

Knowledge and Attitude of Pregnant Women towards ‘Focus Antenatal Care’ Utilization in Ikot Ekpene Senatorial District

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Abstract: The purpose of the study was to investigate the knowledge and attitude of pregnant women towards ‘Focus Antenatal Care’ (FANC) utilization in Ikot Ekpene, Nigeria. Ex-post-facto design was adopted for this study. The sample size was 920. A researcher-made Likert type questionnaire was used for data collection. Five research questions and five hypotheses were formulated. Simple frequency count and Percentage computation were used for the analysis of the research questions while chi-square statistic was used for testing the hypotheses at .05 alpha level. Findings revealed that pregnant women’s knowledge of FANC, attitude, educational status, residential location, and economic status were all significant. It was therefore recommended among other things that adequate awareness and education about Focus Antenatal Care be pursued vigorously among pregnant women in the area of study for improved health care delivery.

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I. Background/Introduction

An effective intervention against maternal mortality exists yet millions of pregnant women die of preventable complications due to lack of knowledge of current government intervention (Bhatia & Cleland, 2009). High maternal death in Nigeria is of utmost concern to public health (Ekele, Shehu, Ahmed & Fache, 2008). Knowledge and attitude towards ‘Focus Antenatal Care’ (FANC) utilization by pregnant women are important in the usage of Antenatal Care facilities for the reduction of maternal mortality (Munjanja, Lindmark & Nystrom, 2006).

Efforts have been made by the government and Non Governmental Agencies to reduce maternal mortality. These efforts according to Umeora, Sunday-Adeoye and Ugwu, (2008), have made little or no impact in Nigeria because of ignorance of effective antenatal care services. In spite of the years of defeat in reducing maternal mortality, scientific knowledge about it continued until 2002 when ‘Focus Antenatal Care’, a goal-oriented antenatal care approach was adopted by the World Health Organisation (WHO) (Munjanja, Lindmark & Nystrom, 2006).

Antenatal care is one of the basic components of maternal care on which the life of mothers and babies depend (Saseendran, Mary & William, 2004). Antenatal care (ANC) is an umbrella term used to describe the medical procedures and care that are carried out during pregnancy. It is the care a woman receives throughout her pregnancy and is important in helping to ensure a healthy pregnancy state and safe childbirth (Magadi, Madise & Diamond, 2010). The Focus Antenatal Care (FANC) refers to a minimum number of four antenatal clinic visits, each of which has specific items of client assessment, education and care to ensure early detection and prompt management of complications (Millennium Development Goals, 2015). According to Bhutta, Chopra, Axelson, Berman, Boerma, Bryce, Bustreo and Cavagnero (2010), Focus Antenatal Care is evidence based, client centered, goal directed care, provided by skilled health providers with emphasis on quality rather than frequency of visits. The approach submits that every pregnant woman is at risk of complication and that all women should therefore receive the same basic care and monitoring for complications (World Health Organisation, 2001). Essential interventions in FANC include identification and management of obstetric complications such as pre-eclampsia, tetanus toxoid immunization, Intermittent Preventive Treatment (IPT) for malaria during pregnancy, and identification and management of infections and other Sexually Transmitted Infections (STI) (Magadi, Madise & Diamond, 2010).

World Health Organisation, the national policy and Ministry of Health guidelines recommend a minimum of four FANC visits, ideally at 16 weeks, 24-28 weeks, 32 weeks and 36 weeks for women whose pregnancies are progressing normally (Ouma, Van Eijk, Hamel & Sikuku, 2010). Focus Antenatal Care is a goal-oriented antenatal care approach, which was recommended by researchers in 2001 and adopted by the World Health Organisation (WHO) in 2002 (Brown, Sohani, Khan, Lilford & Mukhwana 2008).

Aniebue and Aniebue (2010) also opined that FANC aims to give holistic individualised care to each woman to help maintain the normal progress of her pregnancy through timely guidance and advice on birth preparedness, nutrition, immunization, personal hygiene and family planning, counselling on danger symptoms. Simkhada, Teijlingen, Porter and Simkhada (2008) had submitted that in FANC, service providers are guided by each woman's individual situation rather than making the traditional frequent antenatal care visits as a routine activity for all, and categorising women based on routine risk indicators. FANC service according to Ghaffar, Pongpanich, Chapman, Panza, Mureed and Ghaffar (2012) include gathering information about the pregnancy, physical examination, diagnostic tests, evaluating any risk factors and making an individualised care plan. If no abnormalities are identified, the care plan will focus on counselling, birth preparedness and complication readiness. If the mother needs specialised care then the plan will be to refer her to a higher health facility.

