EXAMINATION OF THE FACTORS AFFECTING WOMEN OF CHILDBEARING AGE IN UTILIZING ANTENATAL CARE FACILITIES IN KEFFI LOCAL GOVERNMENT AREA, NASARAWA STATE-NIGERIA

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ABSTRACT

Pregnancy and childbirth are natural and often eventful processes that may expose many women to the risk of developing complications during pregnancy and childbirth. Complications in pregnancy and childbirth are the leading causes of disability and death among women in the reproductive age (15- 49) years in developing countries. This paper is an examination of the factors affecting women of childbearing age in utilizing antenatal care facilities in Keffi Local Government Area, Nasarawa State-Nigeria. The utilization theory was adopted as the working theory to explain the factors affecting women of childbearing age in utilizing antenatal care facilities in Keffi Local Government Area, Nasarawa State-Nigeria. The survey design was employed as a research design for the paper. A systematic random sampling technique was used to draw the respondents from the population of the study. Questionnaires and in-depth interviews were employed to generate data. Findings have shown that there is the high level of awareness among women of the ANC health service provided and the financial status of the family is the major challenge confronting women of childbearing age in the utilization of Antenatal care facilities. Therefore, the study recommended that there are need for government to increase awareness on the need for pregnant to utilize the antenatal care service this will go a long way in increasing the attendance of antenatal care this can be achieved through continuous organizing seminars and radio jingles in the local language of the people. Also, antenatal care is made free and the government should be able to provide all the necessary items.

Keywords: *Women, Child-Bearing Age, Antenatal Care, Utilization, Keffi.*

INTRODUCTION

Pregnancy and childbirth are natural and often eventful processes that may expose many women to the risk of developing complications during pregnancy and childbirth. Complications in pregnancy and childbirth are the leading causes of disability and death among women in the reproductive age (15- 49) years in developing countries (WHO, 2007). Quality antenatal care offers opportunities for the delivery of health information and services that can help enhance the health of mothers and their fetuses. This explains why families are careful in their choice of where the pregnant members of the family seek healthcare.

All over the world, pregnant women are expected to attend the antenatal clinics to have positive feelings towards antenatal. It is a worldwide practice for pregnant women to avail themselves of antenatal care by attending antenatal clinics. Pregnancy is usually viewed by the public as a period of emotional well-being that is protected against mental disorders. According to Bruce (2005), antenatal care traditionally focuses on physical health rather than emotional health. Antenatal care is the aspect of technology, which is broadly accepted as a way to improve women's health (Brookfield, 1996). Pregnant women are encouraged to seek antenatal care, which is a major component of maternity care, as soon as conception is suspected (Brown, 2004). Duplight (2010) suggests that antenatal care is the best preventive care medicine can offer pregnant women to reduce morbidity and mortality in both women and their babies. The accepted antenatal care in most developed countries and some developing countries is the western type of care using medically trained personnel.

Today, the principles of health promotion are seen as critical in the development of antenatal education. Nutbeam (2000) observes that antenatal care provides pregnant women the opportunity to learn skills to practice desired behaviours. Antenatal care according to Nwosu (2006) is a key to improved maternal and infant health. However, survey data from sub-Saharan African indicate that women often only initiate antenatal care after the first trimester and do not achieve the recommended number of antenatal care visits. Parental care, skilled birth attendance and postnatal care strategies have been recommended for several years and are important interventions for improving maternal and child health in general and in developing countries in particular (Nutbean, 2000 & Brokfied, 1996).

According to the WHO (2007), guidelines every woman must get care during pregnancy, childbirth and postpartum period. Recognizing the importance of pregnancy in women, the government of Nigeria has formulated some strategies and interventions for improving maternal and child health in the country. The National Population 2000, the National Health Policy 2002, the reproductive and Child Health programme stipulated the importance of antenatal care. The policies and interventions are designed to improve the health of the general masses especially maternal-child health care and interest among women in Nigeria.

Despite all these efforts, the utilization of care during pregnancy, at childbirth and during the post-partum period has been limited in Nigeria (Nwoye, 2009). He observes that only very few women go for antenatal early. Not only is the utilization of recommended care low, but there are also pronounced inequalities in antenatal and postpartum care. Late antenatal care attendance could be linked to women having a higher rate of prenatal

mortality, premature delivery and birth complications (Prenatal and Maternal Mortality Review Committee (PMMRC), 2010).

