**PREGNANCY DURATION AND CHOICE OF ANTE-NATAL AND DELIVERY CARE**

**ABSTRACT**

Pregnancy duration and choice of care for maternal health are crucial primary health issues that the World Health Organization (WHO) keeps constant in the campaign for all round healthcare delivery for mother and child. To be sure, there is consensus on the need for optimal care for the mother and baby; this is believed to enhance the mother and child social development and biological growth and to reduce maternal and infant mortality and morbidity which are prevalent in Nigeria and other Sub-Saharan Africa countries. The study thus, investigates challenges being faced by the mothers, which are sometime inconsistent to their socio-economic pursuits, growth and maternal well being. Other objectives include understanding of inhibitions and determinants to pregnant healthcare consumptions contribution in terms of culture, income, occupation etc. Methodologically, sample size of 120 respondents was selected for interview through purposeful random sampling among the pregnant and nursing mothers between the age of 15 to 49 years in Ijebu- Yoruba south western Nigeria involving mixed urban (i.e. informal and informal sectors) and the rural societies. The methods of data collection were survey method and in-depth (IDI) interviews. Data revealed strong significant but inverse relationship between the socio-cultural factors and choice of health care also incongruous relationship between the pregnant woman and nursing mother‘s residence and healthcare consumption. The results amongst other things saw culture of patriarch , income ,occupation and where one reside acting as determinants for when commences care and the choice of healthcare centre. The ethnographic result also confirmed this much that men are the key to their wives choice of care during pregnancy this is because majority of them still pay the medical bill. It is therefore suggested that government, international agencies and concerned nongovernmental organization (NGOs) should intensify effort to open up rural and mixed urban settlements to Human Development Amenities (HDA) and bring about a strong intervention to bring about adequate maternal healthcare delivery.

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**CHAPTER ONE**

**INTRODUCTION**

**1.1 Background of the Study**

Antenatal care refers to the care that is given to a pregnant women woman from the time that conception is confirmed until the beginning of labour. This is also viewed as an important point of contact between health workers and women and an opportunity for provision of health education including how to detect pregnancy complications and development of a birth plan to ensure delivery at a health facility. The purpose of antenatal care is to monitor and improve the wellbeing of the mother and the foetus, for this reason the benefits of antenatal care cannot be over emphasized. Antenatal care is one of the important measures used in reducing maternal morbidity. Moreover, antenatal is a type of preventive healthcare, with the goal of providing regular checkups that allow doctors and midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefit mother and child.

The concept of antenatal care (ANC) as an effective public health strategy is credited to the dramatic improvements in maternal and prenatal outcomes witnessed in Europe in the last century, but the impact of antenatal care in these settings has not recorded the desired results. Whereas acceptance of antenatal care in industrialized countries is near universal, in developing countries, the uptake is less, and a large proportion of women deliver outside the health care system. About 63.6% of Nigerian mothers receive antenatal care, while trained personnel attend 41.6% of births. Consequently, high maternal mortality figures and rising perinatal mortality rates are the norm (Fawole, Okunlola &Adekunle, 2008). Nwaeze, Enabor, oluwasola and Aimakhu (2013) further reported that the proportion of Nigerian women that receive antenatal care and those that are delivered by skilled birth attendants have however remained far from acceptance.

The World Health Organization (WHO) reported in 2015 that around 830 women died every day from problems in pregnancy and childbirth. The WHO recommends that pregnant women should all receive 4 antenatal visits to spot and treat problems and give immunization. Although antenatal care is important for improving the health of the mother and the baby, Nigeria unfortunately is among the countries worst hit by maternal death challenges. According to the World Health organization (WHO, 2007) report, Nigeria is the 2nd in the world after India in terms of maternal and infant deaths. The international community has committed to improving maternal health by 2015 with millennium development goal number 5, which aims to reduce maternal mortality by three quarters and reach universal access to reproductive health care. According to WHO, a maternal mortality ratio in 2013 was estimated to be 230 per 100,000 live births in developing countries to 16 per 100,000 live births in developed countries. Even with this commitment, many countries have failed to implement effective programs to reduce maternal morbidity and women continue to suffer from the complications of pregnancy and childbirth.