If FANC complications are detected early by the family and health service provider and interventions are begun in good time, then there will be better outcomes for the women and their babies (Fagbamigbe, Akanbiemu, Adebowale, Olumide, & Korter, 2013). The four visits of FANC have specific activities that are carried out at the antenatal clinic. According to Gerein, Mayhew and Lubben (2003) the first FANC visit ideally occurs before 16 weeks of pregnancy and the following procedures are carried out : Determining the woman's medical and obstetric history in order to collect evidence of her eligibility to follow the routine services of FANC, or determining if she needs special care or referral to a higher health facility, perform basic examinations, determining the gestational age of the foetus if the pregnancy is beyond the first trimester through measurement, providing nutritional advice and routine iron and folate supplementation, advising against misconceptions about diet, providing Prevention of Mother to Child Transmission of HIV (PMTCT) services, advice on malaria prevention and if necessary provide bed Insecticide Treated Nets (ITNs), checking her urine for sugar or refer her to the secondary health facility if there is suspicion she may be developing diabetes in pregnancy, advising her and her partner to save money in case she needs referral, especially if there is an emergency requiring transport to a secondary health facility.

The activities done at the second FANC visit scheduled at 24-28 weeks of pregnancy include the procedures already described for the first visit and additionally addresses any complaints and concerns of the pregnant woman and her partner (Magadi, Madise & Diamond, 2010). The third FANC visit is scheduled between 30-32 weeks of gestation. The objectives of the third visit are the same as those of the second visit. Additionally, the service provider does the following : Direct special attention toward signs of multiple pregnancies and refer her if there is need, review the birth preparedness and the complication readiness plan, perform the test for protein in the urine for all pregnant women since hypertensive disorders of pregnancy are unpredictable, decides on the need for referral based on the updated risk assessment, give advice on family planning and encourage the woman to consider exclusive breastfeeding for her baby (Bhatia & Cleland, 2009).

The fourth FANC visit is the final one for women without complications and occurs between weeks 36-40 of gestation. All the activities already described for the third visit are covered. In addition the abdominal examination is done to confirm fetal lie and presentation (Umeora, Sunday-Adeoye & Ugwu, 2008).

According to Munjanja, Lindmark and Nystrom (2006) FANC is gaining much popularity because of its effectiveness in terms of reducing maternal mortality (deaths) and morbidity (disease, disorder or disability). Ekele, Shehu, Ahmed and Fache (2008) opined that FANC is the best approach for resource-limited countries where health professionals are few and health infrastructures are limited. The need for the adoption of the antenatal care model termed Focus Antenatal Care (FANC) emanated from the desire to correct the limitations of traditional antenatal care (ANC) in developing countries Shaikh & Hatcher, 2005). The FANC model is intended to reduce waiting time during antenatal visits and increase the time spent in educating on pregnancy-related issues in traditional antenatal care (Ochako, Fotso, Ikamari, Khasakhala, 2015).

The traditional Antenatal Care which was formerly practiced had too many ANC visits and the health-care workers were less able to give sufficient time to each woman, and hence the quality of care was lowered and there was an increased chance of missing potential problems of the pregnant woman. The reduced-visits package was adopted as a way of improving the quality of care for pregnant women (Brugha & Aliassime, 2003). Onah, Ikeako and Iloabachie (2006) also submitted that the majority of pregnant women cannot afford the cost incurred by the frequent antenatal visits required by the traditional antenatal care approach. From the logistical and financial point of view Umeora, Sunday-Adeoye and Ugwu (2008) asserted that the traditional approach is not practical for the majority of pregnant women and that it is a burden on the healthcare system.

The traditional approach to antenatal care assumes that better care is achieved by frequent routine visits. The number of visit is 16 to 18 in a pregnancy regardless of risk status. The traditional approach to antenatal care assumes that the more the number of visits the better the outcome (Phoxay, Okumura, Nakamura & Wakai, 2010). Historically, the traditional antenatal care service model was developed in the early 1900s. This

model classifies pregnant women into low and high risk by predicting the complications ahead of time (VanEijk, Bles, Odhiambo, Ayisi&Blokland, 2006). Irungi and Onyango-Ouma (2008) posited that in this approach women are classified by risk status to determine their chances of complications and the levels of care needed.

