ANTENATAL CARE SERVICE UTILIZATION AMONG WOMEN OF REPRODUCTIVE AGES IN EGOR LOCAL GOVERNMENT AREA OF EDO STATE

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Abstract
This study examined utilization of ante-natal care by women in Egor Local Government Area of Edo State. The survey research design was used to elicit information from the respondents using a well-structured questionnaire. A sample of 390 women was randomly selected through the simple random sampling technique from two primary health-care centres in Egor Local Government Area of Edo State. The study collected both primary and secondary data. The primary data collected were analyzed using simple percentage, frequency and mean while the ANOVA and independent T- test were used to analyze the hypothesis of the study. The result revealed that the respondents' utilization of ante-natal care was good. Majority of the respondents responded positively to attitudinal questions on antenatal care and their perception on ante-natal care was generally considered positive. The study further revealed that the majority of the women (60%) booked late at antenatal clinic mostly in the third trimester (7-9months) of their pregnancy. The study recommended that pregnant women should be encouraged to book at ante-natal clinics early specifically in the first trimester of their pregnancy ideally before 12 weeks but not later than 16 weeks as recommended by the World Health Organization for better pregnancy out-comes.

Keywords: Utilization, Antenatal, Women of Reproductive Age, Egor LGA

Introduction

Pregnancy constitutes one of the most sensitive periods of a woman's life, both physically, physiologically and mentally (Katz, 2008). Champagne (2004) noted that during this period, women are prone to some physiological and psychological changes that may adversely affect pregnancy out-comes. Consequently, Brown (2004) charged all pregnant women to seek ante-natal care, which is a major component of maternity care, as soon as conception is suspected. The U.S National Library of Medicine (2012) defines ante-natal/prenatal care (ANC) as a type of preventive health-care with the goal of providing regular check-ups that allow doctors or mid wives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefit both mother and child.Antenatal care according to United Nations Population Funds is one of the four essential elements to maternal death prevention. Estimates by UNFPA indicated that 289,000 women died of pregnancy or childbirth related cases in 2013. In addition, UNFPA (2010) report showed that developing nations accounts for 99% of maternal deaths and the majority of the deaths occurring in sub-Sahara Africa and Southern Asia.

Okoronkwo, Odiral, Nwaneri, Okpala& Okafor (2016) indicate that maternal and infant morbidity and mortality are major public health problems in Nigeria. According to United Nations Children's Education Fund (2010), the country loses 145 women of child bearing age daily due to pregnancy related complications making the country one of the largest contributors of maternal mortality rate in the world. Nigeria's maternal mortality ratio of 560 according to World Health Organization (2013) is higher than the regional average. This maternal mortality ratio indicated an improvement in relation to Hill, Thomas, Abouzahr, Walker, Say & Inoue (2007) which puts Nigeria's maternal mortality ratio at 1,100 per 100,000 live births. With an estimated

59,000 maternal deaths annually according to the Federal Ministry of Health (2005), Nigeria contributes almost 10% of the world maternal death. The high maternal and infant morbidity and mortality in the country may be attributed to, among other factors, non-use of modern health care services by women in Nigeria. A study by Nigeria Demographic Health Survey, 2013 indicates that one third (34%) of women of reproductive ages (15-49) in Nigeria do not receive antenatal care (ANC) at all. While a small fraction (6 percent) receives antenatal care from traditional birth attendants. However, a national survey in Nigeria derived from the 2005 National HIV/AIDS and Reproductive Health Survey (NARHS) shows that about three-fifths (60.3%) of the respondents used antenatal services at least once during their most recent pregnancy (Ministry of Health, 2006).