Many countries have made targeted efforts to ensure the provision and utilization of timely and adequate ANC (Bbaale, 2011). The most common indicators of health and reproductive behavior include utilization rates of antenatal care, age when women give birth, pregnancy order and birth spacing. These factors can be modified if the services can be made accessible and affordable to women and their families.The role of timely and adequate antenatal care visits in ensuring maternal and neonatal health cannot be underestimated. Early antenatal care visits facilitates the follow up and monitoring of fetal growth and maternal health by physicians (Bbaale, 2011). During antenatal care visits, mothers can be informed about the warning signs and symptoms during pregnancy, preventive care and treatment strategies, proper nutrition, breastfeeding, use of contraceptive methods for family planning, prevention of mother to child transmission of HIV (PMTCT), use of SulfadoxinePyrimethamine (IPTp) (Bbaale, 2011). Overall the mentioned issues show the critical need for early initiation of antenatal care (ANC).

Women’s perception of antenatal visits significantly influence their assessment of quality services and are widely recognized as a tool to improve health services in many developed countries. Women’s perceived quality is defined as subjective and dynamic perception of the extent to which expected health care is received by the person. Since the perceived quality invariably affects mothers’ behaviour, a mother may choose not to return and may result in adverse outcome to the mother and child and also result in poor utilization of antenatal care services. Satisfied women are likely to come back for the services and recommend services to others (Wijesinghe and Fernado, 2014). Various factors including attitude of staff, cost of care time spent at the hospital and doctor’s communication have been found to influence patient satisfaction.

**1.2 Statement of Problem**

Annually, an estimated 529,000 women die from complications of pregnancy and childbirth globally. Ninety nine percent (99%) of these antenatal deaths occur in the developing countries and one percent (1%) in the developed countries. This means that every year, close to nine (9) million women suffer some type of injury from pregnancy or childbirth that can have profound effect on their lives and families. Since Nigeria is regarded as a developing country and one of the major sectors of the economy is health which looks to take care of the health status of the people, progress in improving antenatal care, disparities on access to antenatal care remain significant. Women that are with tertiary education are likely to have antenatal care and report four or more antenatal visit as women with secondary or no education. All these are indications that despite the high antenatal coverage, some registrants may not be deriving maximum benefit from the services. Based on these, the researcher intends to find the perception of pregnant women towards antenatal care services and their level of satisfaction.

**1.3 Objective of the Study**

The main objective of this study was to determine the pregnancy duration and choice of ante-natal and delivery care in Ijebu South while the specific objectives were to:

1. To determine the perception of pregnant women towards the quality of antenatal care services in Ijebu South
2. To examine providers’ processes of care in delivering antenatal services in Ijebu South.
3. To determine the level of client satisfaction with antenatal services provided in Ijebu South.

**1.4 Significance of the Study:**

The findings of this study when communicated will:

**To the pregnant women:** Alleviate the complications resulting from maternal and child mortality rate in Nigeria especially in Ogun State.

**To nurses and midwives:** Assist in planning and educating pregnant women attending antenatal clinic in NAUTH on the importance of antenatal care services in Nigeria

**To the researcher:** Acts also as a guide for further studies

**1.5 Research Questions**

1. What is the perception of pregnant women towards the quality of antenatal care services in Ijebu South?
2. What are the providers’ processes of care in delivering antenatal services in Ijebu South?
3. What is the level of client satisfaction with antenatal services provided in Ijebu South?

**1.6 Scope of the Study**

This study is to determine the perception and satisfaction of pregnant women towards the quality of antenatal care services in Ijebu South, Ogun state.