In another development, Collins (2009) noted that antenatal care has improved the rate of maternal death and the use of antenatal care helps to reduce prenatal mortality. He notes also that women in urban cities attend antenatal regularly and they show interest by attending. Antenatal interest is highly valued by scientists and counselors all over the world. Advice and counseling are important components of the antenatal interest, care package and key to improving health behaviour and care-seeking during pregnancy, the post-partum period. The information provided during the antenatal seasons enables women and their family members to adopt health promoting behaviour and to identify and act on medical emergencies that may arise during pregnancy, delivery, and post-partum periods. The information provided during antenatal sessions helps to increase interest and also enables women to take proper care of their newborn, advice on appropriate family planning methods, ensure spacing between the children and prevents unwanted births (Saunders 2004 & Jackson; 2010).

Although there are sufficient pieces of evidence to show the effectiveness of advice and counseling during sessions in developed countries, there is little emphasis on advice and counseling during antenatal visits in developing country settings. Such little emphasis on advice and counseling during antenatal sessions contribute to low interest, the discrepant pattern of high antenatal care, but low skilled attendance in sub- Saharan African country settings (Jackson, 2010).

Improving maternal health is one of the eight Sustainable Development Goals, SDG (formally MDGs) adopted at the 2000 Millennium Summit at the United Nations headquarters in New York. The main focus was to reduce the maternal mortality ratio (MMR) by 75% between 1990 and 2015. To achieve this aim, many nations across the world have realized the importance of communication as an intervention needed to reduce and prevent maternal deaths and hence improve maternal health (WHO, 2005; Alexander, 2005; & Thomson, 2006). Communication is therefore very vital for behaviour change to take place because public health programs invariably require behaviour change; behaviour change cannot occur if the specific target audience is not aware of the message disseminated to them (Alexander, 2005).

Besides the high maternal deaths, there is also the issue of low birth weight of infants. Most of the infants with a birth weight of less than 2,500 grams are born in developing countries. These babies account for 30% to 40% of all infant deaths. Health is a key indicator in any country's Human Development Index, that is why the SDG and Poverty Reduction in Nigeria: Progress and Policy Implication Report (2014) maintained that 'the reduction of maternal mortality (MM) is not only a health issue; it also has economic and human right dimensions. As (MM) is one of the egregious violations of the rights of women to life. Whereas every pregnancy everywhere is risky, no woman should die as a result of preventive causes. Nigeria unfortunately is among the Countries worst hit by maternal death challenges. According to the (WHO, 2007) report, Nigeria is second in the world after India, in terms of maternal and infant deaths. Although Nigeria has adopted many international conventions regarding health, especially reproductive health, Safe Motherhood Initiative launched in Nairobi, Kenya in 1987, is one among many, it aimed to

raise awareness, encourage research and advocacy for increased resources for safe motherhood, the ultimate goal was to achieve low maternal mortality ratio by 2020.

This dogged desire for procreation with craving to survive by mother and child through adequate antenatal care has brought about a dilemma as factors compel families to use any available facility without recourse to the consequences, especially the majority of rural women who are the ones facing these harsh choices. A lot of factors influence their choices, one of which is the availability of antenatal care, in terms of proximity to home. The Multiple Indicator Cluster Survey (MICS) statistics (2011) buttresses this point, in that it reveals that the national coverage of antenatal care is more in the urban area than in the rural areas, as there is 88% in the urban areas against 56% in the rural areas (MICS, 2011). Based on the foregoing, the paper is the examination of the factors affecting women of childbearing age in utilizing antenatal care facilities in Keffi Local Government Area, Nasarawa State-Nigeria

Statement of the Problem

Nigeria's national health indicators are arguably among the lowest in the world for almost all measurable indices (WHO, 2008). For instance, life expectancy, the average number of years a person is expected to live, is 54 years compared to 73 years in China and 83 years in Japan. While maternal mortality rate is 2,100 deaths per 100,000 live births in contrast to 45 deaths per 100,000 live births in China and 6 deaths per 100,000 live births in Japan (WHO, 2008). An established pathway for achieving improved health status is the uptake of medical interventions (UNICEF, 2009).