The traditional antenatal care was the previous approach to antenatal care adopted in Nigeria. Unfortunately many developing countries, like Nigeria adopted this approach without taking into account available resources and peculiar needs of their population (Brugha&Aliassime, 2003). Regrettably the episode of maternal mortality in the state tends to suggest that many people still do not know or do not have a positive attitude towards its intervention

Igbokwe (2004) in a study on Knowledge and Attitude of Pregnant Women towards Antenatal Services utilization In Nsukka Local Government Area Of Enugu State, Nigeria, for instance discovered that Pregnant women from urban area who had secondary and tertiary education had high level of knowledge and developed a positive attitude towards the concept of antenatal services while their counterparts had moderate level of knowledge with a negative attitude towards FANC utilization. The purpose of the study was to ascertain the knowledge and attitude of pregnant women towards antenatal services in Nsukka LGA of Enugu State. The study adopted the descriptive survey design. Specifically, five objectives with five corresponding research questions were formulated to guide the study. A multi- stage sampling technique of balloting without replacement was used to select 259 pregnant women in Nsukka LGA of Enugu State. Data were collected using structured questionnaire and analysis was done using simple percentage and mean responses. Results showed that pregnant women had moderate level of knowledge of concept of antenatal services. Pregnant women from urban area had high level of knowledge of the concept of antenatal services while their counterpart from the rural setting had moderate level of knowledge. Also, it was realized that pregnant women with secondary and tertiary education had positive attitude while those with no formal and primary education had negative attitude to antenatal services, and pregnant women from both urban and rural settings had positive attitude. Based on the findings, the study recommends among others that all health educators and other health professionals should adopt better educational strategies to improve the knowledge and utilization of antenatal services among pregnant women.

Statement of the problem

Focus Antenatal Care (FANC) is a goal-oriented antenatal care approach, adopted by the World Health Organisation with a minimum of four antenatal visits, ideally at 16 weeks, 24-28 weeks, 32 weeks and 36 weeks (Gerein, Mayhew&Lubben, 2003). This approach accepts the view that every pregnant woman is at risk of complication and that all women should therefore receive the same basic care and monitoring for complications (Fagbamigbe, Akanbiemu, Adebowale, Olumide&Korter, 2013). Focus Antenatal Care is the recommended antenatal care that brings about the reduction of maternal morbidity and mortality rates globally (Ekele, 2003). The World Health Organisation estimates that about 600,000 pregnant women die every year, as a direct result of childbearing, and most of these deaths are avoidable (Araoye, 2001). The government of Nigeria in response to the existence of this problem put in place FANC to check the menace of pregnancy complications among its citizens.

In IkotEkpene Senatorial district of Nigeria, pregnant women were having complications and some die out of ignorance. It is against this background that the present study investigates the knowledge and attitude of pregnant women towards Focus Antenatal Care utilization in the area.

Purpose of the study

The purpose of the study was to find out the Knowledge and Attitude of Pregnant Women towards Focus Antenatal Care (FANC) utilization in IkotEkpene Senatorial District. Specifically the study was seeking to:

1. Determine the pregnant women's knowledge of Focus Antenatal Care (FANC) in IkotEkpene Senatorial District.
2. Determine the pregnant women's Attitude towards Focus Antenatal Care utilization in IkotEkpene Senatorial District.
3. Ascertain the influence of residential location on the pregnant women's utilization of Focus Antenatal Care (FANC) in IkotEkpene Senatorial District.
4. Find out the influence of educational status on the pregnant women's utilization of Focus Antenatal Care (FANC) in IkotEkpene Senatorial District.
5. Determine the influence of economic status on pregnant women's utilization of Focus Antenatal Care (FANC) in IkotEkpene Senatorial District.