**1.7 Operational Definition of Terms**

**Antenatal:** before birth

**Pregnancy:** the condition from conception to the expulsion of the foetus

**Foetus:** the term used eight (8) weeks after conception until birth.

**Client:** pregnant women receiving advice and treatment in the hospital/ antenatal clinic

**Perception:** an overview of a pregnant woman’s thought, belief, idea and ability to understand the true meaning and impact antenatal care would make towards health, baby, family and entire populace at large.

**Quality Antenatal Care:** the ability of pregnant women to receive 4 or more antenatal care visits with all necessary care rendered during the visits.

**Satisfaction:** the extent to which specific needs of pregnant women on antenatal care are met.

**CHAPTER TWO**

**LITERATURE REVIEW**

This chapter of study deals with the review of relevant literature, studies and researches previously done that is related to this study. It will be carried out under the following headings:

1. Conceptual Review
2. Theoretical Framework
3. Empirical Review
4. Summary of the Review

**Conceptual Review**

**Antenatal Care**

Antenatal care according to Adesokan (2014) refers to the attention, education, supervision and treatment given to the pregnant mother from the time conception is confirmed until the beginning of labour in order to ensure safe pregnancy, labour and puerperium. It is also known as prenatal care which is a type of preventive health care with a goal of providing regular checkups that allow doctors or midwives to treat and prevent potential health problems throughout the course of pregnancy while promoting health lifestyles that benefit both mother and child.During checkups, pregnant women will receive medical information over maternal physiological changes in pregnancy, biological changes and antenatal nutrition including antenatal vitamins (Adesokan, 2014).

Recommendations on management and healthy lifestyle changes are also made during regular checkups. The availability of routine antenatal care has played a part in reducing maternal death rates and miscarriages as well as birth defects, low birth weight, neonatal infections and other persuadable health problems. The World Health Organization (WHO) reported that in 2015, around 830 women died everyday from problems in pregnancy and childbirth. Only 5 of the women who died lived in high income countries, the vast of the women lived in high income countries. The WHO recommends that pregnant women should all receive four antenatal visits to spot and treat problems and give immunizations. Although antenatal care is important for improving the health of the mother and baby, many women do not receive four visits.

There are many ways changing health systems to help people change their behavior can also play a part. Examples of these interventions are: media campaigns reaching many people, enabling communities to take control of their own health, informative education, communication interventions or financial incentives. A review looking at these interventions found that one intervention helps improve the number of women receiving antenatal care.However, interventions used together may reduce babies death in pregnancy and early life, lower numbers of low birth weight babies born and improve numbers of women receiving antenatal care.

**Aims of Antenatal Care**

The aims of antenatal care are maintenance of health of mother during pregnancy; promote physical, mental and social wellbeing of mother and child; ensure delivery of full term healthy baby; early detection of high risk cases and minimize risks by taking appropriate management; prevent development of complications through health education, adequate nutririon, exercise, vitamin intake and appropriate medical and pharmaceutical intervention; screening for conditions and diseases such as anaemia, STIs, HIV infection, mental health problems and domestic violence; teach the mother about child care, nutrition, sanitation and hygiene; decrease maternal and infant mortality and morbidity; remove the stress and worries of the mother regarding the delivery process; provide safe delivery for mother and educate mother about the physiology of pregnancy and labour. ( Ejike, 2015).

**Types of Antenatal Visits**

Fraser, Cooper and Nolite (2008), classified antenatal visits as the first (booking) and subsequent visits. The first visit is the day the woman visits the clinic that she is pregnant glistered. After the first visit to the clinic, the mother is instructed to make regular visits that is visiting the clinic at monthly intervals until 28th week fortnightly until 36th week and then weekly till term (or she delivers), but if complication arise more frequent visit may be necessary. Also, Hodnett and Osborn (2008) affirmed that a pregnant woman besides all the ways of taking care of herself, needs regular prenatal care from her midwife or doctor. The authors asserted that pregnant mothers should make atleast two visits in the second trimester and weekly visits in the last month of pregnancy.