Maternal health is a predictor of the level of a country's development as health is a parameter for Human Development assessment aside from education and economics. If this is so then the fact that Nigeria constitutes 3% of the world population but contributes 10% to the world's total maternal deaths, and usually pregnancy-related deaths are worrisome (WHO, 2006). Also according to World Bank (2016) report that in Nigeria Maternal Mortality Rate (MMR) is still high as 821 per 100,000 live births. Worst still of the 303,000 women that died globally due to complications of pregnancy and childbirths in 2015, 58,000 women died in Nigeria. Reproductive Health Supplies Coalition (RHSC, 2015), stated in their 18th General Membership Meeting in Brussels, Belgium, the experts who opined that out of the maternal deaths which would have been prevented, 99 percent occurred in developing countries like Nigeria, stress that increasing efforts is needed to meet Sustainable Development Goals in reducing global MMR to less than 70 per 100,000 live births by 2030.

Furthermore, World Bank (2016), reported the key maternal health statistics in Sub-Saharan Africa, according to the World Bank modeled estimate and presented at the reproductive health event, 58,000 Nigerian women died in 2015 due to birth-related complications. In the same report it was stated that Nigeria has a lifetime risk of maternal death of 4.62 percent, the fertility rate of 5.71, and annual births of almost 7 percent, despite these deaths only 37 percent of births happen in health facilities with skilled healthcare personnel.

Good antenatal care remains one of the key safety nets to maternal and child health during pregnancy, because sensitive antenatal care, identifies mothers with high-risk pregnancies, such as grand multiparas who are women with five or more childbirth who are usually at risk of hemorrhage (excessive blood loss) during delivery. And primigravidae women who are pregnant for the first time are also at high risk of increased blood pressure,

and many other potentials for high-risk delivery, and complications after childbirth. The paucity of these facilities as well as the share short distribution of them nationwide also contributes immensely to the incredible statistics of maternal health in Nigeria.

Given the records of the outcomes in Nigeria, there is no doubt about the lacuna between antenatal care availability and patronage. This is because there is more coverage of antenatal care in the urban than the rural areas as the majority of childbearing mothers both young and older ones are more in the rural areas (MICS, 2011). Hence, it raises a serious concern over the national coverage of antenatal care, meaning the limited distribution of care facilities. Many studies have shown that those who manage to utilize the few available health facilities for antenatal care are low and uneven state-wise (Aigbe, 2010; Basu, 2005; UNICEF, 2009). The ratio stands at 25,577 per facility (MICS, 2011).

Studies have been carried out on the impact of antenatal care for pregnant women yet the issues related to women's awareness of antenatal care, socio-economic status of women, and challenges confronting women from utilizing antenatal care by the previous studies have not been addressed in Keffi Local Government Area particularly, Yara electoral ward. One such study is the one done by Bidda (2009) on 'the role of media in enhancing Ante Natal Care' in Keffi Local Government Area of Nasarawa State.

From the above intentions, one can see that the goal of antenatal care is to provide universal healthcare access to all women of childbearing age. However, the larger percentages of the population of women are without access to credible antenatal care. Sadly less than 10% of women have access to antenatal care services (Bidda, 2009). According to research, part of the problems has to do with the awareness of antenatal care programmes, which only a few women are aware of such services with 20 or fewer than women are registered for antennal care (Basu, 2005 & Aigbe, 2010).

Lack of awareness of the existence of antenatal care is yet another factor. Most women are not aware of healthcare; they are completely ignorant of the benefits. This is because women's awareness in a real sense has contributed to the low turnout of women in attending antenatal care. Unfortunately, however, the majority of women are not registered with any modern healthcare centre for antenatal care; since it requires them to pay registration fees which most of them don't even have money for registration. Some women who even attend monthly antenatal care don't give birth in hospitals due to the money involved. While the socio-economic condition of women has affected the utilization of antenatal care in many rural areas. This has probably led to the death of so many expectant mothers in these areas. If these problems persist in this 21st century, then there is a need for empirical study to curb this problem. It is on this premise that this study becomes imperative to examine the factors that affect women of childbearing age in utilizing antenatal care facilities.