Research Questions

1. What is the difference in knowledge of the pregnant women towards Focus Antenatal Care (FANC) in IkotEkpene Senatorial District?
2. What is the attitude of the pregnant women towards Focus Antenatal Care (FANC) utilization in IkotEkpene Senatorial District?
3. What is the influence of pregnant women's residential location on utilization of Focus Antenatal Care (FANC) in IkotEkpene Senatorial District?
4. What is the influence of pregnant women's educational status on utilization of Focus Antenatal Care (FANC) in IkotEkpene Senatorial District?
5. What is the influence of pregnant women's economic status on Focus Antenatal Care (FANC) in IkotEkpene Senatorial District?

Research Hypotheses

1. Pregnant women in IkotEkpene Senatorial District do not significantly differ in their knowledge of FANC.
2. There is no significant influence of pregnant women's attitude towards utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District?
3. There is no significant influence of residential location on pregnant women's utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District?
4. There is no significant influence of educational status on pregnant women's utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District?
5. There is no significant influence of economic status on pregnant women's utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District.

Research Design

The ex-post-facto research design was used for this study. This research design provides an opportunity for collection of data and opinion from the representatives of the entire population in retrospect (Onah, Ikeako&Iloabachie,2006).

Population of the Study

The population for the study comprised all the pregnant women registered in antenatal clinics of public Primary Health Care Centers in IkotEkpene Senatorial District for at least six months. The population size was 3421 (Measurement and Evaluation Unit of Primary Health Care facilities in existing ten LGAs in the Senatorial District).

Sample and Sampling Technique

For this study 926 pregnant women were drawn from the antenatal clinics (ANC) of the health centers in IkotEkpene Senatorial District using simple random sampling technique.

Instrument for Data Collection

The instrument for gathering information for this study was the researcher made questionnaire tagged Knowledge and Attitude Towards Focus Antenatal Care Utilization Questionnaire (KATFANCUQ). The questionnaire was organized in three sections A, B and C. Section A dealt with the demographic information of the respondent, while sections B, and C sought information on their Knowledge and Attitude. The questionnaire was a likert-type scale in five options of Agreed, Strongly Agreed, Disagreed and Strongly Disagreed.

Validation of the Instrument

The questionnaire accompanied by objectives, research questions and hypotheses was content validated by three experts. They were from the Departments of Health Education, Science Education and, Measurement and Evaluation of the University of Uyo. They assessed the suitability of the items, the language, arrangement and appropriateness of the items. Items accepted by them made the final copy of the questionnaire.

Reliability of the Instrument

The instrument was subjected to test of reliability by administering the questionnaire to a trial group of 20 pregnant women not used in the main study but equivalent to the pregnant women in their characteristics. The data generated from the responses were used to conduct item analysis for determining the reliability of the instrument. The data was subjected to Crombachalfa to obtain a reliability co-efficient $r = .82$.

Method of Data Collection

The researchers worked as a team to administer questionnaire and gather data. In some situations, the researchers had to interpret the stem of the items in the local language of the environment which is Annang.

Method of Data Analysis

A total of 920 respondents returned properly filled copies of the questionnaire, and these were analyzed. The responses in the questionnaire were sorted manually per item and tallied by frequency counts. Simple percentage was used to describe the data used in answering the research questions while chi-square test statistic was used in testing the hypotheses at .05 alpha level.

II. Result

Presentation of Descriptive Statistics

Table 1 Pregnant Women’s Responses on their knowledge Towards FANC in percentages

Items	SA	A	D	SD	Total
1. FANC is the approved Antenatal Care by WHO for the pregnant women.	102(11.1)	290(31.5)	322(35)	206(22.4)	920(100)
2. FANC has minimum of four antenatal care visits.	111(12.1)	297(32.3)	315(34.2)	197(21.4)	920(100)
3. FANC visits are during 16 th , 24 th , 28 th , 32 nd , and 36 th weeks of pregnancy.	58(6.3)	194(21.1)	457(49.7)	211(22.9)	920(100)
4. Each visit includes care that is appropriate for the duration of pregnancy.	83(9)	210(22.8)	423(46)	204(22.2)	920(100)
Overall	354(9.6)	991(26.9)	1517(41.2)	818(22.2)	3680(100)

On the table, frequency counts are stated under each subheading with the corresponding percentage in parenthesis.

On Table 1, 9.6 percent of the respondents strongly disagreed, 26.9 percent agreed, 41.2 percent disagreed while 22.2 percent strongly disagreed. Merging disagree and strongly disagree indicates that 63.4 percent of respondents had no knowledge or are unaware of Focus Antenatal Care (FANC).