**Antenatal Health Care Activities**

This include activities done during the first visit and those in the subsequent visits. First visits which is also known as booking visit according to Ejike (2015) is the first contact between a pregnant woman and a midwife in a particular pregnancy, during which pertinent information about the expectant mother are collected by the midwife. Ideally, according to the transitional Islamic Government of Afghanistan (2009), the first visit should occur in the first trimester, around or preferably before 12 weeks of pregnancy. Normally, this visit is expected to take 30-40 minutes.

Ejike (2015) looked into the following objectives as an important principle of booking:

* To assess levels of health by taking a detailed history and to employ screening test as appropriate.
* Ascertain base line recording of weight, height, blood pressure and hemoglobin. To assess normality and for subsequent comparism
* Identify risk factors by taking accurate details of past and present obstetric and medical history.
* Provide an opportunity for the woman and her family to express any concern that they might have about this pregnancy and previous obstetric experience.
* Give general advice on health matters especially those patterning pregnancy for the health of the mother and of the baby
* Start gradually to build a trusting relationship in which realistic plans of care are discussed.

All these objectives would be met through personnel questioning of pregnant mothers based on history taking; personal and social history **(**full name, father’s name, husband’s name, age, address, age of marriage); medical history **(**Ask about history of specific disease and conditions, including: tuberculosis, cardiovascular diseases, hypertension, chronic renal disease, epilepsy, diabetes mellitus, respiratory tract infections/HIV-AIDS, malaria, hepatitis and other liver diseases, any allergies, other chronic diseases, surgeries, blood transfusions, current use of medicines); obstetric history**(**number and type of previous pregnancies (miscarriage, tubal pregnancy, preterm delivery), previous deliveries and any complication or procedure related to the previous deliveries (caesarean section and its indication, if known; forceps or vacuum extraction, manual/instrumental help in vagina breech delivery; manual removal of placenta), date (month, year) and outcome of each event (live birth, still birth, abortion, ectopic, twins, hydatidiform mole, child with any abnormality, neonatal and infant death), birth weight if known, sex of children, specific maternal complications, events and interventions in previous pregnancies ( specify which pregnancies and specific symptoms and signs, such as haemorrhage, headache, fever, convulsion, and retention of placenta); present obstetric history (date of last menstrual period (LMP) (first day of bleeding in the last regular menstrual period), certainty of dates (by regularity, accuracy of recall, and other relevant information), bleeding or spotting since becoming aware of being pregnant; family history (this should be ascertained as some families have some genetic predisposition to certain disease such as psychiatric disorders, diabetes mellitus and essential hypertension. The tendency for these diseases to run in family is there twins run in family).

Also, according to Effendi (2008), screening procedures play an important part in ascertaining health status of the client. This is done to obtain baselinerecord of weight, height, blood pressure, urinalysis and haemoglobin level. These values are used for comparison as the pregnancy progresses. They include:

1. **Height:** The height of the woman is measured because a woman of small stature (less than 1.5m) and shoe size less than 5, may have small pelvis.
2. **Weight:** This is monitored at every visit to the clinic to give a baseline data for monitoring the weight of the woman. This is done because of the health conditions associated with overweight or being obese. For example: diabetes mellitus, pregnancy induced hypertension.
3. **Urinalysis:** This is also taken at every visit to rule out any abnormalities like sugar, protein and ketones, urinary tract infections and genital tract infections.
4. **Haemoglobin Estimation:** Haemoglobin estimation is important to detect anaemia, the cause and appropriate treatment to be commenced.
5. **Blood Pressure:** This is taken at every clinic to rule out elevated blood pressure which can result to pregnancy induced hypertension affecting placenta perfusion.