At some point in the second half of the 20th century, international awareness grew of the dimensions of the tragedy of maternal mortality; national governments collaborated with technical assistance and donor agencies to ensure that pregnant women in developing countries also had access to maternity care. Improving maternal health is one of the World Health Organization's Millennium Development Goals (MDGs) and professional health care during child birth is one of the process indicators in assessing progress towards these goals. WHO (2010) has recommended four strategic interventions or four pillars for safe motherhood. These include; family planning, antenatal care (ANC), clean/ safe delivery and emergency obstetric care. Some of the interventions that have been shown to be effective in detecting, treating or preventing conditions in pregnant women that might otherwise give rise to serious morbidity and mortality are: detection and investigation of anemia, pregnancy - induced hypertension, treatment of severe pre-eclampsia, screening and prevention of infection and diagnosis of obstructed labour. Shafqat, Fayaz, Rahim and Saima (2015) noted that antenatal care is considered as a back bone of obstetrical services of any health care delivery system. It is considered to be important for the health of pregnant women and is the way in which maternal and fetal complications are detected and managed. Utilization of ANC services has been identified in a number of studies as an important factor determining maternal and infant mortality. For all the benefits that have been attributable to ANC, the effectiveness of antenatal care in actually reducing maternal and fatal morbidity and mortality, has never been scientifically proven and because of ethical considerations may never be proven. In a study on the determinants of maternal health services in rural India, it was found that, there is a correlation between household income and utilization of maternal health services (Sharif & Singh, 2002). It was evident that as a result of lack of productive resources for women, income earned by women had negative impact on utilization of Ante Natal Care (ANC) and Post Natal Care (PNC).

Problem Statement

Women and children are the most vulnerable group and they make up a greater percentage of the population. Mortality and morbidity among this group is high in Nigeria. Ajayi &Osakinle(2013) noted that 1 in 13 Nigerian women stand a chance of experiencing maternal death. Neonatal mortality is about 48 per 1000 live births. Estimates by UNICEF (2010) indicated that the country loses 145 women of child bearing age daily due to pregnancy related complications.

One of the major aims of attaining primary health care program in developing countries including Nigeria is to improve reproductive and child health services. This calls for the need to identify and improve those services vital to the health of women and girls. These services include antenatal care, delivery, postnatal care and family planning. Antenatal care aims at preserving the physiological aspect of pregnancy and labour and to prevent or detect, as early as possible, all that is pathological. Antenatal care (ANC) is a key strategy to improve maternal and infant health. Data from Nigeria Demographic and Health Survey (2013) indicated that 34% of women of reproductive ages (15-49) in Nigeria did not receive antenatal care at all. Osubor, Fatusi, &Chiwuzie (2006) reported that among eighty-one women who delivered within a one-year period in Edo state, Nigeria, only 9.9% received antenatal care services. If this trend of low antenatal care utilization persists the implications are: firstly, the goal of employing antenatal care as a veritable tool for the reduction and/or prevention of maternal mortality in developing countries, Nigeria included, may never be achieved. Secondly, government and other stake-holders spend huge amounts of money in making antenatal care

services available. If such services are not utilized or are underutilized, then, such investment in the provision of equipment and training of personnel is wasted.

Study Objectives

1. To determine the socio-demographic characteristics of women within the reproductive ages as they affect antenatal care utilization in Egor LGA, Edo State.
2. To determine the level of utilization of antenatal care service among the women of various yearly incomes in Egor LGA, Edo State.

Study Hypothesis

Ho: There is a significant difference in the utilization of antenatal care services by women of various yearly incomes in Egor LGA.

Literature Review

Concept of Antenatal Care Service

Antenatal care according to Shafqat et al. (2015) is considered as a back bone of obstetrical services of any health care delivery system. It is considered to be important for health of` pregnant women and is the way in which maternal and fetal complications are detected and managed. Ante-natal care has well established recognized role by the pregnant patients in developed countries. In developing countries its importance is not well established hence this situation often leads to poor attendance of antenatal clinics by the pregnant patient. The antenatal period clearly presents opportunities for reaching pregnant women with a number of interventions that may be vital to their health and well-being and that of their infants. According to Mgawadere (2009), ante-natal care is the key entry point of a pregnant woman to receive a broad range of health promotion and preventive services which promote the health of the mother and the baby. Srilatha, Ramadevis, Amma & Vijayakumar (2002) define ante-natal care as pregnancy related health care provided by a doctor or a health worker in a health facility or home.

