

Importance of Antenatal Care, Factors Affecting Utilization of ANC in Bombali District- Northern Sierra Leone

Prince T. Lamin-Boima and Catherine M Norman

Milton Margai College of Education And Technology

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Abstract- Maternal mortality continues to pose challenges as Sierra Leone record the highest maternal mortality rates in the world (857 per 100 000 live birth). This study sought to determine the importance of antenatal care and factors affecting utilization of antenatal care service in Bombali district Northern Sierra Leone. A cross-sectional study that combines both qualitative and quantitative data collection methods were conducted for 174 Antenatal Care attendees and 26 health care providers. The collected data is analyzed using a simple descriptive statistics with the help Excel Microsoft ware. The findings observe that; women were not satisfied with the care, although they are still engulfed in the traditional myths and misconceptions. A statistical significance was found in relation to knowledge, ignorance, low income, age and distance to the health facilities. The study recommend to improve women access and utilization of Antenatal Care services by continuous community based health education and facility-based education.

Index Terms- Antenatal care, free health care initiative, maternal mortality rates, focussed antenatal care

I. INTRODUCTION

A 1.1 Background of the study

Antenatal care (ANC) in Sierra Leone is regarded as an important health care and health promotion activity that aims at enhancing maternal and foetal well-being during pregnancy as well as favourable pregnancy outcomes. Reduction of maternal and neonatal mortality remains a major challenge to attaining global social and economic development. Worldwide, more than 515,000 women die each year from pregnancy and childbirth complications while four million babies die within the first week (neonatal period) of life. (ROK, 2006; WHO, 2007).

Maternal morbidity and mortality in developing countries, like Sierra Leone, continue to pose challenges to the health care delivery system. The Sierra Leone Health and Demographic Survey 2008 reported that 87% of pregnant women had attended antenatal care at least once, only 25% of births were institutional deliveries and 43% were supervised by skilled attendants. In addition to its high child mortality rate, Sierra Leone has one of the highest maternal mortality rates in the world, with a maternal mortality ratio of 857 per 100 000 live birth. The proportion of babies born in a health facility was generally low in most regions

but was lowest (15.5%) in the Northern Region. The MDG report postulates that maternal deaths can be reduced if women have access to ANC and other maternal services and that maternal services should aim at empowering Sierra Leonean women.

Globally, Sierra Leone is ranked among the countries with the worst maternal and child health indicators. The death of women and children can be prevented by simple cost-effective community-based interventions. However, there has been a tremendous decline in maternal mortality ratio (MMR) worldwide. Despite this recent decline, Sub-Saharan Africa has the highest MMR in the world albeit strategies and interventions that prioritize maternal health (Hogan et al. 2010; WHO 2012).

Globally scientific evidence has shown that low utilisation of Focus Antenatal Care services is influenced by some factors such as low maternal education, teenage pregnancies, multiparity, unplanned pregnancies and cultural factors (Simkhada et al. 2008). The maternal mortality ratio (MMR) and proportion of births attended by skilled personnel are important indicators of quality maternal health (APHRC, 2002). The MMR is unacceptably high at 414 per 100,000 live births with 30 women suffering long-lasting injuries and illnesses per every woman who dies. Only 42% of women deliver with a skilled provider (CBS, 2004; ROK, 2006). Studies clearly indicate that countries with high maternal, perinatal and neonatal mortality have inadequate and poor quality of health services. Studies have linked low utilization to poor pregnancy outcomes, which ultimately lead to higher maternal and neonatal morbidity and mortality (Raatikainen et al. 2007).

One of the strategies aimed at addressing maternal mortality in developing countries is the implementation of focussed antenatal care (FANC), which is the care a woman receives throughout her pregnancy (WHO 2002). Trials conducted in Argentina, Cuba, Saudi Arabia, and Thailand proved that FANC was safe and was a more sustainable, comprehensive, and effective antenatal care (ANC) model (WHO 2002). Based on results from trials on FANC, the World Health Organization (WHO) in 2001 issued guidance on this new model of ANC for implementation in developing countries. The new FANC model reduces the number of required antenatal visits to four, and provides focused services shown to improve both maternal and neonatal outcomes.

1.2 Geography and administrative system of Bombali district

d. What barriers might impact negatively on the utilisation of ANC services?

e. What can be done to enhance the current practices and perceptions of health care providers towards the utilisation of ANC services in Bombali?

1.5 Null hypotheses

There are no important factors affecting utilization of antenatal care services in Bombali district of Sierra Leone

1.6 Objectives of the study

1.6.1 General objective

The general objective of the study was to examine the importance of antenatal care, factors affecting utilization of antenatal care service in Bombali district of Sierra Leone.

1.6.2 Specific objectives

The study's objectives sought to:

- 1) To determine factors influencing late attendance for antenatal care services in Bombali district
- 2) To establish the challenges faced by care providers in the provision of quality antenatal care.
- 3) To establish the knowledge of mothers about the benefits of seeking ANC early.
- 4) To establish the current practices and perceptions of health care providers towards antenatal care services.

1.7 Significance and anticipated output

Improvement of quality of ANC is a major strategy used by hospitals and health care facilities to reduce maternal death and morbidity. The study was aimed at identifying gaps and barriers in the provision of quality ANC facilities, which when addressed will go a long way in strengthening the capacity and credibility of public ANC. This will result in improved client satisfaction, sustained use of services and improved outcomes of care. Women presenting themselves for ANC services will be empowered to make informed decision on their health and that of their infants, and reap maximum benefits from care. Effective utilisation of ANC services, through early booking for ANC, receiving health promotion information and health care, is crucial to enhancing maternal and foetal health during pregnancy and reducing mortality and morbidity statistics.

II. LITERATURE REVIEW

2.0 Antenatal care

Antenatal care is a necessary health sector for every pregnant woman and the newborn baby. Pregnancy is a crucial time to promote health behaviors, prevent complications and avoid new born-illness. Essential interventions including, TT immunization, identification and management of STIs, malaria prevention and treatment, identification and management of pregnancy complications such as anemia, nutrition, counseling, preparedness and counseling on maternal and new born danger signs.

