighty (80) Of the respondents representing 22% of the total respondents mentioned delays that are always characterized the provision of ANC services sometimes discouraged primigravidae from attending ANC clinics in the municipality. Also, seventy six (76) respondents representing 20% expressed poor family support as a factor that determines the utilization of ANC services among primigravidae. This follows by 71 and 67 respondents representing 19% and 17% respectively also mentioned harsh attitudes of health care providers and witchcraft as determinants interfering in primigravidas decision to access antenatal care services in Gushegu municipality.

4.4 Strategies to improve the Utilization of ANC among Primigravidas.

The researcher wanted to find out from the opinions of the respondents regarding what they felt could enhance the utilization of ANC services amongst primigravidas. Sometimes it is easy to prescribe measures that will improve a situation but it is always better to take a bottom up approach so that the issues will be understood from the perspective of those who are directly involved. Before making any recommendations, the researcher decided to sample the views of respondents. When the researcher asked the women what could be done in promoting ANC services attendance among primigravidae in Gushegu, their responses were as varied as shown below.



Figure 4.4 Strategies to Improve ANC utilization among women in Gushegu municipal



Source: Field Survey, 2018

As shown in figure 4.4 above, about one hundred and sixty five (165) persons, representing 43% of the total respondents mentioned that there should be public education and sensitization so that women will have more indept knowledge on the benefits associated in accessing ANC services as well as dangers that may occured when one fails to attend ANC services during pregnancy. Another one hundred (100) persons, representing 26% of respondents stated that ANC service utilization in Gushegu municipality will be increased if health workers change their attitudes to women. Also, eighty-five (85) persons, representing 22% of the total respondents mentioned that the distance that women sometimes have to travel and the delays associated with accessing ANC services were quite discouraging and so more nurses and midwives should be posted to the various facilities so that accessing ANC services will be easier and faster.



About 34 respondents representing 9% of the total respondents mentioned that adolescence ante-natal service centers should be established in some of the facilities so as to encourage teenage pregnant women to access the services with ease.



CHAPTER FIVE

DISCUSSIONS

5.0 Introduction

This chapter discussed the results obtained from the field survey. It highlights issues such as perceptions and understandings of ANC services, socio-demographics of respondents, psycho-social determinants of primigravidas ANC utilization as well as strategies to improve ANC services utilization among primigravidae.

5.1 knowledge of antenatal care service

With regards to knowledge of ANC services among the respondents, the survey took a look at the understanding of antenatal care in pregnancy, when to access ANC services, whether or not a healthy pregnant woman could access ANC services, number of visits and source of information as well as benefits associated with the usage of ANC services. The results revealed that most primigravidars in Gushegu municipality had fair knowledge of antenatal care service. About 76.5% of the respondents mentioned that such visits should be done during the first trimester of the pregnancy, that is during the first three months, while 60% of the total respondents mentioned that women should visit the hospital at least four times before delivery.

This corresponds with the recommendation of the WHO (2009) when it indicated that before delivery primigravidas should be observed at least four (4) ANC visits. The initial visit or service is to confirm the pregnancy, calculate the probable term, detect, treat and administer preventive, make an emergency plan and prepare the birth plan, while the other three visits are assigned to tasks such as evaluation of maternal and faetal wellbeing, exchanging gestational hypertension and anaemia, taking preventive



measures, revision and modification of the emergency plan and preparation for birth. Respondents further demonstrated their knowledge about ANC services by enumerating a number of benefits of ANC services which were consistent with those highlighted by (WHO, 2009).

When the researcher asked the respondents to enumerate the benefits of accessing ANC services, their responses were ranged from access to professional advice about pregnancy and delivery from trained midwives, access to ante-natal drugs, safety of fetus (118), health of mother and fetus (102) and counseling on STIs, drug abuse and personal hygiene (98) among others. This is a clear indication that respondents had a fair knowledge of what ANC is all about. The findings corroborates that of Hailu and Berthe (2014) when they discovered that in Ethiopia, women with exposure to maternal health service information were over eight times likely to maximize ANC services and give birth in health center relative to those who did not received information on maternal health . Mills et al (2007) reported also in Ghana that, women with exposure to mass media such as, watching television, reading newspaper and listening to radio has greater chances to use ANC service during pregnancy and even have delivering at health facility as compared to those who are unexposed. In another study by Amosu et al (2011) have shown that inadequate knowledge about FANC by pregnant women and services provided was one of the factors determining ANC service usage. Also, Sumankuuro et al (2017) discovered that negative perceptions about medications such as; folic acid, fesolate, multivariates, calcium and sulphadoxine-pyrimethane (SP) etc which are provided during antenatal care demotivates pregnant women ANC service utilization in Ghana. Other findings that supported this finding were that of Deo et al (2015) and that