Ante-natal care is the routine health control of presumed healthy pregnant women without symptoms (screening), in order to diagnose diseases or complicating obstetric conditions without symptoms, and to provide information about lifestyle, pregnancy and delivery. Ante-natal Care includes education, counseling, screening and treatment to monitor and to promote the well-being of the mother and the fetus. It is a key entry point for a pregnant woman to receive a broad range of health services including nutritional support and prevention and treatment of anemia; prevention, detection and treatment of malaria, tuberculosis and sexually transmitted infections (STIs/HIV/AIDS). Consequently, Shafqat et al. (2015) assert that antenatal care is considered as a back bone of obstetrical services of any health care delivery system. Although antenatal care a healthcare facility by health professionals such as doctors, nurses and midwives is said to be the best form of antenatal care, traditional birth attendants (TBAs) also play an important role in providing antenatal care at home. Raatikainen, Heiskanen&Heinonen(2007) and Nigeria Demographic and Health Survey (2013) noted that antenatal care (ANC) for pregnant women by health professionals maintains women's health during pregnancy and improves pregnancy outcomes by identifying and managing pregnancy related complications.

Socio-Economic Factors and Utilization of Antenatal Care Services

Maternal health care services such as antenatal care are designed with the aim of improving maternal health. Improving maternal health is one of the World Health Organization's Millennium Development Goals (MDGs) and professional health care during child birth is one of the process indicators in assessing progress towards these goals. The utilization of maternal health care services is important for early detection of mothers who are at high risk of illness and mortality during pregnancy. Hence, AbouZahr& Wardlaw (2004) state that the utilization of maternal health service definitely is essential strategy in reducing the risks associated with pregnancy and child bearing in the reproductive age (15-49). Despite the scientific evidences of ANC as a useful tool in improving maternal health, some pregnant women do not utilize it. Dairo and Owoyokun (2010) assert that these problems are even more prevalent in the developing countries due to the current socio-economic conditions and inaccessibility of health facilities.

The use of health services is a complex behavioural phenomenon. It is affected among other factors by socio-economic factors such as age, occupation, education, marital status, religion and income. Mekonnen and Asnaketch (2002) note that maternal age, parity, income, standard of living of households, antenatal care user's fees and travel distance to antenatal care providers are the common economic factors that have been cited by previous researchers on the factors that affect the utilization of health facilities. Several studies have found income and class as determinants of antenatal care utilization. In such studies antenatal care utilization were found to be high among women with higher economic status, better education, few children, married women and employed women. Mekonnen and Asnaketch (2002) note that these studies indicated that 'households in the highest income quintile are approximately twice more likely to utilize private hospital services than those in the lowest, other things being equal. There are a number of published and unpublished works that explore women's experiences, views, and beliefs in relation to delivery in Bangladesh. These studies have found a wide range of factors that may contribute to low levels of use of professional services to delays in the decision to seek care, or refusal of referrals for service. It was found that women from low-income families were less likely to seek prenatal care, visit the town health centres or local private clinics; whereas women from high-income families used country hospitals or higher medical institutes which provided better quality care. These findings led to the recommendation that low income should be taken as "high-risk factor" for poor maternal health (World Bank, 1993).

When the daily survival of the family is at risk, mothers will use fewer resources for their own health. Beside one's economic stance, residence locale plays an important role in the utilization of antenatal care services. Oladapo, Iyaniwura and Sule (2008) opined that the place of residence of pregnant women as well as age and level of education has been found to consistently determine utilization of antenatal care service. In corroboration, Igbokwe (2008) indicate that urban and rural locations have great impact on the utilization of antenatal services. According to him, expectant mothers in the urban areas utilize antenatal services better than their counterparts in the rural areas who have the problems of accessibility to mother and child health services; some pregnant mothers in the rural areas may have basic knowledge of the importance of antenatal services but due to problems of accessibility to health facilities will not be able to utilize such facilities.