Furthermore, according to Fraser, Cooper and Nolte (2008), physical examination of a pregnant woman is done from head to toe on a couch in the examination room in order to rule out any abnormalities (infections, oedema and anaemia) and note any changes that might occur during the period of pregnancy. Several parts of the body like head, face, eye, ear, tongue, neck, breast, arms, genitalia, legs, and back are examined for several pregnancy symptoms. Additionally, Benneth and Brown (2008) stated that women do not always appreciate the importance of attending regular examination but the midwife will be able to explain the chief aim which is to establish and affirm the abdominal norms of the body whose aims are to observe signs of pregnancy, assess foetal size and growth and foetal heart rate, diagnose the location of the foetal parts, detect any deviation from normal. This examination is made up of three parts namely: Inspection, Palpation and Auscultation

1. **Inspection:** Observe the shape of the abdomen whether it is ovoid, board, pendulous, saucer shaped depression in case of occipito posterior position, foetal movement, striae gravidarum, linea nigra and any post operative scar.
2. **Palpation:** The midwife uses her hand during palpation to determine the gestational age but prior to palpation, the midwife should rub her hands together to warm it because cold hands could stimulate uterine contractions. This includes fundal height estimation to determine fundal height, lateral palpation to determine the lie and pelvic to determine which is presenting and engagement.
3. **Auscultation:** The foetal heart can be heard by means of pinnards (foetal) stethoscope through the abdominal wall. The range of the foetal heart rate should be between 110-160b/m and while listening to the foetal heart beat, you crosscheck with maternal pulse. The foetal heart beat should be faster than the maternal pulse.

For laboratory test investigation, Fraser, Cooper and Nolte (2008) explained that for every pregnant woman, blood examination should be carried out routinely at the initial and subsequent visits. Blood test is done to determine ABO blood group and rhesus factor, haemoglobin level, venereal disease research laboratory test (VDRL) to exclude syphilis, HIV, Rubella and other blood disorders. Women are very receptive to advice in the antenatal period and this is a wonderful opportunity for health education. Mostly the advice is given by the midwife in private discussion or to small groups at parent craft classes.

The teaching and talk should be planned to provide good knowledge on how to live in order to keep healthy and produce a live, healthy baby, confidence and a good relationship between the midwife and her clients and explanation of the demands of the coming baby on the family, and also care about it. In this talk, mothers are advised on personal and environmental hygiene, clothing, exercise, travelling, diet, smoking, coitus, breastfeeding.

Lastly, Skykes (2015) explained that antenatal visits are each four to six weeks until 28 weeks, then each two to three weeks and then weekly until your baby is born. If there are any pregnancy complications or special considerations, you may need some extra visits. These visits are usually straight forward check-ups. They are necessary to check your progress in pregnancy, your wellbeing, the wellbeing of your baby, to identify problems, to address any queries or concerns you may have, and to start planning your delivery. Recently with the invention of focused antenatal care, a woman is expected to make a minimum of 4 visits throughout pregnancy. These visits are as follows:

* **1stvisit :** Within the first 16th week or when she feels she is pregnant.
* **2nd visit:** 20-24 week or at least once in 2nd trimester
* **3rd visit:** 28-32 weeks
* **4th visit:** At 36 weeks or later than that

During these visits, the already explained examinations are carried out as required with regular care on blood pressure, urine testing, fetal heart rate and fundal height.

**Benefits /Importance of Antenatal Care**

The numerous benefits of antenatal care is embedded in the primary aims of antenatal care. The achievement of these aims brings about a great deal of benefit to any pregnant mother who has a clear perception of the concept of antenatal care. As reported by Ejike (2015), Antenatal care benefits include the following:

1. To prepare for birth and parenthood as well as prevent, detect, alleviate or manage the three types of health problems during pregnancy that affect mothers and babies which are; complication of pregnancy itself, pre-existing conditions that worsen during pregnancy and effects of unhealthy lifestyle
2. It also 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 breastfeeding, and assistance with deciding on future pregnancies in order to improve pregnancy outcomes.
3. Antenatal care improves the survival and health of babies directly by reducing stillbirths and neonatal deaths and indirectly by providing an entry point for health contacts with the woman at a key point in the continuum of care.
4. Antenatal care indirectly saves the lives of mothers and babies by promoting and establishing good health before childbirth and the early postnatal period. The time periods of highest risk.