Research Questions

This study is guided by the following research questions:

i. What is the level of awareness among women of childbearing age in the utilization of antenatal care facilities in Keffi Local Government Area of Nasarawa State-Nigeria?

ii. What are the challenges confronting women of childbearing age in the utilization of antenatal care facilities in Keffi Local Government Area of Nasarawa State-Nigeria?

iii. What are the policy measures required to enhance women of childbearing age in the utilization of antenatal care facilities in Keffi Local Government Area of Nasarawa State-Nigeria?

CONCEPTUAL AND THEORETICAL FRAMEWORK

Antenatal Care

Antenatal care (ANC) is the care a woman receives throughout pregnancy to ensure that both the mother and child remain healthy. A healthy diet and lifestyle during pregnancy is important for the development of a healthy baby and may have long-term beneficial effects on the health of the child (Carroli et al, 2001). For Pay, Frøen, Staff, Jacobsson, and Gjessing (2013) Antenatal care is the routine health control of presumed healthy pregnant women without symptoms (screening), to diagnose diseases or complicating obstetric conditions without symptoms and to provide information about lifestyle, pregnancy, and delivery.

Bhalwar, Dudeja & Jindal (2018) said that the care of women during pregnancy is called Antenatal care. It includes pregnant woman's visits to antenatal clinic, examination, investigations, immunization, supplements (iron, folic acid, calcium), and the required interventions. This is a comprehensive approach to medical care and psychological support to the family that ideally begins at conception and ends with the onset of labor. It envisages ongoing assessment of risk, identifying and managing problems through education, counseling, and medical interventions. The goal of ANC is to have a healthy mother and a healthy baby at the end of pregnancy. The positive impact can be achieved through screening for pregnancy problems, assessing pregnancy risk, treating problems that may arise during the antenatal period, giving medication that may improve pregnancy outcomes, providing information to the pregnant woman, preparing physically and psychologically for childbirth and parenthood (WHO, 2011). For this paper, antenatal care is operationalized as the care women undergo during pregnancy to ensure safe motherhood and the health of their infants.

Theoretical Framework

This paper is hinged on Utilization Theory. Identifying the significant determinants of ante-natal can be very challenging (Andersen, 1995). This is because factors influencing the choice to seek ante-natal care and which provider to use are very diverse; They include knowledge, perceptions, demographics, health belief, culture, economics, access, belief in efficacy, as well as the social context. To facilitate a detailed understanding of ante-natal care utilization complexities, several theories and models of antenatal care utilization have been developed. Suchman developed stages of illness and medical care theory (Suchman, 1965), while Mechanic proposed a general theory of help-seeking (Mechanic, 1978), and Parsons developed sick role theory, (Parsons, 1951). Other models include Young's choice-making model (Young & Young-Garro, 1982), Rosenstock's health belief model (Rosenstock, Strecher, & Becker, 1994), and Andersen's health behaviour model (Andersen, 1995). These theories and models were aimed at understanding the need for and identification of key factors influencing the sources of variability in health care utilization.

In this study, the utilization model which was developed by Andersen (1995), was adopted. The model was in phases. Phase one of the model, which dealt with behavioural changes, categorized the determinants of antenatal care utilization into three broad categories of characteristics: (A) the predisposing characteristics (demographics, the social

structure, and health beliefs), (B) enabling characteristics (resources found within families and communities), and (C) need-based characteristics (individuals, social, or clinically evaluated perception of need for ante-natal care services, Andersen, 1968; Wolinsky, 1988). This behavioural model has been used in earlier studies (Fagbamigbe, Akinyemi, Adedokun, & Bamgboye, 2011).

While in phase two, the health care system, which consists of health policy, resources and organization, was included. It had emphasized that resource management, volume and distribution of labour, capital, equipment, and qualification of health care personnel, as well as the changes in these overtime influences access to and use of health services. The model stressed that the use of antenatal care is a reflection of customer satisfaction, which is a function of convenience, quality, availability, financing, and types and levels of health care providers (Aday & Andersen, 1974).