Theoretical Framework on Antenatal Care

In this study, the conflict theory will be adopted to explain the concept of antenatal care. The conflict theory is one of the macro- theoretical perspectives which seek to explain the nature and dynamics of human society as a whole as well as the social institutions. The theory was formulated by Karl Marx in the 19th century and has at its core three major elements- power, interest, values, and ideas. The theory is quite relevant to health and

antenatal care in that it focuses on the inequalities in the healthcare system. The problem inherent in the healthcare system especially for pregnant women in need of care can best be examined using the conflict theoretical framework. The major assumption of the Conflict theory is that Social inequality characterizes the social system and that individuals from low socio-economic backgrounds are at the receiving end.

Conflict theory sees human societies/ social institutions existing in a system of dialectics (dialectics means conflict is natural and will occur in the system due to opposing forces) within social/structural arrangements. It states that tensions and conflicts arise when resources, status and power are unevenly distributed between groups in the society and these conflicts become the engine for social change. In this context, power can be understood as control of material resources and accumulated wealth, control of politics and the institutions that make up the society.

Methodology

The survey research design was adopted for the study. The population comprised of all women residing in the local government area of the study which amount to 94,623 women. The Yamane statistical formula was used in selecting the sample size for administration of questionnaires. The simple random sampling technique was used to select two health centers from the nine health centers in the local government area of study. Then a total of 398 sample size was further drawn from the two health centres using the same technique. The respondents were chosen on the spot when the researcher paid a visit to the health centers with the intention of collecting data from them. The researcher with the help of two research assistants kept paying visit to the health centers at intervals until the desired number of respondents was obtained. A total of 390 questionnaires were retrieved and found valid for the data analysis. The study also engaged the use of primary and secondary sources of data. Primary data were collected through in-depth interviews and well-structured questionnaires titled 'Utilization of Antenatal Care Services Questionnaire (UACSQ)'while on the other hand, secondary sources of data involved extensive and thorough literature research and, use of archival documents in the subject areas. Quantitative and qualitative data were generated through field surveys and results were compared with each other through the process of triangulation. From the data collected, the demographic and questionnaire information of the respondents were analyzed through simple percentages and means while the T-test of independence and Analysis of variance (ANOVA) was used to test the hypothesis at the 0.05 level of significance.

Data Analysis and Interpretation

Table 1: Socio-demographic Characteristics of Respondents

Age of respondents	**Frequency**	**Percentage**
15 – 25	78	20.0
26 – 35	181	46.4
36 – 45	109	27.9
Above 45	22	5.6
Total	**390**	**100.0**
Occupation of Respondents		
Housewife	85	21.8
Runs small business	189	48.5
Formal employment	116	29.7
Total	**390**	**100.0**
Yearly Income of Respondents		
Less than 60000	102	26.2
60000 - 120000	148	37.9
121000 - 180000	62	15.9
181000 - 240000	23	5.9
Above 240000	55	14.1
Total	**390**	**100.0**
Education Distribution of respondents		
Primary	46	11.8
Secondary	153	39.2
Tertiary	191	49.0
Total	390	100.0

Source: Field Survey, 2019

The result in table 1 shows the socio-demographic characteristics of the respondents that participated in the research. The study found that 78 (20.0%) of the respondents are within 15-25 years, 181(46.4%) are within 26-35 years, 109 (27.9%) are within 36-45 years while 22 (5.6%) of the respondents are above 45 years. This therefore implies that the majority of the women that participated in the research fall within 26-35 years which is within the child bearing age of women; hence they have adequate knowledge on the subject matter. By this age bracket, it is expected that the women must have attained their tertiary education and are already in their prime for reproduction. Data on occupation of respondents reveal that 102(26.2%) receive yearly income that is less than #60000, 148(37.9%) receive yearly income within the range of #60000 -#120000. The result further showed that 62(15.9%) receive yearly income within #121000 - #180000, 23(5.9%) receive yearly income within #181000 - #240000 while 55(14.1%) receive yearly income above #240000. The findings showed that majority of the respondents get yearly income of #60000 - #120000 may not be unconnected with the fact that most of them run small scale businesses which can only bring relatively less yearly incomes. The respondents level of education shows that 46(11.8%) received primary education,

153(39.2%) received secondary education while 191(49.0%) received tertiary education. From this finding, it is seen that most of the respondents are relatively highly educated. This perhaps explains the reason for the high level of utilization of antenatal care as it is presumed that their education might have exposed them to the importance of antenatal care to health of mother and child.