Table 2 Pregnant Women’s Response on their Attitude towards Utilization of FANC

Items	SA	A	D	SD	Total
1. I prefer FANC for use.	205(22.3)	209(22.7)	251(27.3)	255(27.7)	920(100)
2. FANC prevents deaths of pregnant women.	161(17.5)	167(18.2)	292(31.7)	300(32.6)	920(100)
3. Attending FANC is for wellbeing of the pregnant.	139(15.1)	140(15.2)	318(34.6)	323(35.1)	920(100)
4. FANC detects disease early in pregnant woman.	160(17.4)	168(18.3)	293(31.8)	299(32.5)	920(100)
Overall	665(18.1)	684(18.6)	1154(31.4)	1177(32)	3680(100)

On Table 2, 18.1 percent of all respondents strongly disagreed, 18.6 percent agreed, 31.4 percent disagreed while 32 percent strongly disagreed. Merging disagree and strongly disagree gives 63.4 percent of respondents with a negative attitude towards FANC utilization.

Table 3 Responses of Pregnant Women’s Utilization of FANC Based on Residential location

Items	SA	A	D	SD	Total
1. I live close to health facility.	102(11.1)	290(31.5)	322(35)	206(22.4)	920(100)
2. FANC is accessible because I live close to health facility.	111(12.1)	297(32.3)	315(34.2)	197(21.4)	920(100)
3. I spend less on transportation to attend FANC.	58(6.3)	194(21.1)	457(49.7)	211(22.9)	920(100)
4. My proximity to FANC makes my attendance possible.	83(9)	210(22.8)	423(46)	204(22.2)	920(100)
Overall	354(9.6)	991(26.9)	1517(41.2)	818(22.2)	3680(100)

On Table 3, 9.6 percent of the respondents strongly disagreed, 26.9 percent agreed, 41.2 percent disagreed while 22.2 percent strongly disagreed. Merging disagree and strongly disagree indicates that 63.4 percent of total respondents are not utilizing FANC irrespective of their location to the services.

Table 4 Responses of Pregnant Women’s Utilization of FANC Based Educational Status

Qualification	SA	A	D	SD	Total
Tertiary	48(29.4)	58(35.6)	36(22.1)	21(12.9)	163(100)
Secondary	58(20.4)	83(29.1)	93(32.6)	51(17.9)	285(100)
Primary	57(19.9)	72(25.2)	95(33.2)	62(21.7)	286(100)
No.Schooling	35(18.8)	47(25.3)	67(36)	37(19.9)	186(100)

On Table 4, 29.4 percent of the women who had tertiary education responded strongly agree, 35.6 percent agreed, 22.1 percent disagreed while 12.9 percent strongly disagreed. Merging agree and strongly agree showed that 65 percent of women who had tertiary education agreed to the utilization of Focus Antenatal Care. The table also showed that 20.4 percent of the women who had secondary qualification responded strongly agree, 29.1 percent agreed, 32.6 percent disagreed while 17.9 percent strongly disagreed. Merging agree and strongly agree showed that 49.5 percent of women who had secondary qualification agreed to the utilization of Focus Antenatal Care. 19.9 percent of the women who had primary qualification responded strongly agree, 25.2 percent agreed, 33.2 percent disagreed while 21.7 percent strongly disagreed. A total of 45.1 percent of women who had primary education agreed to the utilization of FANC. Finally, 18.8 percent of the women who did not attend school responded strongly agree, 25.3 percent agreed, 36 percent disagreed while 19.9 percent strongly disagreed. A total of 44.1 percent of the women who did not attend school agreed to the utilization of FANC. This indicates that a greater percentage of the women who had tertiary qualification utilized FANC the most, followed by secondary, primary and non schooling in that order.

Table 5 Responses of Pregnant Women’s Utilization of FANC Based on income level

Socioeconomic Status	SA	A	D	SD	Total
High	75(29.4)	71(27.8)	57(22.4)	52(20.4)	255(100)
Average	91(25.6)	86(24.2)	86(24.2)	93(26.1)	356(100)
Low	50(16.2)	81(26.2)	103(33.3)	75(24.3)	309(100)

As shown on Table 5, 29.4 percent of the women in high socioeconomic status responded strongly agree, 27.8 percent agreed, 22.4 percent disagreed while 20.4 percent strongly disagreed. A total of 57.2 percent of women in high socioeconomic status agreed to utilization of FANC; 49.8 percent in average socioeconomic status agreed to utilization of FANC; while 42.4 percent in low socioeconomic status agreed to the utilization of Focus Antenatal Care (FANC).