The third phase incorporated health outcomes (perceived and evaluated health status and consumer satisfaction), in addition to the existing primary determinants (characteristics of population, the health care system, and the external environment) and health behaviours (personal health practices and use of health services), which are the direct precursor for health policy and reforms (Andersen, Davidson, & Ganz, 1994).

The fourth phase, described as the "emerging model" in 1995, emphasized the dynamic and recurrence nature of health service use. This includes health status outcomes. The emerging model portrays the multiple influences on health status services use and subsequently on health status and incorporated a feedback loop showing that the outcome, in turn, affects subsequent predisposing factors, perceived needs and health behaviour, (Andersen, 1995).

Andersen (1995), also introduces the concept of the mutability of his factors. The idea here being that if a concept has a high degree of mutability (it can easily change) perhaps policy would be justified in using its resources to do rather than a factor with low mutability. Characteristics that fall under demographics are quite difficult to change, however, enabling resources is assigned a high degree of mutability as the individual, community, or national policy can take steps to alter the level of enabling resources for an individual. For example, if the government decides to expand the Medicaid Program an individual may experience an increase in enabling resources, which in turn may beget an increase in health services usage. The RAND Health Insurance Experiment (HE) changed a highly mutable factor, out-of-pocket costs, which greatly changed individual rates of health services usage.

The sixth iteration of Andersen's conceptual framework focuses on the individual as the unit of analysis, and goes beyond health care utilization, adopting health outcomes as the endpoint of interest. This model is further differentiated from its predecessors by using a feedback loop to illustrate that health outcomes may affect aspects such as health beliefs and need. It added genetic susceptibility as a predisposing determinant and quality of life as an outcome by using the framework's relationships, we can determine the directionality of the effect following a change in an individual's characteristics or environment. For example, if one experiences an increase in need as a result of an infection, the Andersen model predicts this will lead to increased use of services, (all else equal). One potential change for a future iteration of this model is to add genetic information under predisposing characteristics.

LITERATURE REVIEW

Factors Affecting Antenatal Care Utilization

Several studies have examined ANC use concerning demographic and socio-economic variables (WHO, 2008). Several the socio-demographic characteristics of the individuals affect the underlying tendency to seek care. In this regard, good examples are maternal age, parity, lower educational attainment and family income, which have been repeatedly examined as determinants of health care utilization (Melkamu, 2005).

A similar study in South Africa demonstrated that women who didn't obtain ANC were more likely to be of lower socioeconomic status, higher parity and farther away from health services than were ANC- attendees (Pattison, 1990). Among the several reasons for failure to obtain ANC given by those who did not attend were lack of support (21%), lack of time (44%), family responsibility (20%), and other reasons. For this reason, therefore, it is expedient to x-ray these factors established by various studies to uncover some silent factors that affect women in utilizing antenatal care during pregnancy and childbirth in Nigeria and by extension Africa.

Level of Education

Education is a strong predictor of ANC service utilization but the extent and nature of the relationship between the two are not uniform across social settings. For instance in Bangladesh and Thailand women with primary education did not differ from women with no schooling in ANC utilization (UNICEF, 2004). With the introduction of the Structural Adjustment Programmes policy in the middle 1980s in Nigeria, many Nigerian women lost their jobs because of the unskilled nature of their jobs and low positions and because they do not have the educational qualifications to benefit from globalization. This effect of globalization on Nigerian women has intensified the involvement of Nigerian women in international prostitution. According to Orubuloye, Caldwell and Caldwell, (1994), there is a changing image of contemporary prostitution and the emergence of the new breed of prostitutes in Nigeria. They are young and often very educated and most of the respondents entered the sex trade because of the financial gratification which it attracts and this gratification is in dollars which have become gold in recent times due to the devaluation of the Naira.

Due to the general poverty in Nigeria, many families that would have objected to their daughters' involvement in the sex trade are even happy for it because in such families, these girls have become bread winners and God-sent (Eboiyehi & Muoghalu 2008). Nevertheless, the contribution of women to boosting family income, cannot be overemphasized, by and large, their role of second fiddle in the society given the nature of African society could be attributed to some of the factors responsible for women input in the overall income of the average family in this part of the world. However, the financial strength of a family unquestionably has a tendency to influence maternal clinics (especially, expectant mothers), considering the level of awareness of the attendant implications.