Table 2: Socio-demographic characteristics of women within the reproductive ages and their utilization of antenatal care Services in Egor LGA

Religion of Respondents	**Frequency**	**Percentage**
Islam	51	13.1
Christianity	309	79.2
ATR	30	7.7
Total	**390**	**100.0**
Marital Status of Respondents		
Single	38	9.7
Married	323	82.8
Divorced	13	3.3
Widow	8	2.1
Separated	8	2.1
Total	**390**	**100.0**
Number of Children of Respondents		
1 – 3	212	54.4
4 – 6	157	40.3
Above 6	21	5.4
Total	**390**	**100.0**
Residence of Respondents		
Urban	313	80.3
Rural	77	19.7
Total	**390**	**100.0**

Source: Field Survey, 2019

The result from table 2 showed the socio-demographic characteristics of respondents as it affects their utilization of antenatal care services. The findings of the study revealed that 51(13.1%) are Muslims, 309(79.2%) are Christians while 30(7.7%) belong to that of African Traditional Religion. The justification for this finding which indicated that majority of the women were Christians is based on the fact that the study was done in the part of the country where the people are predominantly Christians; it therefore implies that their religious affiliation determine utilization of antenatal care services. Marital status of the respondents reveals that 38(9.7%) are single, 323(82.8%) are married, 13(3.3%) are divorced, 8(2.1%) are widow while

8(2.1%) of the respondents are separated. Having a greater proportion of the respondents married may justify the high use of antenatal care. Married women may be more confident in using antenatal care than unmarried adolescents who may shun antenatal care because they do not wish to be labeled promiscuous or they do not have the wherewithal to pursue antenatal care services. Data on the number of children show that 212(54.4%) have up to 1-3 children, 157(40.3%) have up to 4-6 children while 21(5.4%) have more than 6 children. This finding may not be unconnected with the use of family planning techniques which promote proper child spacing which in turn leads to fewer number of children per a woman. Lastly, on the socio-demographic characteristics of women of child bearing age that participated in the study, the residence of respondents shows that 313(80.3%) of the respondents reside in urban areas while 77(19.7) reside in rural area. This may explain the reason for the high usage of antenatal care services among the majority of the respondents as it is presumed that such services are much more easily available and accessible in urban centers than in rural areas where they are usually insufficient. These findings therefore imply that the socio-demographics of women of child bearing age affect their utilization of antenatal care services during the course of their pregnancy.

Table 3: Utilization of Antenatal Care Services by Women of Reproductive Age in Egor LGA

Utilization of ANC	**Frequency**	**Percentage**
Who provided ANC services to Respondents		
Doctor	34	8.7
Nurse/midwife	14	3.6
Auxiliary midwife	78	20.0
Health workers	156	40.0
Traditional birth attendant	108	27.7
Total	**390**	**100.0**
Where Does Respondents Receive Antenatal Care		
Government hospital	32	8.2
Government health center	145	37.2
Private clinic/hospital	68	17.4
Your home	145	37.2
Total	**390**	**100.0**
Month When The Respondents First Receive Antenatal Care		
1 -3 months	8	2.1
4 – 6 months	74	19.0
7 – 9 months	234	60.0
Never	74	19.0
Total	**390**	**100.0**
Number of Times Respondents Received Antenatal Care		
Less than 3 times	59	15.1
3 – 4 times	126	32.3
5 – 6 times	205	52.6
Total	**390**	**100.0**
Activities Done During Respondents' Visit to Antenatal Clinic		
Antenatal talk	4	1.0