Hypotheses Testing

Hypothesis 1:

Pregnant women in IkotEkpene Senatorial District do not significantly differ in their knowledge towards Focused Antenatal Care (FANC).

Table 6: Chi-square Analysis of Responses of Pregnant Women on their knowledge Towards Focus Antenatal Care (FANC)

Items	SA	A	D	SD	df	X _{cal}	X _{cri}
1.	102(11.1)	290(31.5)	322(35)	206(22.4)	9	94.05	16.92
2.	111(12.1)	297(32.3)	315(34.2)	197(21.4)			
3.	58(6.3)	194(21.1)	457(49.7)	211(22.9)			
4.	83(9)	210(22.8)	423(46)	204(22.2)			
Overall	354(9.6)	991(26.9)	1517(41.2)	818(22.2)			

As showed in Table 6, the calculated chi-square value (94.05) is greater than the critical chi-square value (16.92). Therefore, the null hypothesis is rejected. This implies that pregnant women in IkotEkpene Senatorial District do significantly differ in their knowledge towards Focused Antenatal Care (FANC).

Hypothesis 2:

There is no significant influence of pregnant women’s attitude towards utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District. This research hypothesis is answered on Table 7.

Table 7 Chi-square Analysis of Responses of Pregnant Women's Attitude towards Utilization of FANC

Items	SA	A	D	SD	df	X _{cal}	X _{cri}
1.	205(22.3)	209(22.7)	251(27.3)	255(27.7)	9	44.35	16.92
2.	161(17.5)	167(18.2)	292(31.7)	300(32.6)			
3.	139(15.1)	140(15.2)	318(34.6)	323(35.1)			
4.	160(17.4)	168(18.3)	293(31.8)	299(32.5)			
Overall	665(18.1)	684(18.6)	1154(31.4)	1177(32)			

On Table 7, the calculated chi-square value (44.35) is greater than the critical chi-square value (16.92). Therefore, the null hypothesis is rejected. This implies that there is significant influence of pregnant women's attitude towards utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District.

Hypothesis 3:

There is no significant influence of residential location on women utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District. This research hypothesis is answered on Table 8.

Table 8: Chi-square Analysis of Responses of Pregnant Women's Utilization of FANC Based on Residential Location

Items	SA	A	D	SD	df	X _{cal}	X _{cri}
1.	102(11.1)	290(31.5)	322(35)	206(22.4)	9	94.05	16.92
2.	111(12.1)	279(32.3)	315(34.2)	197(21.4)			
3.	58(6.3)	194(21.1)	457(49.7)	211(22.9)			
4.	83(9)	210(22.8)	423(46)	204(22.2)			
Total	354(9.6)	991(26.9)	1517(41.2)	818(22.2)			

On Table 8, the calculated chi-square value (94.05) is greater than the critical chi-square value (16.92). Therefore, the null hypothesis is rejected. This implies that there is significant influence of residential location on pregnant women's utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District.

Hypothesis 4

There is no significant influence of educational status on women utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District.

Table 9: Chi-square Analysis of Responses of Pregnant Women's Utilization of FANC Based Educational Status

Qualification	SA	A	D	SD	df	X _{cal}	X _{cri}
Tertiary	48(29.4)	58(35.6)	36(22.1)	21(12.9)	9	21.34	16.92
Secondary	58(20.4)	83(29.1)	93(32.6)	51(17.9)			
Primary	57(19.9)	72(25.2)	95(33.2)	62(21.7)			
No Schooling	35(18.8)	47(25.3)	67(36)	37(19.9)			

On Table 9, the calculated chi-square value (21.34) is greater than the critical chi-square value (16.92). Therefore, the null hypothesis is rejected. This implies that there is a significant influence of educational status on women utilization of Focused Antenatal Care.

Hypothesis 5

There is no significant influence of Income status on women utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District. This hypothesis is answered on Table 10.