The usual recommendation nowadays is for booking (first antenatal visit) to take place in early pregnancy, prior to 14 weeks. The World Health Organization (WHO) recommends that pregnant women in developing countries should seek ANC

within the first 4 months of pregnancy. A WHO Technical working Group recommended a minimum of four antenatal visits for a woman with a normal pregnancy (lancet, 2001). However, some women require more than four visits especially those who develop complications (lancet, 2001). Although progress has been made globally in terms of increasing access and use of one antenatal visit, the proportion of women who are obtaining the recommended minimum of four visits is too low.

The coverage, affordability, and sustainability of ANC services package need to be assess over time. This requires countries to respond to certain key questions: How to re-organize services to ensure delivery of a comprehensive, integrated package and assessing the contribution of the package to improve quality of care and components required in strengthening over time.

The person with midwifery skills who is part of and lives in the community can offer ANC services. However, in developing countries like Sierra Leone which have a shortage of well-trained health care personnel, ANC care is often provided by less qualified staff such as auxiliary nurse/midwives, maternal and child health aid, and Traditional birth attendants (TBAs) whose background may be conditioned by strong cultural and traditional norms which may hamper the effectiveness of their services. For the fulfillment of complete set of tasks required to manage normal pregnancies and births, their skills need to be improved through education, training and supervision by well-trained midwives.

The world health organization estimates that there are 5.1 million deaths in the new born period; that is before the baby is one month old. Almost 3.4 million of these occur during the first week of life, while 4.3 million fetal deaths are estimated to take place before or during delivery. These prenatal deaths are largely consequences of poorly managed pregnancies and deliveries or the result of inadequate care of neonate during the first critical hours of life.

Every year some 200 million women become pregnant. It is estimated that more than 50 million women each year develop pregnancy-related complications, which require medical attention (Murray C.J.L, 1997). For close to 600,000 women pregnancy-related complications are fatal (WHO, 1996). Nearly all maternal deaths occur in developing countries and among the most vulnerable and disadvantaged population groups. The current global estimates show that in the developing world approximately 65% of pregnant women receive at least one antenatal care visit. 40% of deliveries take place in health facilities and slightly more than half of all deliveries are assisted by skilled personnel. This contrasts sharply with developed countries where practically every woman receives regular care during pregnancy, delivery and postpartum period. By the end of 20th century, it was estimated that every year an estimated 45 million pregnant women were still receiving no antenatal care, more than 75 million births take place at home and 60 million women giving birth with only a traditional birth attendant or a family member present; in many cases the mother is alone.

In less developed countries 35% of pregnant women receive no antenatal care at all during pregnancy, 70% and 90% of women receiving antenatal care return for a second visit. The proportion of women continuing care for 4 visits or more is, however, markedly lowers. Data on the timing of the first

antenatal visit reveal care usually starts sometime in the first 5 or 6 months.

Generally, many factors contribute to less utilization and access to antenatal care services: high rates of teenage pregnancy, low perception of pregnancy related risks, low level of female involvement in reproductive health and rights, harmful and negative culture on reproduction, gender relations, and health seeking behavior as well as poor infrastructure.

2.1 Barriers to utilization of Antenatal care services

A good deal of literature has identified a number of barriers faced by women in seeking professional health care, particularly for maternal services (Park Hurst J, country report, 2005). The perception of a normal versus a complicated delivery, for instance, appears to influence where women will look to deliver, regardless of other barriers at times. In Sierra Leone lack of resources and skilled staff to improve quality and delivery of maternity services, despite good policies and concerted efforts, have hindered the increase in the utilization of those services by women or a reduction in the high ratio of maternal deaths (Kanu JS, Tang Y, Liu Y 2014). Yet there has not been an increase in the utilization by women of emergency obstetric services at health facilities nor a corresponding significant reduction in maternal deaths. The proportion of women delivering in health units remains low and there is a gap between the numbers attending antenatal services and those delivering in health services (Statistics Sierra Leone (SSL) and ICF Macro 2008).

ANC is an opportunity to promote the use of skilled attendance at delivery and healthy behaviors such as breastfeeding, early postnatal care, and postpartum family planning for limiting or spacing births. However, studies have shown that there are many missed opportunities for care, both because of client- and health system-related factors. Mothers and children may face risks because of limited or late-term ANC visits, low-quality care during visits due to poor provider training, infrastructure and administrative weakness at facilities (Armar-K, 2006).

The individual's use of the health facility is also influenced by the characteristics of the community in which the person lives, indicating a need to look beyond the individual factors when examining health seeking behaviors (Stephenson R, 2002). First, consumers lack of the human capital-education to promote their own and their families' health (Tim Ensor, 2004). Education may provide consumers with a basis for evaluating whether they or a dependent require treatment inside or outside the home. Education provides the consumer with the basis for evaluating whether they require treatment. While it is sometimes suggested that individuals are unable to assimilate information on treatment options, this assumption is challenged by Leonard's recent work in Tanzania (Leonard K.L, 2002).

Studies in many countries have also shown that barriers such as distance may be surmountable, as evidenced in cases where individuals bypass local services to reach ones of higher quality or when Distance is given as a reason for non-use, despite health facilities being available. There is much evidence to suggest that distance to facilities imposes a considerable cost on individuals and that this may reduce demand. In studies reviewed for this study, transport as a proportion of total patient costs, a study carried out in Bangladesh suggested that, transport to

health facilities was the second most expensive item for patients after medicines (CIET Canada, 2000).

Location and distance costs are often seen to negatively impact ANC service utilization. A study in Vietnam found that distance is a principle determinant of how long patients delay before seeking care (Ensor T, 1996) Another, in Zimbabwe, suggested that up to 50% of maternal deaths from hemorrhage could be attributed to the absence of emergency transport.

A study in Australia found that the impact of costs fell most heavily on the poor. Two types of barrier are critical: physical and financial. In poor countries, the density of health infrastructures equipped and staffed with competent, available and committed personnel is low (Koblinsky M, et al, 2006). For women this often means they are too far to walk' and they prefer to deliver at home rather than embarking on a long and difficult journey to under-equipped health centres or poorly staffed district hospitals. When women or the family decision-makers decide to attend an appropriate health service, the next obstacle is money.

Cultural and socio-economic factors such as the low status of the female in society, limited decision making powers, social immaturity and financial limitations might contribute to poor utilization of ANC services, resulting in an increased incidence of pregnancy and obstetric complications. Bouwer et al added that religious beliefs in certain societies may pose barriers to the utilization of ANC services. Bouwer et al recommended that health workers should understand variations in family composition, social class, health beliefs and behaviors and be able to bridge the gaps between the beliefs and behaviors. At the community level the TBA is also vital in influencing demand. One study in Rajasthan found that more than 90 percent of women that did not obtain referral care were advised against it by the TBAs (Hitesh J, 1996).