Age of Expectant Mother

Maternal age is a main predisposing factor of the use of health services given that the incidence of pregnancy and associated health needs are age-specific, occurring to mothers only during certain age groups. This can explain why women of younger age are those usually associated with fistula. However, environmental influences are also associated with low attendance of ANC. The urban society implicitly regards ages 15-19 as schooling/training

periods for the youths, so pregnancy at this age is mostly out of wedlock, often frowned at, and usually stigmatized. The young mothers' response to such societal attitude is, in most cases, the choice of ANC source that "shields" them from public glare. The traditional birth attendants (TBAs) and other unorthodox sources of care readily shield them. The same goes for older women in urban areas, who the society expects to have ceased or stopped childbearing. On the other hand, the middle-aged mothers seek every available opportunity "to flaunt the fulfillment of motherhood", as stated by a 32-year-old lady in a Focus Group Discussion, cited in (Aigbe, 2010).

Religious Belief

In Muslim communities such as Bangladesh, rural women do not usually converse with strangers, particularly males. This behavior is particularly pertinent because male physicians attend most deliveries at rural health centers. This situation acts as an important social and religious barrier to using health care services (Rumsey, 2002). In Ethiopia, few studies revealed the various barriers to women's use of ANC. A community-based survey was conducted revealed that attendance was high for pregnant women whose income was low, whose husband's attitude was negative or unknown, and who were first pregnant at the age of 10 to 18 years (Fantahun, 1992; Berhane, 2000). Similarly, Kwast (2004) in their study on maternal mortality found women who did not have prenatal care were often those of high risk, i.e. illiterate, had a low level of awareness of problems of childbearing, had low income, and were unmarried (Kwast, 2004). In the same vein, there are two major types of teenage pregnancy, namely intended or unintended pregnancy. Intended teenage pregnancy occurs when the teenager is consciously motivated to fall pregnant. This usually occurs where there is a lack of educational and vocational goals other than motherhood. Pregnant teenagers falling in this group might notice early that they are pregnant and, because they might be supported by their parents and/or friends, may seek early antenatal clinic services. Unintended pregnancy, on the other hand, results, when the adolescent engages in sexual intercourse without the knowledge of the cause and effect relationship of this activity and pregnancy, ensues thereafter. Due to denial, these adolescents may fail to recognize that they are pregnant and therefore seek antenatal care services late.

Cultural Practices

In Nigeria, maternal mortality is very high and one of the highest in the world. There are cultural and social factors that exacerbate the problem in Nigeria. In a study by (Adetunji, 1996) in a Yoruba community in Nigeria, he pointed out that in the choice of a caregiver in pregnancy, since the enemies at stake might use supernatural powers, the caregiver's qualification would include the ability to protect the mother and the fetus from both natural and supernatural enemies. Therefore, preference tended to be given to a caregiver who was both an herbalist and a diviner. In a study of Traditional belief systems and maternal mortality in Ekpoma in Southern Nigeria, by (Chiwuzie & Okolocha, 2001), they found that traditionalists believe that bleeding of pregnant women is caused by witchcraft or infidelity on the part of the pregnant woman or violation of cultural taboos. According to them, it is very common to hear "Your grandmother bore eleven children, your mother had you and twelve other children, none of them had any problems with either conception or childbirth. How come you have brought us all these problems" This suggests a general belief that most of a woman's obstetric problems result from her having gone against the traditions of the land. The same study also found that there is a belief that modern care centres have little role to play in dealing with bleeding in pregnancy coupled

with the fact that the people consider it in-accessible and wasteful considering that many do not even have the money to transport themselves to the hospital. Another important factor is the attitude of the government hospital staff (who sometimes neglects the patient), which also discourages the people from going to the hospital. In the study, a woman made the following statement "Is it not more honourable to die peacefully at home than to borrow money and travel to the government hospital only for the doctors to watch you die". Furthermore, many Nigerian men are polygamists with more than one wife and these men may not have the time and financial power to look after all the wives when they are pregnant and this also contributes to maternal mortality.