From the result in table 3 above, it can be deduced that respondents engaged the services of different health practitioners in order to receive antenatal care services. It can be deduced from the findings that 34(8.7%) of the women of child-bearing age visited a medical doctor, 14(3.6%) visited nurse/midwife, 78(20%) visited auxiliary midwife, 156(40%) visited health workers and 108(27.7%) visited traditional birth attendants. From the result, it is clear that majority of the women visited trained health-care workers to receive antenatal care services while some other women still patronize the services of traditional birth attendants. The major implications of these findings can be adjudged to the following: majority of the respondents reside in urban areas where healthcare facilities are situated which perhaps may not be unconnected with where the women receive antenatal care as many of them received care from government health centers situated in urban areas. Secondly, it may imply that services of the health workers are more accessible and probably more affordable than their counterparts. Responses on who the respondents saw for antenatal care reveals that 32(8.2%) received antenatal care in government hospitals, 145(37.2%) got ANC services in government health centers, 68(17.4%) receive in private clinic/hospital and 145(37.2%) receive ANC in their home. The majority of the women received antenatal care at government health center and their home. The reason for this may not be too far from the fact that government hospitals are adjudged to be more affordable to use for health services than private health facilities. Responses on where the respondents received antenatal care indicates that 8(2.1%) first receive antenatal care between 1-3 months, 74(19.0%) received between 4-6 months, 234(60.0%) received between 7-9 months while 74(19.0%) never receive antenatal care. The majority of the women first receive antenatal care in their 7-9 months of pregnancy. This implies that majority of the women do not have the right attitude to antenatal care. Month when the respondents first receive antenatal care shows that 59(15.1%) receive antenatal care less than three times, 126(32.3%) receive between three to four times and 205(52.6%) receive between five to six times. This is quite commendable as a greater proportion of the respondents receive antenatal care four or more times which meets WHO's recommended standard of at least four antenatal visits for low risk pregnancies. Number of times respondents received antenatal care shows that 4(1.0%) receive antenatal talk during their visit to clinic, 13(3.3%) receive physical examination, 7(1.8%) have their BP, urine and blood examined, 65(16.7%) receive drug against malaria, 57(14.6%) were given folic/iron tablets and tetanus injection administered to 244(62.6%). This implies that majority of the women were given TT injection during their antenatal visit; these activities are done during respondents' visit to the antenatal clinic.

Level of Utilization of Antenatal Care Services	N	Mean	Std. Deviation	Decision
Modern health care professional provide better antenatal care services that their counterparts	390	3.7436	1.15880	Accept
Where did you receive it (Hospitals)	390	2.8359	1.02350	
How many months pregnant were you when you first receive antenatal care	390	2.9590	.67900	Accept
How many times did you receive traditional antenatal care	390	2.3744	.73359	Accept
Activity(ies) done during any of your visit enhance quality of health for mothers and child	390	5.2821	1.11887	Reject
				Accept

Source: Spss 20.0 Result Output

The results in table 4 showed the level of utilization of antenatal care services among women of reproductive ages in Egor LGA. It can be observed that the women of child-bearing age prefer to utilize modern antenatal care services from health care providers. The result above also shows the average level of utilization of antenatal care in summary. A closer look at the mean figures reveals that the level of utilization of antenatal care by women is high when compared to the criterion mean of 2.5.

Test of Hypothesis

H1: There is significant difference in the utilization of antenatal care services by women of various yearly incomes in Egor.

Table 5: Description of utilization of antenatal care by women of different yearly income

Yearly Income(#)	N	Mean	Std. Deviation
less than 60000	102	15.9608	2.82815
60000-120000	148	17.0676	2.63070
121000-18000	62	17.7097	2.60760
181000-24000	23	18.3043	2.91446
above 240000	55	18.7818	2.70590
Total	390	17.1949	2.85159

Source: SPSS 20.0 result output

Table 5 shows a mean and standard deviation of utilization as 15.96 and 2.83; 17.06 and 2.63; 17.70 and 2.60; 18.30 and 2.91; and 18.78 and 2.70 for less than 60000, 60000-120000, 121000-180000, 181000-240000 and above 240000 yearly incomes respectively. It can be deduced that all the items were above the mean cut off of 2.5, hence income affect utilization of respondents affect utilization of antenatal care services.