of Titaley et al (2010). These findings indicated how exposure to mass media or maternal information influences the decision of pregnant women to utilize ANC services or not.

5.2 Socio-demographic features that determined primigravidas ANC service utilization.

The data gathered revealed that demographic characteristics of respondents had an influence with regards to primigravidaes ANC services utilization in Gushegu municipality. This finding revealed that, those that were unwilling to access ANC services were aged below twenty (20) years and were mostly single. They never wanted to visit the clinics for obvious reasons about the pregnancy conception. In traditional societies like Gushegu, it is shameful for a woman to be pregnant without getting married. And some of them were married, but felt they were too young to get pregnant. So the desire not to let people know about their pregnancies kept them away from accessing ANC services. About 294 persons, representing 76.6% of the total respondents agreed that women who were still in their teenage ages found it difficult to access ANC services because of insults from the elderly in the society. This finding corresponds with the findings of Aderonke (2014) when he discovered that age has a positive relationship with ANC utilization in Nigeria. Awusi et al (2009) confirmed age as a significant determinant of antenatal care services utilization among pregnant women in Sefwi-Wiasu most especially among primigravidas.

It was also discovered that mothers who were aged above 30 years and are primigravidas were also less willing to access ante-natal care services because they felt they could deliver successfully even if they don't access ante-natal care services. This finding also corroborate that of Doku's (2012) when he discovered that adolescent mothers had the



tendency to make a minimum of four antenatal care attendance relative to those who are 35 years and above. This indicates that as mother's age increases, their chances of receiving antenatal care service diminishes as well.

Asiimwe (2010) also discovered that most primigravidas are young and lack the skills of bearing children and experiencing the pregnancy for the first time, puts fears on primigravidas to make good use of ANC more than those who have experienced child birth severally. The study therefore revealed that age affects accessibility to ante-natal care services. Teenage mothers shy away from ANC so that they will not expose their pregnancy status.

In terms of ANC service utilization among pregnant women, marriage plays an important role in improving the knowledge levels of primigravidas on ANC service utilization in the municipality. In the specific context of the study, the majority of the primigravidas decision regarding the place and ANC services utilization are highly influenced by husbands. In addition, this assertion made depends on the socio-cultural and economic settings of households, especially in the Gushegu municipality where the majority of the household decisions and assets are controlled by husbands. The study confirmed that married primigravidas had the support of their husbands to access ANC services were more willing to do so than those who were either single or divorced. A single lady has no husband so getting pregnant means that she is promiscuous. They know a divorced woman has no husband yet so when she gets pregnant many people will speculate that she got divorced because she was unfaithful to her husband. These stigmas associated with pregnancy in Gushegu municipal prevent women from accessing ante-natal care services. This finding corroborates that of WHO (2003) when they found out





that, primigravidas who are unmarried tend not to seek ANC services because of the stigma associated with their pregnancy as well as poor economic and social support from spouses, guardians and parents. Married adolescent primigravidas also lack social independence and the power to make decisions with regard to ANC attendance. Yeboah (2012) also observed that, unmarried women in Akontombra had a higher chance of not initiating or utilizing ANC services relative to married women. The findings, however, contradicts that of Daniels et al (2013) when she observed that most of the maternal health problems has a linked with marital status. Also, single primigravidas were not in good position to use Maternal Health Service (MHS) more often relative to married primigravidas. The study therefore, revealed that unmarried primigravidae in Gushegu Municipality might not access ante-natal care services relative to married primigravidas.