Adewuyi (1999) posited that in many homes in Southwest Nigeria, a husband's permission is required before a wife can seek healthcare and it then depends on whether the husband sees the ill health as strong enough to warrant hospital treatment. In this way, many women lose their lives because it may be late by the time the husband sees the illness as life-threatening.

On pregnancy and food taboos, in a study of Ibadan and Ife by (MacLean, 2001), it was found that pregnant women were warned not to eat large plantains with cleft so as not to have babies with rigid skulls. In Ile-Ife, many traditional healers discourage pregnant women from eating snails, snakes, or okra soup, as these would harm the babies. Chiwuzie and Okolocha (2001) found out that the traditional belief is that pregnant women should not take milk and egg so that the baby may not grow up to be a thief. A pregnant woman should not be rude to her husband to avoid bleeding.

METHODOLOGY

This study was conducted in Keffi Local Government Area of Nasarawa State. Hence, the paper adopted a survey design. The survey was used to obtain data from large respondents who are women of childbearing age and health workers in Primary Health Clinics in Keffi Local Government Area of Nasarawa State. Due to unavailable data on the ward from the National Population Commission, the study subscribed to the data from Sub-Immunization Plus under the coordination of the National Primary Health Care Development Agency (NPHCDA, 2020). The data shows that the population of registered women for antenatal as at April 2020 stood at 25,110. Since it is not easy to get in touch with the entire number of households in the ward, the study arrived at a sample of 346 households at a 5% margin of error and 95% confidence level (Research Advisor, 2006). To select the sample from each of the settlements systematic random sampling technique was used to select the required number of households from the settlements. The study utilized both questionnaires and in-depth interviews in collecting data from the respondents. The questionnaire was administered to the selected women of childbearing age who could read and write and those who could not read and write, interview was equally conducted for them to carry all the women along through an interpreter. Also, an in-depth interview was conducted among health personnel who are the heads of units of the selected PHCs in Keffi Local Government Area of Nasarawa State. Statistical Package for Social Sciences (SPSS) software was used to process and analyze the data obtained from the questionnaire administered. The data were descriptively analyzed using frequency distributions and percentages. Data obtained through the in-depth interviews was analyzed using content analysis.

Table 1: Whether respondents are aware of antenatal care facilities

Response	Frequency	Percentage (%)
Yes	278	80.5
No	67	19.5
Total	345	100

Source: Field Survey, 2021

Table 1 shows whether respondents are aware of antenatal care facilities with an affirmation of 80.5 percent of the respondents accepting that they are aware of antenatal care facilities in the study area. This implies that an overwhelming proportion of the respondents acknowledged the existence of antenatal care facilities in the study.

The result of the In-Depth Interview (IDI) further confirmed that women of childbearing age are aware of antenatal care facilities in the study area. As one of the respondents aptly put it:

> *Yes, women are aware of ANC facilities, there are many programmes, at media houses like ya takene, lafiyan iyali, talk your own, these are the programmes to educate public on health-related issues and create more awareness not only ANC but health-related issues.*

Table 2: Respondents view on challenges confronting women of childbearing age in the utilization of Antenatal care facilities

Response	Frequency	Percentage (%)
Cultural and religious belief	59	17.1
Financial status of the family	109	31.6
Distance to the antenatal care centre	35	10.1
Inadequate manpower	42	12.2
Availability of equipment	47	13.6
Human relations	53	15.3
Total	345	100

Source: Field Survey, 2021

Table 2 indicates respondents view on challenges confronting women of childbearing age in the utilization of Antenatal care facilities in Keffi Local Government Area of Nasarawa State-Nigeria. The data of the study revealed that the financial status of the family is the most common challenge confronting women of childbearing age in the utilization of antenatal care facilities. However, there are other challenges to include cultural and religious beliefs, distance to the antenatal care centre, inadequate manpower, availability of equipment and human relations respectively. This denotes that a larger percentage of the respondents agreed that cultural and religious belief is the major challenge confronting women of childbearing age in the utilization of antenatal care facilities.