Table 6: ANOVA of Utilization of antenatal care by women of different yearly income

Yearly income	**Sum of Squares**	**Df**	**Mean Square**	**F**	**Sig.**	**Remark**
Between Groups	340.997	4	85.249	11.630	.000	Significant
Within Groups	2822.193	385	7.330			
Total	3163.190	389				

Source: SPSS Output, 2019

Table 6 shows an F value of 11.630 and a p value of .000. Testing at an alpha level of .05 the p value is less than the alpha level, so, the null hypothesis which states that "There is no significant difference in the utilization of antenatal care by women of various income level in Egor" is rejected. Consequently, there is a significant difference in the utilization of antenatal care by women of various yearly incomes in Egor.

Discussion of Findings

This study revealed that 78(20.0%) of the respondents are within 15-25 years, 181(46.4%) of them are within 26-35 years, 109(27.9%) are within 36-45 years while 22 (5.6%) of those that participated in the study are above 45 years. This finding implies that older women who may have attained higher level education may value utilizing antenatal care services than their younger counterpart's particularly pregnant adolescents who may have attained only low level of education and may not value utilizing antenatal care services. Older women are possibly more confident and influential in household decision-making than younger women. More so, older women are advised by health workers to deliver in a facility since old age is a biological risk factor to pregnancy.

Among the women, 212 (54.4%) have had (1-3) number of children, 157(40.3%) have had (4-6) number of children while 21(5.4%) have had more than 6 number of children. A greater proportion of the women (234, 60%) did not attend antenatal care within the first trimester of pregnancy but waited till the last trimester precisely 7-9 months of pregnancy. Only 8 (2.1%) made their first antenatal visit within the first trimester (1-3 months). 74(19.0%) declared the period of the first antenatal care visit is between the 4th and 6th month of pregnancy while the same percentage never made any antenatal visit. This negative attitude to antenatal care may not be unconnected with the relatively large number of the respondents who had limited financial resources as a result of not fully economically empowered. Furthermore, women including adolescents are sometimes reluctant to use maternity care services because health care providers are perceived to be rude, insensitive and threatening to these young mothers.

In order to enjoy the full benefits of antenatal care it is important that pregnant women book early for antenatal care. To this end, WHO recommended that antenatal care for women whose pregnancies are progressing normally should commence in the first trimester ideally before 12 weeks but no later than 16weeks. However, the findings of this present study indicate that despite almost all the women utilized antenatal care, many did not book for care early enough during their pregnancy. This finding is not consistent with WHO's recommendation that antenatal care for women whose pregnancies are progressing normally should commence in the first trimester ideally before 12 weeks but no later than 16 weeks. Adekanle&Isawumi (2008) note that the late booking for antenatal care has become a persistent pathology in the country other developing countries of the world. Several reasons have been advanced by expectant mothers for initiating ANC late. Specifically, Yazdoni, Islam, Nadeem, Hayat and Mushtaq (2008) note that among others, financial constraint, distance from the health care facility, lack of permission from spouse, and cultural/personal perception of their health status are the reasons why women initiate antenatal booking late.

Despite the fact that majority of the women did not register early enough for antenatal care, slightly above average of them (205, 52.6%) were able to make up to 5- 6 visits before delivery of their babies. 126(32.3%) made up to 3-4 antenatal visits before delivery while 59(15.1%) made less than 3 visits before delivery. This

finding indicated that a smaller percentage of the women fell short of the WHO's recommendation of at least four antenatal visits for a pregnancy that is progressing normally. Furthermore, the study showed a high usage of antenatal care. This finding is consistent with the finding of a previous study byAkanbiemu et al. (2013) which showed that majority of the respondents (95.4%) used antenatal care facilities. In the same vein, Adewoye et al. (2013) indicate that antenatal care attendance among their respondents was high, precisely (76.8%) with high patronage of government health facilities. The implication of the findings of these various studies is that there is the likelihood that more women are getting aware of the potential benefits of appropriate care during pregnancy. This action therefore accounts for the high utilization of antenatal care by expectant mothers