Table 10: Chi-square Analysis of Responses of Pregnant Women's Utilization of FANC Based on Income status

Socioeconomic Status	SA	A	D	SD	df	X _{cal}	X _{cri}
High	75(29.4)	71(27.8)	57(22.4)	52(20.4)	6	22.11	12.59
Average	91(25.6)	86(24.2)	86(24.2)	93(26.1)			
Low	50(16.2)	81(26.2)	103(33.3)	75(24.3)			

On Table 10, the calculated chi-square value (22.11) is greater than the critical chi-square value (12.59). Therefore, the null hypothesis is rejected. This implies that there is significant influence of socioeconomic status on women utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District.

III. Discussion Of Findings:

Findings are discussed here to affirm the knowledge and Attitude of Pregnant Women towards FANC utilization in IkotEkpene Senatorial District. The pregnant women had low knowledge of FANC. As much as 63.4 percent of the total respondents actually did not have knowledge of FANC. This is in consonance with the findings of Phoxay, Okumura, Nakamura and Wakai (2010) that there is low level of knowledge of FANC among pregnant women. The low knowledge is probably due to the fact that much sensitization and awareness is yet to be created on FANC among pregnant women. This supports the assertion of Brown, Sohani, Khan, Lilford, and Mukhwana (2008), that adequate sensitization on a health program enables the people to possess adequate knowledge on it. A total of 63.4 percent of the entire respondents had a negative attitude towards FANC utilization. This corroborates Akin-Otiko and Bhengu, (2012) and also Onah, Ikeako and Iloabachie (2006) that pregnant women had a negative attitude towards FANC utilization. This, the sources attributed to poor level of knowledge of FANC among pregnant women. The women can only develop a positive attitude towards FANC when they have the knowledge of it. Results indicated a significant influence of residential location on pregnant women's utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District. This result is in line with the findings of Igbokwe (2004) who reported that residential location had impact on the utilization of the antenatal services. Igbokwe had reasoned that pregnant women who lived close to the health facility patronized FANC than those who lived far, and that pregnant women who lived close had higher level of knowledge of concept of antenatal services than the pregnant mothers who lived far from the health facility. This study is in consonance with Saseendran, Mary and William (2004). Results also indicated that there is significant influence of educational status on women utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District. The finding here is in agreement with Aniebue and Aniebue (2010) that the level of knowledge of women about FANC varied due to their educational status. The same source discovered that the level of education tended to influence the way in which women acquire and utilize information about antenatal services. Women with lower level of formal education were limited to their peers for dissemination of health information, while women with higher level of formal education had diverse sources of information like newspapers and radio programs. (Onah, Ikeako and Iloabachie (2006)). Finally, results indicated a significant influence of income status on women utilization of Focused Antenatal Care (FANC) in IkotEkpene Senatorial District. This result agrees with Qi (2009) that most parturient who utilized antenatal care were pregnant women who had a higher economic status. However, contrary to the finding of this study, Ouma, VanEijk, Hamel and Sikuku (2010) discovered that there was no significant influence of economic status on pregnant women's use of FANC. In that study all the women reported for FANC services on their appointment days. They accepted the view that four visits were adequate to achieve their desires for antenatal care. The positive attitude of the pregnant women was attributed to high level of knowledge through health education. It is therefore inferred that adequate health education on FANC would be a powerful tool for pregnant women's acceptance of FANC.

IV. Conclusions

The study concluded that:

- Pregnant women significantly differ in knowledge of FANC.
- There is significant influence of pregnant women's attitude towards utilization of Focus Antenatal Care (FANC).
- There is significant influence of residential location on pregnant women's utilization of Focus Antenatal Care.
- There is significant influence of educational status on pregnant women's utilization of FANC.
- There is significant influence of economic status on pregnant women's utilization of FANC in IkotEkpene Senatorial District.

V. Recommendations

Based on the findings and conclusions of the study it is recommended that:

1. There should be intensification of Health Education on FANC among pregnant women.
2. The AkwaIbom State Ministry of Health should build and strengthen the capacity of the staff of Primary Health Care Centres through special workshops and seminars on FANC.
3. Women of child bearing age should be educated on the effectiveness of FANC so that they can develop positive attitude towards using it .

4. Special attention should be paid to people of low socio-economic level because of the severity of health problems in that population.
5. Government should equip health facilities with more health personnel.
6. Policy makers should implement changes in the health care delivery system towards FANC.

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