In terms educational status of the respondents 37.5% were uneducation, while 62.5% had some form of formal education in the municipality. The study further revealed that primigravidas with some form of education had the ability and willingness to access ANC services without prejudice. Where as those who are illiterate initially saw it as a form of compulsion to copy western lifestyle which saw them put some initial resistance in accessing the services. This finding corroborates that of Oladokum (2010) when he observed that higher education assist pregnant Nigerian women to develop a positive attitude towards receiving information on maternal care which increases primigravida's knowledge on the benefits of seeking health care more especially ANC services. In Nigeria, higher education was found to have a linked with ANC services initiation within the first trimester relative to those with no or less education. Also Wado et al (2013) observed that in Ethiopia maternal education was a determinant of ANC service



utilization as well as delivery of health facilities. Stephenson et al (2006) also found out that, in Ghana, Kenya and Malawi women who are well educated had the greater chance to utilize ANC service relative to those with primary or less education. Anita (2012) also points out education as the most single influential determinant of complete maximization of ANC service even if other socio-economic factors are taken into account.

In terms of religion, Islam is the most predominant religion practiced in Gushegu municipal, it was revealed that 70% of the research participants were Muslims and out of this, 60% of them revealed that Islam is more conservative than other religions and that accessing ANC may receive some back lashes from some religious leaders because many of them could not differentiate between family planning and ante-natal care. Once you go to clinic, it is assumed that one is going to seek family planning which is ignorantly associated with promiscuity. The researcher observed that more Christian women were willing to access ante-natal care services than either the Muslims or Traditional women. The findings corroborates that of Dixon et al (2014) when they observed that in Nigeria and Ghana Muslims and traditionalists start ANC services late and more likely to have fewer visits or not to maximise ANC services at all in comparism with their Christian counterparts. Abor and Abekah (2011) also observed that religion may be modeled by different belief systems which to some extend influence how women use health services including ANC services. It was therefore revealed that, religious beliefs affect the accessibility of ANC services among women who are primigravidas in Gushegu Municipality.

It was further revealed that about 60% of the respondents were farmers and the general level of income was not very high because of their engagement into subsistence farming.



Most of them depended on their husbands, relatives and friends for financial support. 99% of the women who were traders confirmed to have attended antenatal services at least three times before their delivery. Those who were farmers and students, (65%) had attended ANC clinic only twice. The study revealed that women who were better up economically expressed more willingness than those who rely on their relatives and husbands. This corroborates the findings of Arthur (2012) when he observed that in central Nepal, there was a significant difference in the utilization of ANC service between women in service and women in agriculture. Nearly 81% of women engaged in service sector received ANC services relative to 35% in agriculture. Dixon et al (2013) observed that employment has relationship with antenatal care service due to consultation cost, buying of drugs as well as transportation cost associated with ANC. This implies that primigravidas with employment or wealth had a greater chance to utilize ANC services because of their ability to manage the cost and expenses to incur in using ANC service as compared to the poor in the society. Asundep et al (2013) also suggested wealth as a determinant of antenatal care services or attendance with associated adverse pregnancy outcomes. This implies that pregnant women (primigravidas) who are unemployed and cannot afford to pay for the cost limits the actual number of visits or attendance and consequently ANC services obtained.

The researched also realised that 80% of primigravidas were registered for national health insurance and out of this 70% of them had their cards being active or valid and could access free ante-natal services, the rest were inactive and could not access ante-natal services



The researcher observed that those who had active cards would be willing to access ante-natal care services in comparison with those who had not registered for health insurance or had their cards deactivated. This finding corroborates Wiley et al (2013) when he observed that, irrespective of socio-economic and demographic effects, primigravidas who registered for the insurance card made regular antenatal care visits as compared to those who failed to register for the service. According to Sekyi and Demanban (2012) and Aboagye and Agyemang (2013) primigravidas with health insurance had a chance to utilize health care services relative to those without insurance. The study therefore suggested that, primigravidas without insurance cards or who had inactive cards, feared to incur cost in accessing ante-natal services and so stayed away from it, but women with active health insurance cards accessed the services almost regularly until they delivered.

5.3 Psycho-social and Cultural Factors that Determine Primigravidae ANC services Utilization

Psycho-social factors refer to variables such as stigmatization, attitudes, poor family and social support, low decision making power and peer pressure that when exposed to, may have some effects on the chances of primigravidae to utilize ANC services. Cultural factors are beliefs, norms and value systems that may hinder or promote ANC utilization among primigravidae.