This was in line with the view of interviewees' during an in-depth interview that:

> *The major problem associated to is socio-economic status, why, because when a woman comes for ANC for the first, she is asked to go for a laboratory test, to know her health status and to purchase some drugs which they usually find very difficult to buy and diet. A pregnant woman is expected to eat a balance diet for the sake of her*

fetus and blood during childbirth. The unfortunate thing is that some families cannot afford meat, fish, fruits and other types of food that are always explained during health talk nutritional value of these foods, not affording that is disturbing with that they may have a reason not to come to the clinic again

Table 3: Whether there are policy measures required to enhance women of childbearing age in the utilization of antenatal care facilities

Response	Frequency	Percentage (%)
Yes	232	67.3
No	113	32.7
Total	**345**	**100**

Source: Field Survey, 2021

Table 3 illustrates whether there are policy measures required to enhance women of childbearing age in the utilization of antenatal care facilities. The result from the study established that there is a need for policy measures required to enhance women of childbearing age in the utilization of antenatal care facilities with an affirmation of 67.3 percent of the respondents in the study area. This implies that a higher percentage of the respondents acknowledged that.

This was corroborated during an in-depth interview as thus:

The government has been making such publicity through social media, a lot of platforms have been created from the government to NGOs such effort should be continuous from the outreach and home visit should be given more emphasis because it helps. People are becoming more aware of things around them, although such as outreach and visit.

DISCUSSION OF FINDINGS

The findings of this study found that there is a high level of awareness among women of the ANC health service provided in Keffi Local Government Area of Nasarawa State-Nigeria. This was supported by Owumi (2013), who reported that most women of childbearing age are knowledgeable about the antenatal care services available. It shows that women's awareness of the ANC services is high compared to those that are not aware of the services. Data from Sub-Saharan African indicate that women often only initiate antenatal care after the first trimester and do not achieve the recommended number of antenatal care visits.

Likewise, the study findings unraveled that the financial status of the family is the major challenge confronting women of childbearing age in the utilization of Antenatal care facilities. This submission was supported by Okonufua et al (1994) which state that user charges in hospitals and PHCs drove people to run to alternative sources of birth delivery of their babies resulting in many complications and deaths. According to then, when these pregnant women were interviewed, they said that these other sources are far cheaper than hospitals or PHCs user he is a key variable in the use of health facilities both for preventive and curative health care. The negative association between cost of care and use of health facilities for preventive care is expected because payment for antenatal care is mainly out-of-pocket payments due to limited access to health insurance by the majority of mothers.

Finally, the findings established that there are policy measures required to enhance women of childbearing age in the utilization of antenatal care facilities. This was in line with the submission made by Evans and Ulasevich (2005) that government has a comprehensive health promotion programme through raising awareness using the mass media to improve uptake of ANC services. The media have also been recognized as powerful mechanisms to promote the awareness and education of public issues and can probably influence decisions of government and policymakers on health policies and medical care

CONCLUSION AND RECOMMENDATIONS

The rising challenges that come with the lack of utilization of antenatal care by women pose a threat to the future generation, this can be attributed to the belief model of such an individual or lack of awareness on the health benefit for antenatal care utilization, for Nigeria to reduce its maternal mortality and infant mortality there is an urgent needs for more expectant mothers to learn how to utilize the antenatal care service; Nigeria today is saddle with the high rate of maternal mortality and this may be due to women not utilizing antenatal care even though these antenatal care has been given top priority by the government, NGO and stakeholders. The paper makes the following recommendations:

i. This study recommends the needs for government to increase awareness on the needs for pregnant to utilize the antenatal care service they should shade more light on the importance of antenatal care, this will go a long way in increasing the attendance of antenatal care this can be achieved through continuous organizing seminars and radio jingles in the local language of the people.

ii. In the same vein, this study recommends that antenatal care be made free, the women shouldn't able to pay any amount during registration or contribute money to buy anything during antenatal services but rather government should be able to provide all the necessary. Items, for Antenatal and delivery such as gloves, delivery towels, disinfectants, etc.

iii. Finally, there is a need for government to balance the income level of women or make antenatal care free without any hiding charges so that women with low or no income can be able to attend antenatal care without any fair or doubt in their minds about any charges this can be achieves through government enacting law restricting health workers from charging these women any fee or contribution to get some items.

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