Cultural norms, restrictions, can prevent women from seeking health care outside the home for themselves and their children. This barrier is often raised still further when men provide services, and has been offered as one reason why Asian women living in Western countries often make little use of health services. Another example of culture as a barrier to using health services is the perception and unacceptability of modern contraception among men in parts of many rural areas.

In general most specifications do not include interaction variables between demand-side barriers and income. As a consequence, most literature indicates the specific contribution of economic status on demand for services rather than indicating whether barrier-elasticity differ by economic status. The evidence certainly provides some support for the intuitive hypothesis that barriers are more important for the poor. There is, however, a dearth of evidence that quantifies these barriers. In addition, in some cases lower opportunity costs among low-income groups may sometimes mean that barriers are greater for the non poor.

A review by WHO found that the direct costs of maternal health care range between one and five percent of total annual household expenditures, rising to between five and 34% if the woman suffers a maternal complication (WHO, 2006). Globally, \$15 billion is estimated to be lost every year due to reduced productivity related to the death of mothers and neonates.

Policy interventions on the demand and supply sides must progress in cycle.

Poor quality of health services is a major problem in many, but not all, developing countries (World Bank Report, 2004). However, facilities open and close irregularly; absenteeism rates of doctors and nurses can be very high; staff can be hostile, even violent to patients; misdiagnosis is not uncommon, medicines are all too often unavailable, sometimes due to staff pilfering for use in private practice; and there is inappropriate prescribing and treatment. Deficiencies in quality have direct implications for access to effective health care. Further, one expects that demand will diminish in response to the poor quality of the care offered. This confirmed by the example of Ghana where a decline in quality of public health care was associated with 40% fall in utilization within only five years (1979-1983).

A second problem is that the available resources are not allocated to the most effective interventions, are geographically concentrated in large cities, and do not reach the poor. Despite the WHO *Alma Ata Declaration*, the bulk of public health expenditure continues to be absorbed by hospital based care delivered at some distance from poor rural populations. Shifting the balance of resources further toward primary care would not necessarily have the desired impact on the level and distribution of population health. However, there are major deficiencies in the quality of primary care delivered in many developing countries.

2.2 Intervention measures to the barriers affecting the utilization of Antenatal care services

In the health sector, there are a number of policies with implications for maternal service provision. To expand the platform for health care services, the private sector is foreseen to play an important role in the implementation of the national health policy and a public-private partnership policy has been drafted to set the modalities of the collaboration (Freddie S Sengoba, 2004).

Women's disproportionate poverty, low social status, and reproductive role expose them to high health risks and preventable death. Yet cost-effective interventions like the free health care initiative (FHCI) in Sierra Leone makes it possible for more women and children have easier access to health care and stop these unnecessary inequalities. To achieve the greatest health gains at the least cost, national and donor investment strategies have given considerable emphasis to health interventions for women, particularly during their reproductive years. There has been much progress in improving women's health; however, some challenges remain and new ones keep emerging.

Prevention of unwanted or ill-timed pregnancies is also essential to improving women's health and giving them more control over their lives. Safe motherhood interventions can strengthen the performance of the overall health system. The effectiveness of maternal health services is often hampered by organizational and institutional constraints. Improving access to good-quality maternal health care remains a challenge in many countries because it requires a functioning primary health care system in the community and a referral system to a health facility capable of providing emergency obstetric care. Safe motherhood

interventions designed to integrate various levels of the health sector can thus bring about improvements that more broadly affect the health system.

Interventions to improve women's educational attainments are potentially wide reaching and mostly outside the traditional scope of the health sector. Apart from improving the general standard of, and access to, education, targeting schemes for raising female enrolments have been developed to include financial and non-financial. Schemes to empower women may be helpful in breaking down historical barriers to seeking care. Services that are sensitive to prevailing cultural conventions, without compromising medical standards, may also have an impact on the demand for services.

Promoting health and confronting disease challenges requires action across a range of activities in the health system. This includes improvements in the policymaking and stewardship role of governments, better access to human resources, drugs, medical equipment, and consumables, and a greater engagement of both public and private providers of services. Experience has shown that, without strategic policies and focused spending mechanisms, the poor and other ordinary people are likely to get left out.

If health services are not of adequate quality, no amount of demand stimulation will induce people to access them. It is also important to realize that many potential interventions on the demand side are extremely wide ranging and often stray a long way outside what is traditionally seen as the health sector. In practice many of the interventions may have to be conducted through ministries other than health a challenge for cross-government collaboration. The development of poverty strategies provide one forum for such joined up policymaking and suggest a real opportunity for grounding many of the interventions in genuine collaboration.

Delivery of essential services concentrates on improving the quality of staff skills, protocols of treatment, availability of supplies and environment of health facilities. Yet while these interventions are important, they do not address many of the barriers to accessing services faced by a patient in a low-income country.

III. METHODOLOGY

3.0 Study design

This research is a cross-sectional study. A combination of qualitative and quantitative data collection methods was used. In depth interviews and focused group discussions were conducted to both ANC attendees and providers at the public/private hospitals. A pre-tested questionnaire was administered to ten participants. After the pilot phase a semi-structured questionnaires were administered to ANC attendees on exit after receiving ANC services and ANC providers at the Clinic.

3.1 Study area

The study was carried out in Makeni city, Bombali District of the northern Sierra Leone and focuses on three hospitals/clinics (one government and two private). Currently, Bombali district has 16 community health centres (CHC), 18 community health posts (CHP), 48 maternal child health posts (MCHP), 1 government hospital, 1 military hospital, 1

community hospital, 3 mission Clinics, 3 mission hospitals and 3 private clinics. Endemic diseases are Yellow Fever and Malaria across Sierra Leone. The city had a population of 80,840 in the 2004 census and a current estimate of 112,489.

3.2 Sampling procedure

The study population comprised of mothers and pregnant women in the reproductive age group (15–49 years) seeking antenatal care services in Makeni city. Participants were purposively approached for selection from Makeni city. At hospitals/Clinic potential participants were selected systematically. Every second participant was approached for interview each working day of the week. A list of antenatal care attendees on a clinic day was prepared and a number assigned for each attendee. Attendees were picked at every third interval that is 3, 6, 9 until the required number of participants was reached. The same sampling procedure was used to come up with respondents for in depth interviews. A sample of 174 women from the ANC hospitals/clinic was selected (40 first trimesters and 134 late trimesters).