The researched revealed that many people fear stigmatization and this fear is a huge determining factor in the utilization of ANC services among primigravidae in Gushegu municipality. In a society where teenage pregnancy is frowned upon, teenage girls who get pregnant fear that going to ANC clinics may publicize their state of pregnancy and



expose them to so much criticism and stigmatization. This finding corroborates the findings of Pell et al (2013) when he observed that for adolescent primigravidae, initiation of ANC is strongly influenced by pregnancy disclosure; many young women choose to delay disclosure in order to attend school for longer periods of time, and to avoid stigma if they are unmarried. The United Nations (UN, 2013) also discovered that adolescent females including primigravidae face greater barriers to accessing ANC service, increasing the likelihood of complications related to pregnancy and childbirth. Primigravidas who are adolescent girls are more likely to be stigmatized due to early pregnancy and as a result, may have lower levels of family and social support as compared to older women.

The huge delays that characterize the accessibility of ante-natal services in Gushegu municipal also came up as another determining factor in accessing ANC services. About 22% of the total respondents mentioned that the delays that are always involved in accessing services sometimes discourage primigravidae from accessing ANC services because they do not like to be kept waiting on long queues as they are already stressed up because of their pregnant conditions and the distance most of them will take to reach the health centers most especially those from the hinterlands or those who live far from health centers.

It was also revealed that primigravidae, especially those who get pregnant out of wedlock often lose the support of their parents and relatives so they lack both the financial and social support they need to utilize ANC services. Chaibva et al (2010) observed that Primigravidae who are adolescent girls and are not married could be branded promiscuous as a result of early pregnancy, and may experience poor social and



family support in comparison with older and married primigravidas. Also, primigravidas are regarded to have experienced limited autonomy in terms of making decision and financial resources. These challenges encountered by primigravidas kill their spirits to seek out ANC services.

Another factor that was revealed as a determinant in utilizing ANC services in Gushegu Municipality is fear of witchcraft. In many African societies, the belief in witchcraft is very strong. Pregnant women fear that their unborn babies may be killed by other people who do not wish them well in their families. In Africa also, child bearing is very important in marriages. Marriages which are not blessed with children easily crash sometimes. The belief that someone may like to killed their child in order to spoil their marriages often keep pregnant women especially primigravidae from accessing ANC services because they do not want to publicize their pregnancies. This implies that primigravidae failed to maximize ANC services because of witchcraft. This corroborates the findings of Birmeta et al, (2016) when they found that in Zimbabwe, the fear of wizards and witches were considered to be a strong determinant of antenatal care service among primigravidas. Pregnancy in most African societies is considered to be mystery and does not require early disclosure and pregnant women are convinced of booking late beyond fifth and sixth months when the secret cannot be kept anymore and be sure that she will not attacked by evil spirits and curses (Celestin et al, 2016).

A final factor that came up strongly as ANC service determinant was the poor attitudes of healthcare providers toward primigravidas in Gushegu municipality. About one hundred (100) respondents, representing 19% of the total respondents mentioned that pregnant women feel reluctant to go for ANC services because some of the workers are



unfriendly and hostile to them. Also Matua (2004) found that in Nigeria, the behaviors exhibited by health care providers and society towards pregnant adolescents have psychological effects on them in terms of the usage ANC services. At the time of pregnancy, women already have some psychological problems like mood swing, stress and sometimes depression, additional harassment from health workers who are supposed to persuade them to access the service is a great turn off for many pregnant women especially the primigravidae.

5.4 Strategies to improve the Utilization of ANC among Primigravidas.

The researcher wanted to find out from the opinions of the respondents what they felt could improve ANC services utilization amongst primigravidas. Sometimes it is easy to prescribe measures that will improve a situation but it is always better to take a bottom up approach so that the issues will be understood from the perspective of those who are directly involved.

The study revealed many of the research participants want the Ghana Health Service to embark on a massive campaign for ANC through public education and sensitization so that women will have more indept understanding on the benefits of accessing ANC services as well as the dangers that may occur when one fails to honour ANC services in pregnancy. Many of them also stressed that men should be involved in the education and sensitization process so that they could come to support their women and encourage them to access the services during pregnancies.