This study indicates that majority of the women (72.8%) received care from trained medical personnel. This finding is consistent with the finding of a study in Nigeria (NDHS, 2013) which indicated that 61% of women of reproductive ages (15-49) in Nigeria received antenatal care from a medical professional, such as doctors, nurses and midwives. According to the report, only a small fraction (6 percent) received antenatal care from traditional birth attendants. This aspect however contradicts the finding of this present study which indicated that 27% of the women received care from traditional birth attendants. Furthermore, the study indicates that 37.2% of the women did not receive antenatal care from any of the designated health facilities. This finding corroborates Fagbamigbe and Idemudia (2015) submission that over one third of pregnant women do not attend antenatal care (ANC) service during pregnancy in Nigeria. According to reports submitted by Nigeria Demographic and Health Survey (NDHS, 2013) and National AIDS and Reproductive household survey (NARHS, 2012), 33.9% and 34.9% of women respectively did not attend any ANC services in Nigeria. This ugly trend probably explains the World Health Organization's assertion in 2014 that attendance of antenatal care and delivery in a facility by a trained birth assistant in Nigeria are far lower than most other African countries. Several reasons have been given for the choice to deliver outside hospital settings in Nigeria. According to Ahmed et al. (2005) the choice to deliver outside hospital settings in Nigeria could be motivated by varying factors such as economic, social, physical, cultural, or institutional.

This study indicates that there is a difference in the utilization of antenatal care by women of various yearly incomes. Consequently, there is significant difference in the utilization of antenatal care services by women of various yearly incomes in Egor hypothesis one which stated that “There is no significant difference in the utilization of antenatal care by women of various yearly incomes is rejected as it was realized that women with yearly income of above #240,000 were much more predispose to using antenatal care than their counterpart with lower yearly income. It is assumed that a relationship might exist between income and the utilization of antenatal care. In Linecetto et al. (2010)'s submission, inability to pay for antenatal care services or prescribed treatment is an important barrier to utilization of antenatal care. This corroborates the finding of a study on the determinants of maternal health services in the rural India which indicated that, there is a correlation between household income and utilization of maternal health services (Sharif and Singh, 2002). According to them it was evident that as a result of lack of productive resources for women, income earned by women had negative impact on utilization of antenatal care and postnatal care.

Conclusion

Based on its findings, this study, firstly, first concludes that the respondents' utilization of antenatal care was good as the respondents excellently demonstrated that they knew the term antenatal care, its purposes and services. Secondly, that majority of the respondents (60%) booked late at antenatal clinics mostly in the third trimester (7-9months) of their pregnancy and this negative attitude towards antenatal care may not be

unconnected with the educational level of some of the respondents due to the fact that some previous studies have revealed that educational level could influence utilization of the antenatal care and the understanding of the importance of seeking health care promptly. Lastly, that a greater proportion of the respondents demonstrated perception of antenatal care and their attitude to antenatal care was generally considered positive based on the questions answered.

Recommendation

Based on its findings, the study recommends the following for stakeholders:

1. Firstly, since antenatal care provides women and their families with appropriate information and advice for a healthy pregnancy, safe childbirth, and postnatal recovery, including care of the newborn, promotion of early, exclusive breast-feeding, and assistance with deciding on future pregnancies in order to improve pregnancy out-comes, all pregnant women should endeavour to utilize antenatal care and also book early for it specifically in the first trimester of their pregnancy ideally before 12 weeks but later than 16weeks as recommended by the World Health Organization for not better pregnancy outcomes.
2. Secondly, in order to improve utilization of antenatal care services, efforts to relieve poverty, and empower women economically are needed. Consequently, women should endeavour to engage themselves in productive ventures so as to be economically empowered.

Thirdly, antenatal care services should be made accessible to all pregnant women irrespective of their location. Some pregnant mothers in the rural areas may have basic knowledge of the importance of antenatal services but due to problems of accessibility to health facilities, they will be hindered from getting such services. So, it is recommended that government should provide more qualified medical practitioners and equipment to health centres in the rural areas so that the problem of inadequate health- care providers and equipment in rural areas is reduced to the barest minimum.

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