A semi-structured questionnaire focusing on demographic characteristics, socio economic indicators, knowledge of ANC, drugs administered to women and alternatives to ANC being undertaken in early phases of pregnancy was administered to the participants.

3.4. Focus group discussions (FGD)

Four Focus group discussions were conducted to seek opinions and knowledge on ANC practices in relation to new born health at the community and household levels. Participants included mothers, fathers and other community based caregivers. Group discussion were conducted focusing on the places where women go for antenatal care, when they go for antenatal care, alternatives to ANC mothers use in early phases of pregnancy, why they go for antenatal care, antenatal care services provided, medicine given during antenatal care, visits and changes the mothers feel should be done to improve antenatal care services and child management.

3.5 Data analysis

The list of indicators that were used included dependent variables such as first trimesters and late trimesters, independent variables included age, marital status, education, literacy among others. Social demographic characteristics of the sample were reported using descriptive statistics. Qualitative data from focus group discussions and key informant interviews were typed edited and entered into a computer and summarized.

3.6 Ethical considerations

Participants were asked for their consent to participate in focus group discussion and fill in structured questionnaire. But most importantly, the values and norms of the local people were studied well and respected to avoid any misconception and all the necessary permission from the university and the district authorities where the research was carried out.

The study covered a population of 200 respondents. To obtain data from the field a total of 174 questionnaires, 174 women from the ANC hospitals/clinic was selected (40 first trimesters and 134 late trimesters) but interviews and Focus Group Discussions (FDG) were also conducted. The four categories of respondents included; District health officials /providers, ANC attendees, Women and men in Makeni city.

For easy analysis and interpretation of data collected from the field, the data was captured in the different responses and categorized into different themes.

4.1 Social demographic characteristics of the respondents

This section focuses on both ANC providers and ANC attendees as the study set out to establish in terms of age, gender, and economic status, level of education, marital status, religion, and gravidity.

Table 1- 6: Socio-Demographic Characteristics of ANC attendees

The tables below demonstrate the socio-economic characteristics of ANC attendees in the government hospital and privates hospital/clinic.

Table 1 Age

Category	Government n=34	Private Clinic 1 n=84	Private Clinic 2 n=29	Private Clinic 3 n=27	Total
14-24	13	37	11	12	73
25-35	11	22	8	7	48
36-46	10	15	5	6	36
47- 57	-	10	5	2	17
	34	84	29	27	174

The majority of ANC clients were in the age bracket of 14-24 years (41.9%) and more ANC client attend Private clinics than the Government hospital (80.5%).

Table 2 Marital Status

Married status	Government n=34	Private Clinic 1 n=84	Private Clinic 2 n=29	Private Clinic 3 n=27	Total
Married	16	25	14	10	65
Single	9	41	10	7	67
Widowed	9	18	5	10	42
Total	34	84	29	27	174

Majority (38%) of the ANC attendees were singles, the study revealed that single status plays a significant role in determining women's utilization of ANC service. It was

IV. DATA PRESENTATION AND ANALYSIS

4.0 Introduction

discovered that most married women go for antenatal care early than single, widowed and divorced mothers.

Table 5 Income

Category	Government n=34	Private Clinic 1 n=84	Private Clinic 2 n=29	Private Clinic 3 n=27	Total
Low	19	48	19	15	101
Fairly high	15	36	10	12	73
Total	34	84	29	27	174

Table 3 Occupation

Category	Government n=34	Private Clinic 1 n=84	Private Clinic 2 n=29	Private Clinic 3 n=27	Total
House wife	13	37	11	12	73
Farmer	11	22	8	7	48
Petty Traders	10	15	5	6	36
Civil Servant	-	10	5	2	17
Total	34	84	29	27	174

The results show that majority of the women 42.0% were House wives, while 27.6% of the ANC attendees were farmers and their level of income was low. 20.7% were petty traders and only 9.8% of them were civil servants and none of them attend ANC at the Government hospital.

Table 4 Education

Category	Government n=34	Private Clinic 1 n=84	Private Clinic 2 n=29	Private Clinic 3 n=27	Total
None	12	38	12	12	74
Primary	19	29	9	7	64
Secondary	2	4	5	6	17
Tertiary	1	13	3	2	19
Total	34	84	29	27	174

74 respondents (42.5%) of the ANC attendee had no formal education while 9.8% had secondary education and 10.9% had tertiary education. This correlate to the number of civil servants and the income they earn. There was significant difference in proportion of the ANC attendees in the timing for antenatal care and use of other ANC alternatives in relation to literacy levels. The study findings revealed that, the low levels of education had significantly influenced the timing and utilization of ANC at health facilities.

The overall level of income of the ANC attendees was low (58.0%). This means that there are high poverty levels among women in the area of study which in one way or the other affects their ability to access and utilize ANC facilities that are in most cases located kilometers away from their area of residence. Level of income at a household was defined on the basis of one member having permanent job, engaged in small scale business and subsistence farming. Low income level households were those that depended on subsistence farming for their living. Households with a reasonable source of income were categorized as having fairly high income.

Table 6 Gravida

Category	Government n=34	Private Clinic 1 n=84	Private Clinic 2 n=29	Private Clinic 3 n=27	Total
Gravida 1-2	14	22	17	12	65
Gravida 3-4	9	30	10	8	57
Gravida 4 and above	11	32	2	7	52
Total	34	84	29	27	174

The majority of ANC clients were of gravidity 1-2 (37.4%). There were fewer respondents in the gravida 4 and above (29.9%). The distribution of respondents by gravidity revealed that mothers with less gravida (1-2) pregnancies start ANC early in pregnancy than those who have experienced more pregnancies.

All these contribute to limited ability to utilize ANC and therefore poor antenatal care seeking behavior. Education of the mother and that of members of the household were found to be significantly associated with the levels of utilization of ANC services.

Respondents reported having first attended an antenatal clinic during the second trimester of pregnancy, and had attended at least once before the third trimester. Some respondents whose first ANC visit was later than the second trimester, the reasons given for late attendance were: having had no problems during pregnancy and therefore no need to visit the clinic; a long distance to travel from home to the clinic, avoiding making many trips to the health facilities, and thinking they were earlier on in gestation than actually was.