In a patriarchal society like Gushegu, it is not unusual for men to prevent their women from ANC services accessibilty. A public education and sensitization will give men



adequate information on the relevance of ANC services and push them to encourage their women to access such services. The massive campaign for ANC utilization could be done by using the radio stations or increasing the frequencies of outreach services so that nurses and midwives could carry out large scale education during those visits. Public sensitization and education will enhance their knowledge on the availability of the service, its accessibility and benefits. As noted by WHO, (2009) Knowledge on when to start antenatal care services, customization of benefits and risks are low as demonstrated in most studies in Africa, thus increasing the need for public awareness and requiring the development and delivery of specific messages about the early antenatal care service utilization.

Another measure to improve ANC utilization amongst primigravidae in Gushegu Municipal was attitudinal change of health care providers. The study indicated that 100 respondents representing 26% of the total respondents mentioned that, there would be an increased of ANC usage in Gushegu municipality if health workers change their attitudes to women. They stressed the fact that many of those who go to access the services are no longer small children and require the respect that they deserve from the ANC service providers.

Many of them mentioned that sometimes nurses shout at them, push them around and say offensive things which indignity them. This makes them less willing to return to the clinic during the next visit. Of the 100 persons who complained about the negative attitudes of workers, 80% of them were age between 18-23 years. This shows that health workers are more likely to be impolite towards younger pregnant women as compared to the older ones. This outcome corroborates that of Awusi et al (2009) when they observed

that in West Africa, Health workers sometimes display unprofessional attitudes to clients through verbal abuse and unfriendliness and that this discourages patients from accessing maternal health care services.

Also, these findings indicated that eighty-five (85) persons, representing 22% of the total respondents mentioned that the distance that women sometimes have to travel couple with the delay associated with accessing ANC services is often discouraging and so more nurses and midwives should be posted to the various facilities so that accessing ANC services will be easier and faster. Of this, 87% mentioned that ANC services should be decentralized so that women can access them in their various communities without having to go to the designated few available facilities which are often congested. This finding is supported by the findings of Babinard & Roberts (2006), when they discovered that women are more likely to begin ANC after twelve weeks, attain less than four visits or deliver outside the health facility due to challenges resulting from long walking distances to health facilities and absence of transportation to ease travelling to seek care from trained personnel.

In Gushegu for instance, there are villages in the hinterlands which are already prone to default in the use of ANC, simply because of their location. They are hardly accessible by road. These villages lack most, if not all, of the basic necessities in life. Their roads are not passable especially in the rainy season, place of abode is a problem, what to eat is not guaranteed, no viable source of income, malnourished and no better source of drinking water. Even the water sources they have are the ones they share with their livestock and during dry season they spent much time in search for water which eventual affects their



ANC service utilization in the municipality. Establishing health facilities in such villages will increase ANC service utilization.

Some research participants also suggested that adolescence ante-natal service centers should be established in some of the facilities so as to encourage teenage pregnant women to access the services. The stigmatization that teenage pregnant girls suffered from older women and the community at large discourages them from making their pregnancies public because of the shame and guilt associated with teenage pregnancies in some communities. The establishment of such centers will encourage teenage expectant mothers to access ANC services. 95% of those who suggested this strategy were age below 20years and admitted to have been victims of stigmatization during ANC service.



CHAPTER SIX

6.0 SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

This chapter contains summary of main findings as indicated above in the analysis of both primary and secondary data. The major findings are highlighted, conclusions drawn and recommendations made.

6.1 Summary of Findings

It was revealed that primigravidae in Gushegu Municipality have adequate knowledge about ante-natal care services (71.4%) and that most of them recognize the need for women to attend ante-natal care clinics within the first trimester in pregnancy and continues to the last trimester (93.5%)

It was also reported that demographic factors such as age (19.3%) Marital status (21.5%), educational background (19.5%), religion (19.5%), employment (16.3%) and the membership of NHS (3.7%) interfere in the utilization of available ANC services in Gushegu Municipal. Younger primigravidas especially those who are not married may shun ANC services due to stigmatization while married women who are married and above twenty years may be more willing to utilize the ANC service. Again, women who had western education had the greatest opportunity to access the services relative those who are not well educated. Intertwined with these factors are employment and religion. Women who are employed and can earn some income will be in good position to access the services in comparism with those who are completely dependent on their husbands, parents or relatives. Christian women in Gushegu had more chance to access and utilize ANC services than both Muslims and Traditionalists women (56%). This is because of varied belief system and long held myths on ANC services.