Reasons	Frequency
Poor Quality	28
Myths and misconceptions	3
Traditional beliefs	8
Financial difficulties	86
Alternatives to ANC	12
Ignorance	32
Age	5
Total	174

4.2. Characteristics of ANC providers

The ANC providers were contacted during this study were 26 including the District medical officer, medical doctors, senior nursing officers, nurses and midwives offering ANC services in these hospitals/clinics.

Table 7: Social –demographic characteristics of ANC providers.

Variable	Male	Female	Total
Sex	10	16	26
Cadre			
Medical doctor	5	-	5
CHO	2	1	3
Public health Sister	-	2	2
Registered midwife	-	4	4
Registered nurse	1	5	6
SECH Midwife	-	1	1
SECHN	2	3	5
Total	10 (38.5%)	16 (61.5%)	26

According to the study findings, majority of the ANC providers were females (61.5%) and majority was nurses comprising 69.2% and had been in service for the period of 0-5years (47.1%). ANC providers had a positive perception towards antenatal care and were helping ANC seekers obtain the necessary services. However, ANC providers identified challenges of shortage of facilities and equipments necessary for ANC services.

4.3. Factors influencing Antenatal care late attendance

One of the objectives of the study was to determine reasons for ANC late attendance by pregnant women. To investigate the timeliness of ANC attendance, a categorization of 'early first attendance' was defined as a first visit to ANC at or before 4 months gestation, while those who made their visit after four months were categorized as late starters/beginners.

Through exit interviews with ANC attendees, participants from each group (early and late starters). The responses from both groups of ANC clients had knowledge about the dangers/disadvantages of starting ANC late in pregnancy. The study intended to establish why women sought ANC late. ANC providers and attendees gave the following views as the reasons why mothers seek ANC late:

Table 4: Reasons for late attendance Reasons mentioned by ANC providers and attendees for late attendance

4.3.1 Poor Quality of Care

Poor quality care at the health facility was mentioned by the respondents. The type and quality of antenatal care services that the women reported receiving were inconsistent and inadequate, and differed greatly from Ministry of Health. Fewer than half received any type of immunization services, and no hemoglobin tests, urine analysis, syphilis screening, or voluntary counseling and testing for HIV. Moreover, no counseling on risk factors and warning signs and symptoms during pregnancy were reported, and no adequate information related to delivery was given to women.

In this regard one woman mentioned that, the reputation of nurses and midwives regarding care for delivering women was not good and as a result many women were scared of their bad behavior. Another significant finding from the study in relation to poor quality care was mistreatment by ANC providers, especially in government hospitals. With respect to delivery care, nearly most of the women were not satisfied with the care they received at their final place of delivery, because they reported health providers were rude and not treated well or were not treated in a timely manner.

The above findings contravene the fact that; every woman has the right to free health care and access high quality maternal health services that in turn must be accessible, affordable, effective, appropriate and acceptable to them in order to avoid preventable morbidity and mortality. Many complications of pregnancy and child birth that lead to mortality can be prevented by providing quality care that involves early detection of problems and appropriate timely interventions. Within the scope of this study, the researcher did not attempt to examine the quality aspect of ANC services for several reasons.

This again represents a significant discrepancy from the Free Health Care guidelines as providers are expected to develop delivery plans with the women during their first visit, and to review these plans in the third and fourth visits. The reasons offered by providers for these assessments included ; some women sought ANC services in the last days of their pregnancy which could not allow health workers draw delivery plans for them and even this made the risks higher.

4.3.2 Myths and misconceptions

The knowledge, perceptions and attitudes of ANC attendees were assessed. The study established that pregnant women and mothers had myths and misconceptions about seeking ANC early and in health units. The main reasons cited for failure to attend ANC early were based on the woman's own beliefs that the facilities would provide quality care, or on the advice given by family members.

Beliefs and attitude of mothers were yet another factor advanced by the respondents regarding ANC late attendance. As observed through the interviews, focused group discussions complimented by structured questionnaires, attitudes influence decisions on where and when to attend ANC. On the reasons why some mothers did not attend antenatal care services in health units; reasons such as smooth experience with previous pregnancies were given. This means that if nothing is changed, a

perceived negative attitude of health workers and poor quality of care would remain barriers to attending ANC early.

All of the ANC attendees and other women in the villages pointed out that the government facility health care providers are not polite in handling patients. They do not explain when doing procedures; misplace records and reject referrals sent by TBAs. This sometimes demoralizes some women. However, as reported by some women and ANC providers, such are misconceptions for there was no way a trained health provider would do such a thing.

However, this calls for supportive supervision to monitor service delivery standards and to ensure that abusive health workers are held accountable for mistreatment of clients. The study is not able to confirm independently the reports of negligence leading to abuse of patients at any point in the service delivery cycle. However, the negative experiences of women regarding the care they received and the belief among many participants that late attendance was caused by providers requires a thorough investigation into the quality of maternity services.

4.3.3 Traditional Beliefs and Practices

The study demonstrates that many women in the study area are still engulfed in the traditional past. The respondents' views revealed that many women seek ANC services late. ANC attendees and women reported that community norms were significant constraints in planning for early ANC and Facility-based delivery. Others even have the false belief that medical officials harass them. It was established that the status of women in the area of study was still low and they cannot make independent decisions about their health even when they have money and are aware of the advantages of attending ANC early. One respondent added that, heavy work load makes it impossible for pregnant women to start ANC before 5 months. It is a common practice that women go to the health facility if they have a problem that requires medical attention.

It was also reported that, some pregnant women feel shy and do not want anybody else to look at their private parts. They will deliver outside a health facility since they have heard or experienced the fact that health workers look at and touch their private parts when they go to deliver. In the focus group discussions it was found out that there are very few times when women's genitals are looked at either by herself or by other people during her life time as such even those that would wish to use health services take their time thinking about that.

4.3.4 Financial Difficulties

As established by the study, the level of income of the respondents based on their economic activities was so low. As a result their utilization of ANC facilities/services was reported to be minimal. It was established that, perceived expense of the ANC hinder early attendance, the respondents stressed that transport costs, physical inability to travel long distances make many women utilize the available ANC alternatives and visit health units late.

The fact that predisposing characteristics and enabling resources accounted more for the variation in pregnancy duration at entry to ANC than needs implied that inequality existed between women. Younger women, especially teenagers, are more

likely to have unplanned pregnancies and lack information and the resources to access ANC services.

Early entry to antenatal care (ANC) is important for early detection and treatment of adverse pregnancy related outcomes. The World Health Organization (WHO) recommends that pregnant women in developing countries should seek ANC within the first 4 months of pregnancy. However, due to financial constraints women tend to seek ANC in the seventh or even the ninth month of pregnancy.

In this study, majority of women complained of poverty and sometimes their finances being in the hands of their husbands while the widowed lacked control of property left to them. This reflects the real situation in the area of study.

4.3.5. Alternatives to ANC

The ANC providers indicated that some mothers undertake other alternatives in early phases of pregnancy. Some mothers use Traditional birth attendants and come for ANC in the seventh month—. As a result substantial proportions of women do not receive services offered by the ANCs such as breastfeeding and newborn counseling, malaria prevention and counseling on complications. Yet the ANC through the health care system remains the primary source of information about pregnancy and newborn care.

This survey provides missed opportunities on pregnancy programming and planning. It is clear that maternal mortality from within and without the health care system is not well addressed. The low ANC rate found in this survey is inconsistent even though many strategies have been laid by the government as well as District authorities. The research survey indicates the need to target outreach about the importance of ANC to those most at risk for not being aware of or able to access appropriate care. There is also need to focus on women with no formal education and particularly those who have already had lost a newborn or young infant.

Late ANC attendance does not provide women with a chance of benefiting fully from preventive strategies, such as iron and folic acid supplementation, and intermittent preventive malaria treatment in pregnancy among others. To encourage earlier ANC attendance, service delivery must be improved and messages that aim at removing barriers to ANC utilization should be increased.

4.3.6. Ignorance

The study established that, the majority of the respondents had less education levels which were also a reflection of the entire community. In this regard some ANC providers revealed that most of the women access antenatal late because of ignorance. Many mothers do not want to make many visits to the hospital/clinics. Thus they start ANC late to make fewer visits.

Because of the high illiteracy levels among women interviewed in the survey and generally among ANC attendees, there is need for outreach efforts by employing community engagement strategies, and counseling and educational materials used during ANC also need to be audio-visual, interactive and pictorial. This will enable the health providers to reach the uneducated women most at risk for not attending ANC or learning the details about assessing their own risk if they do not attend ANC early.

There have been many studies on factors relating to late entry to ANC in the world. The related factors include education. Due to the fact that many women are illiterate, they also have limited information on the dangers related to late entry to ANC. It was observed that there was also poor knowledge about ANC in the communities and the benefits are not easily appreciated. The main purposes of antenatal care are to prevent certain complications, such as anemia and identify women with established pregnancy complications for treatment or transfer. Antenatal consultations is said to provide opportunities for health education, health promotion and social support at both the individual and community level. Late attendance was reported to be as a result of ignorance about the values of ANC which demonstrates the weakness of government policy in promoting health and safe motherhood in the country.

4.3.7 Age

The results of the study indicate that ANC late attendance was associated with age. The frequency distribution of ANC attendees by gravida illustrated majority of the respondents were young mothers. 65 mothers were in 1-2 gravidity a likelihood of early marriages. Young mothers tend to go for antenatal care late for fear of being identified that they are young mothers by ANC providers and even in the community which puts their life at a risk. As reported by one nurse, many hospital deaths among pregnant mothers were due to age and mostly common in young mothers. Conversely, women with more previous pregnancies may be more confident because of their experience and they may also find it harder to attend ANC because of difficulties with child care.

4.4. Knowledge of mothers about benefits of attending ANC early

Data collected show high level of knowledge among ANC attendees. When prompted with a series of questions; of why mothers go for ANC, problems a mother may encounter when she does not seek ANC early, services offered when seeking ANC. The responses indicated that the respondents had knowledge about dangers a mother might come across when attended ANC late in pregnancy.

It is evident from the responses from both groups of ANC clients that their knowledge levels of the perceived benefits of starting ANC early are the same. The responses from the two groups were almost the same and they fell within the premises of the benefits/importance of starting ANC early. Therefore both the early and the late starters had similar knowledge on the benefits of starting ANC early in pregnancy.

4.5. Alternatives to ANC undertaken in early phases of pregnancy.

The study set out to establish whether there were alternatives used by pregnant women in the area of study. According to the respondents' responses, many pregnant women reported that indeed there were alternatives being undertaken by mothers and pregnant women in the area of study. ANC providers were asked to give their views about alternatives mothers try out in the early phases of pregnancy; their responses showed that mothers were trying out other alternatives before accessing antenatal care.

The study findings show that many mothers and pregnant women in the area of study use a number of alternatives during pregnancy. Respondents indicated use of TBAs and the use of herbs in the early phases of pregnancy.

4.5.1 Traditional Birth Attendants

The study established that TBAs are widely used by pregnant women and mothers in the study area. The study revealed that TBAs are appreciated in the community as they adhere to the norm of deliveries, always being an emergency in the community and that they act quickly and are always available.

The respondents mentioned visiting TBAs because they are nearer/closer to the mothers than ANC facility. The commonly cited reason for use of TBA's was the difficulty in transport that left mothers with no alternative but to use TBAs. The respondents added that TBA's were more accessible, and flexible enough to carry out a delivery in one's home than health units. However, some respondents raised concern that TBA's were incompetent and not well trained. TBA's also were known for not referring clients who failed to deliver and therefore contributing to high levels of deaths in the area of study.

The researcher observed that TBAs were also giving local herbs to their clients and they were not aware of most diseases common to mothers. This therefore identifies the need for TBAs to be informed about how certain diseases that are common among pregnant women and mothers occur and how they can be prevented and treated, since they demonstrated a high level of ignorance as regards dangers associated with failure to attend ANC early. Additionally, TBAs need to be informed about when and where to refer women in case of prolonged obstructed labor and other emergencies.

4.5.2 Use of herbs

The study findings indicated use of local herbs by most women in the area of study as an alternative to seeking ANC from health facilities. It was reported that, the majority of women and mothers take traditional medicine during pregnancy, labor, or delivery. These were taken orally and bath tonics. Some mothers bathe their children with herbs for the first two years. According to a nurse in a public hospital, women take herbs during pregnancy to prevent diseases, clean the baby in the womb, soothing body pains, treating malaria and prepare the mother for delivery by giving her strength and softening her pelvic bones. One woman in a private clinic reported that using traditional medicine such as local herbs helps in making one deliver normally.