This outcome further indicated that psycho-social and cultural factors such as the fear of stigmatization (23%), delays in accessing ANC services(21%), poor social support systems (20%). Harsh attitudes of health workers (19%) and the fear of witchcraft (17%) impact negatively on the utilization of ANC services by primigravidae in Gushegu Municipal. Many primigravidae who were pregnant at teenage age were afraid to open up to access ANC services because of the stigma they will get from community members especially older women who also access the service. The delays involved which is often caused by the number of women ANC service providers have to attend to was a frustrating factor to many primigravidae as they could hardly cope with the long hours of waiting. The poor family support which primigravidae, especially those who get pregnant at home, receive often does not encourage them to access ANC services. Couples with these factors are the harsh attitudes of health workers and the fear of witchcraft. Some unprofessional attitudes of ANC service providers such as shouting, unfriendliness and sometimes verbal abuse serve as a turn off to many primigravidae who would otherwise wish to access ANC services. Many also fear to reveal their pregnancy status because they fear their unborn babies may be killed by witches right inside their bellies.

It was also revealed that primigravidae would love public education and sensitization through the radio stations and increased number of outreach programs so that more women would get to know about the benefits, availability and accessibility of the ANC services to increase its utilization by women in Gushegu municipal (43%). Attitudinal change of both health workers and older women would encourage primigravidae to access and utilize ANC services (26%). When facilities are established in many communities including hinterland communities, congestion at the centers will be



decreased, less time would be used to deliver ANC services to pregnant women. There will also be a reduction in the transportation cost which combines with delays in accessing services to scare pregnant women away from using ANC services (22%). Respondents also felt that the establishment of a teenage service facility will encourage primigravidae to access and utilize ANC services because they will not be subjected to the ridicule and stigma that always come with attending ante-natal clinics with older women (9%).

6.2 Conclusion

Ante-natal services are essential in ensuring good health of both mother to be and foetus from conception to delivery. Apart from the physical and obstetric examinations that pregnant women go through to detect any abnormalities and correct as early as possible, pregnant women receive education on the importance of antenatal care, physiological effects that occur during pregnancy, diet and nutrition for pregnant women, personal hygiene, malaria prevention, the need for exercise and danger signs to expected during pregnancy. If Ghana intends to achieve its aim of zero maternal mortality, then it must increase awareness on the utilization of ANC services. Even though it was indicated during the study that a good percentage of primigravidas have some form of knowledge on the benefits of ANC, a good number are still ignorant of this and even those who have some knowledge about it are yet to see it as a priority.

Demographic factors such as age, education, religion, employment status, marital status and location of residence always prevent primigravidae in Gushegu municipal from accessing and using ANC services related to these are Psycho-social and cultural factors such as stigmatization of teenage pregnancy, the fear of witchcraft, poor support from



husband, parents or relatives, poor attitudes of service providers, delays in providing services to clients which combine to discourage primagravidae from accessing ANC services in the Municipal. Women in Gushegu think that public education and sensitization through the media and outreach services will not just expose women to the benefits of the services but also enlighten their husbands on the issues involve so that they can support their women to access ANC services.

6.3 Recommendations

The Minicipal Health directorates in collaboration with the Ghana Education Service should be empowered by the Government of Ghana to embark on a massive education and sensitization exercise on advantages of ante-natal services to women most especially primigravidae and inform them about the possibility of serious complications during delivery if the services are not utilized.

The Ministry of Health should organized professional development workshops and seminars for all health workers in Ghana so that they could be reminded of their professional requirement to be cordial and friendly to clients who seek medical services.

The Gushegu Health Directorate should request for more midwives and Community Health Nurses so that more health facilities would be open in the communities so that ANC services will be brought to the door step of rural women.

The Social Welfare Department in Gushegu Municipal should educate parents, husbands, relatives and friends on the need to support teenage girls who get pregnant out of wedlock so as to reduce the stigma associated with teenage pregnancies and the stress it exerts on teenage expectant mothers.

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APPENDIX

Questionnaire for assessing determinants of ANC services utilization among primigravidae in Gushegu Municipal.