There was a general feeling in the focus group discussions that women should use local herbs to help with minor problems during early pregnancy. However, it was observed that this prevents them from attending antenatal care during that period. Although some traditional practices and beliefs are fading away, most women believe in the use of traditional herbs which are given to them by the mothers-in-law, TBAs and older women in the community. The women and men do not see the need for going to ANC early when it is made safe by the herbs.

4.6. Distances to ANC health facilities.

Seeking and utilization of ANC services by pregnant women and mothers is determined by a number of factors of which distance and mode of transport is one of them. To establish what influences women to seek ANC alternatives and attend late, the researcher took the task of knowing how far the ANC attendees had traveled to the clinic/hospitals. The study findings on the availability and distances of antenatal care clinics revealed that women cover long distances to the health facility where antenatal care services are provided. This was expressed by respondents during questionnaire interviews, in depth interviews and focus group discussions.

4.7. The mode and means of transport used by ANC attendees

The majority of respondents indicated that they walk to antenatal care health facilities when they want antenatal care services.

Exit interviews with ANC attendees revealed that a bigger proportion of respondents had to walk to antenatal care hospital/facility. In depth interviews with ANC attendees, many mothers reaffirmed that they walk from their homes to hospital for ANC services or use a motor cycle (okada) for which they cannot afford hiring cost.

V. RESEARCH DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

The results are discussed in line with the research findings as presented in chapter four.

5.1 Alternatives to ANC in Bombali District

The research findings show that; majority of the ANC attendees had other alternatives to ANC they were undertaking in their early phases of pregnancy. These included use of local herbs, traditional birth attendants and traditional healers. This implies that, cultural beliefs are still a determining factor to women's decision in seeking ANC services.

The study established ill treatment of ANC attendees by ANC providers. Some ANC providers are rude; abuse mothers and sometimes shout on them especially at that critical time when a mother is having labor pains. This demonstrated less ethical values among health providers. In addition research findings obtained, there was an observation some mothers seek ANC alternatives because the husbands were refusing to accompany or even block them from attending antenatal care. This was because some husbands are afraid of testing for HIV/AIDS and yet it is a requirement in all ANC facilities.

5.2 Antenatal Care late attendance

The study findings also illustrate that almost all of the respondents accessed ANC late in their fifth and sixth month contrary to the recommended 0-16 weeks by the Ministry of Health and Sanitation. There is evidence to suggest that mothers seek ANC late because of poverty. The study findings show that many of the respondents' income is low, so mothers fail to raise money for transport, lunch while on ANC visit and lack what to put on like maternity dresses and knickers. Thus some mothers

seek ANC late because the husbands cannot raise money for the wife to use going to Hospital/clinic.

The data obtained from the study show that distances from health units and hospitals contribute to mothers seeking ANC late. Many of the ANC health facilities are within a distance of over 5km to 10km. From data analyzed the biggest percentage of ANC attendees traveled longer distances to the hospital/health facility.

The findings indicated that women in the area of study are engaged in both in-home and tedious out-door farming activities for which they allocate little time for seeking medical care in general. A number of respondents attended ANC at least once before the third trimester of pregnancy and approximately half made their first visit early-during or before the fourth month of gestation, which is consistent with other reports of ANC attendance. However, no evidence was found of an association between early ANC attendance and uptake of intermittent preventive treatment, a key malaria preventive strategy. This suggests that efforts to encourage timely ANC attendance alone are unlikely to improve the uptake of this intervention.

However, the type and quality of ANC services that the women reported receiving were inconsistent and inadequate. Fewer than half received any type of immunization services, and a minority of women reported that the health worker listened for the fetal heartbeat. A few women had their blood pressure checked, were advised to eat a balanced diet, or were weighed. No hemoglobin tests, urine analysis, syphilis screening, voluntary counseling and testing for HIV, or counseling on risk factors and warning signs and symptoms during pregnancy were reported. The findings also suggest that other factors, aside from service availability, may drive service utilization differentials between and among rural women. These factors include disparities in economic and cognitive access, perceived quality of ANC services, and differences in individual knowledge and attitudes towards ANC services. A comprehensive conceptual framework of how different dimensions of access to and quality of health services affect service utilization in Bombali district. Such a framework should also take into account the emergence of non-public sectors that are increasingly involved in the provision of health services. A more comprehensive understanding of the service environment, consisting of all sectors and how different dimensions of service provision may affect utilization, will guide efforts to improve service utilization.

The study established that, late attendance was attributed to women seeking alternatives to ANC. This is a clear marker of how health and social systems threaten the capacity of women to deliver safely. While not attending ANC services as presented by the respondents, its true causes are grounded in women's acute socio-economic vulnerability which denies them access to timely and appropriate care. The severe shortage of qualified health workers, unavailability of transport to facilitate emergency referrals, searing poverty that denies people to afford health care; lack of education regarding basic reproductive health and the complications of childbirth. More tragically, however, lack of adequate ANC services has contributed to the continuing and unabated acceptance that women naturally die in childbirth, or are left with devastating disabilities.

Age was identified as a factor in ANC late attendance, slightly more than half of the women in the study whose age was reported were less than 30, and the majority of respondents were on their third pregnancy. The findings indicate the potentially serious health effects of early pregnancy. It also highlights the need for girls and young women to possess the fundamental rights to determine freely when they will marry and when they will begin having children. While it remains vital to recognize the severe impact of ANC late attendance on young girls, the findings expand on the widely held assumption that ignorance on seeking proper and adequate ANC services predominantly affects very young women on their first pregnancy.

The findings of the study highlighted that those women who are slightly educated have maximally availed delivery care services when compared to less educated and illiterate women. Significant differences have been observed according to women's education in consulting a health professional. Women with only primary and middle school education are less likely to see a professional in connection with their pregnancy and delivery. Attainment of education has a major influence on utilization of maternal health care services.

In terms of delivery assistance, antenatal checkup and place of delivery, there appears to be a big gap according to the women's standards of living. Women from poorer sections of the population are less likely to avail of maternal health care services than rich women. The reason might be that the cost of delivery care at private or public medical facilities is high. Poor families do not find themselves in a position to be able to bear the cost of delivery care service. Even if they wish to avail the public sector medical facilities, they have to bear the cost of medicines and are expected to give gift in kind or cash to the attending doctors and other paramedical staff.

A quick review of research findings shows that some pregnant women received antenatal care from health units. Paradoxically, when it comes to delivery time, a glaring smaller proportion of these women give birth in these units, instead they deliver elsewhere. The enthusiasm to establish why some women attend antenatal care in health units and fail to deliver in these same health units has not been carried out by the District health authorities. This calls for detailed study on what encourages mothers to go for antenatal care and not deliver from hospitals.

5.3 Respondents recommendations on how to improve ANC utilization

The study identified that it was significant to provide women with education and counseling on pregnancy, labor, and delivery. In particular, the danger signs of pregnancy and labor and the need for skilled delivery assistance should be emphasized. This means that Women in general should be encouraged strongly to deliver in a health facility so they can receive emergency care promptly when needed. Public education and programs to prevent women from seeking dangerous ANC alternatives must therefore, target all women of reproductive age. In particular, maternal health services should provide accurate and timely counseling to women as well as key decision makers, such as husbands, mothers-in-law and parents on the importance of utilizing ANC in early days of pregnancy and delivery, and encourage women and their families to have a birth plan in place as well as provisions for handling emergencies.

Training for health workers on clinical skills, as well as on client-provider interaction, was suggested as critical to ensure high quality, professional ANC and delivery services. Supplies and equipment must be available to health workers, and supportive supervision instituted to monitor service delivery standards. Health workers, in turn, need to be supported through training and supervision to provide essential, adequate, services to ANC attendees.

The Government should pursue its efforts to improve the availability of ANC services at existing and/or new health facilities, particularly those that are offering ANC services. Any interventions that aim to increase maternal health service utilization should include efforts to target women of lower health status and educational achievements, as well as areas where women in general do not have high educational achievements.

TBAs also need to be informed about how pregnancy complications occurs and how it can be prevented and treated, since there were many misconceptions about them by hospital and clinic workers. Additionally, TBAs need to be informed about when and where to refer women in case of prolonged obstructed labor and other emergencies.

Broad-based educational and advocacy programs are needed to dispel negative myths about seeking ANC at health units as well as to encourage social support for girls and women living with HIV to always visit health facilities. Consistent and reliable information on where and when services are available also needs to be disseminated to assist women to access treatment quickly.

By safeguarding maternal health and well-being the health, economic and societal benefits will be enormous, far outweighing any investments made. However, this requires strong political will and commitment.

From the findings, it is clear that ANC programs must address the reduction of maternal mortality from within and without the health care system. The low ANC rate found in the survey is an indication that, there is need for community outreaches about the importance of ANC to those most at risk for not being aware of or able to access appropriate care. There is also need to focus on women with no formal education and particularly those who have already had lost a newborn or young infant. Although the perceived expense of the ANC may hinder attendance, it is uncertain that free ANC would increase coverage substantially because transport costs, physical inability to travel long distances, and a perceived negative attitude of health workers and poor quality of care would remain barriers.

5.4 Conclusions

The health and survival of newborns has gone unnoticed for too long. However both immediate and long term opportunities exist to improve the situation at all levels. Existing policies and guidelines have not been fully disseminated, integrated or implemented by service providers, leading to poor and inconsistent utilization of ANC services especially in the areas of study. There is an opportunity for policy makers to take a leading role to improve utilization of ANC from the highest level in both public and private facilities. This can be achieved through making and disseminating appropriate policies, improving staffing and supervision in facilities and creating an enabling environment for community level care.

5.5 Recommendations

The study findings unveiled a number of gaps in the provision of ANC services and midwifery educational programs; gaps in information dissemination systems to pregnant women and structural and organizational barriers relating to accessibility of ANC services. Thus in order to change the habit of women seeking alternatives and attending ANC late, the study recommended thus;

5.5.1. Health workers should be encouraged to take opportunity of the numbers of mothers that attend ANC services and educate them on the unpredictability of complications of pregnancy and delivery.

5.5.2. Having realized the weaknesses in the health service in the District, there is need for training health workers providers in the concept of focused ANC, with specific emphasis on scheduling of visits, continuity of provider for each client, incorporating PMTCT and developing an Individual Birth Plan (IBP) to respond to existing knowledge gaps.

5.5.3. To improve women access and utilization of ANC services in these areas, there is need to establish or strengthen national policies and locally adapted guidelines to protect the rights of all women, regardless of their socioeconomic status or place of residence. There is a need for evidence-based guidelines at the national level detailing the essential minimum components of ANC, in line with the country epidemiological profile and country priorities and based on WHO guidelines and recommendations.

5.5.4. The study also recommends the need to strengthen the quality of ANC services by promoting evidence based guidelines and standards for focused ANC. This is because quality improvement approaches and tools help identify and overcome local constraints to providing client-orientated, effective ANC and ensure that women return after their first ANC visit.

5.5.5. The study suggests that strategies should be developed for empowering communities to overcome obstacles to reach ANC. These may include using community channels to identify pregnant women, targeting those more likely to be nonusers, such as adolescents and women who are poor and single, and making the services more responsive to the needs of women.

5.5.6. Quality and performance improvement to mitigate factors affecting performance of ANC providers were identified as a way of ensuring quality of ANC. This interdisciplinary approach should include key stakeholders, including district and regional health management teams, to identify service gaps. Based on the gaps identified, priority interventions should be implemented focusing on a range of performance factors such as supervision, knowledge and skills; development, and availability of key resources, supplies and equipment to ensure sustainability and long-term results.

5.5.7. The study established that many of the medical personnel handle their clients in an inhuman manner a sign of poor client handling. Training for health workers on clinical skills, as well as on client-provider interaction, is critical to ensure high quality, professional ANC and delivery services.

5.5.8. Continuous community based health education and facility-based education, peer group discussions in the

community and group education among pregnant women and mothers and at the same time raise the issue and discuss ANC and its advantages will help to create a sense of belongingness, build their consciousness to seeking health services.

5.5.9. Government should enforce on the free health care and also provide pregnant women with social and financial support, as well as transportation to health facilities. The need for women themselves to generate and save income for transport and delivery costs was also highlighted.

5.6.0. The study recommends an improvement in health care systems at all levels and improving maternal survival and well-being, through improving physical infrastructure, essential drugs supplies, equipment to improve the extremely difficult working conditions for staff and enable providers to offer quality care.

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AUTHORS

First Author – Prince T. Lamin-Boima- Milton Margai College
Of Education And Technology