Verbal consent

Greetings

Hello! My name is _____ from the University for Development Studies, Department of public Health. I am conducting a research on the topic “determinants of antenatal care service utilization among primigravidae in Gushegu municipality of Northern Region”. You are kindly requested to be included in the study; your effective contribution will lead to the success of the study. Information given will be treated as confidential.

May I continue?

If yes, continue interviewing

If No, thank her and stop interviewing

KNOWLEDGE ABOUT ANTENATAL CARE

1 What do you understand by Antenatal Care Services?.....

2. How did you hear about Antenatal Care Services?

1. through friends
2. through relatives
3. during a visit to health institution
4. through the media





3. Should healthy pregnant women (primigravidae) access ANC services?
 1. Yes
 2. No
4. If yes when should pregnant women access Antenatal Care Services?
 1. 1st Trimester
 2. 2nd Trimester
 3. 3rd Trimester
5. How many visits should a pregnant woman make to the Antenatal Care Services during the entire period of pregnancy?
 1. 1
 2. 2
 3. 3
 4. 4
 5. More than 4 (Specify)
6. Do you know some of the dangerous health problems related to pregnancy?
 1. Yes
 2. No
7. If yes, can you mention at least two (2) pregnancy health related problems you know?.....
8. Did any of the above mentioned problems determine your decision to access ANC services?
 1. Yes
 2. No
 3. Don't remember
9. If yes, which one? Do you have reasons for that?

.....



.....
.....

10. What are some of the benefits of Antenatal Care Services?

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

SOCIO-DEMOGRAPHIC CHARACTERISTICS DATA

11. Age of respondents

- 1. 14-----18
- 2. 19-----23
- 3. 24-----28
- 4. 29-----33
- 5. 34+

12. What is your occupation?

- 1. Salaried worker
- 2. Farming
- 3. Trading
- 4. Artisan

5. Casual worker

6. Student

13. Educational status

1. Non formal

2. Primary

3. Middle /JHS

4. Secondary /SHS

5. Vocational / Technical

6. Tertiary (Univ, Poly, Training College)

7. Others (Specify)

14. Religious Denomination

1. Islam

2. Christianity

3. Traditional Religion

4. Others (specify)

15. Marital Status

1. Single

2. Married

3. Divorced

4. Widowed

5. Separated

16. Ethnicity / Tribe

1. DAGOMBAS

2. KONKOMBAS

3. Others





17. Employment status
 1. Self Employed
 2. Not Employed
18. Type of employment (specify).....
19. Employment status (husband).....
 1. Employed
 2. Not Employed
20. Type of employment (specify).....
21. Source of income
 1. Self
 2. Spouse
 3. Parents/guardian
 4. Other (specify).....
22. Do you have health insurance?
 1. Yes
 2. No
23. Where have you registered for NHIS card?
 1. District insurance office
 2. Agent
 3. My house
24. Was your health insurance valid at the time you became pregnant?
 1. Not valid health insurance
 2. Valid health insurance
 3. None of the above
25. Is your home to the insurance office far?

1. Yes

2. No

26. If yes how does it affect your early registration for maternal health insurance card?

1. Waste of time

2. Waste of money

3. Not applicable

27. How many weeks did it take you to get the insurance card?

1. 1

2. 2

3. 3

4. 4

28. How does it affect your initiation of antenatal care services?

1. First trimester

2. Second trimester

3. Third trimester



PSYCHO-SOCIAL AND CULTURAL FACTORS THAT DETERMINE PRIMIGRAVIDAE ANC SERVICES UTILIZATION.

29. Identify at least four (4) factors that motivate you to access ANC service.

.....

.....

.....

.....



30. Which of these people influence your decision not to use ANC services?

1. parent/guardian
2. Peers
3. Media
4. Others (specify)

31. Which of these determinants prevent you not to access ANC services in your community?

Tick the correct option you think is applicable

	yes	No
Fear of stigmatization		
Fear of witchcraft		
Fear of HIV positive		
Unfriendly healthcare provider attitudes		
Poor family and social support		
Low decision making power		
Peer influence		
Parents influence		
Dalliance in providing services to clients		
Older clients attitudes		

32. What strategies do you think can promote ANC service utilization among primigravidae?