**Perception of Pregnant Women towards Antenatal Care Services**

The perception of pregnant women towards antenatal care service influences its utilization. According to a study conducted by Lino and Chompikul (2011) in Thailand reported that perception of pregnant women regarding antenatal care was categorized into negative and positive and 60% of the women had positive perceptions. It also showed that increasing positive perceptions of pregnant women regarding antenatal may influence the percentage of pregnant women to make ANC visits and improve the state of maternal and child health. They also identified some factors that influence the perception of antenatal care. Married women were more likely to have positive perceptions because married pregnant women can receive more support from their husbands and those who had fair access to ANC information were more likely to have negative perception compared with those who had easy access.

Also study conducted by Edie, Obinchemti, Tumufor, Njie, Njamen and Achidi (2015), revealed that 99% of the respondents affirmed that ANC was important not only for the mothers but for the foetus as well. It also showed that women who had attended antenatal visits in their previous pregnancy thought that it was beneficial to start antenatal care early in pregnancy un like those who did not have this experience and who opted for third trimester enrolment. Again, primigravida, younger and single women were less likely to know how many antenatal visits they were expected to attend during the gestational period when compared to older and multiparous women.

**Factors Influencing Perception of Women towards Antenatal Care Services**

Lino, Sillabulra and chompikul (2011) observed that many factors that influenced the perception of pregnant women towards antenatal care were identified. These factors may be implicated in perception of women towards antenatal health services in Ijebu South. These includes, education level, marital status, knowledge regarding ANC, family support, accessibility to antenatal information, and pregnancy intention

 **Education Level**

Level of education influences pregnant women positively or negatively. Positive perception is associated with women who are highly educated. This may be because those with high education levels understand antenatal care better than those with low education level.

 **Marital Status**

There is a significant association between marital status and the perception of pregnant women. Married women have positive perceptions towards antenatal care. This may be because married pregnant women receives moiré support from their husbands.

 **Family Support**

Family support has a significant association with perception of pregnant women regarding ANC. Many pregnant women receive supports from their husband in terms of advising for regular check-ups, and sharing information of antenatal care.

 **Pregnancy Intention**

 Women who planned to have their pregnancy have positive perception. This is because those who intend to get pregnant make greater efforts to have good health and healthy infants. They are willing to have ANC and make them have good knowledge and positive perception.

**Quality of Antenatal Care Services as related to Satisfaction**

Users’ satisfaction is considered clients judgment on the quality and goodness of care. Client satisfaction is thus indispensible to quality improvement with regard to design and management of health care systems (Srivastava *et al*., 2015). The ratings of women satisfaction indicate generally ratings across developing countries. In 24 studies, more than 75 percent of the women reported care to be satisfactory. In10 studies the proportion ranged between 50-70 percent, while in only three studies, it was less than 50 percent. Nine studies discussed rating interns of mean scores, eight studies did not report any specific numerical value of satisfaction as they were qualitative in nature (Srivastava *et al*., 2015). A large spectrum of determinants influencing women’s satisfaction were summarized according to the Donabedian framework of structure, process and outcome, besides access, socio-economic determinant and other determinants. This includes structure (physical environment, availability of medicines, supplies and services, interpersonal behaviour, privacy and confidentiality),cost, and outcome (delivery outcome)

**Structure**

**Physical Environment**

Good physical environment and efficient management were significant in women’s positive assessment of health facility and maternal care services. These included good building infrastructures with water supply, electricity, beds, cleanliness. Adequate room space, seating arrangement and waiting areas as found in Nigeria. Women who rated the availability of services at the facility (a composite of waiting area, drinking water, clean toilet) as “good” were significantly most satisfied with care than those who rated services as “poor”.

**Availability of Medicine, Supplies and Services**

Availability of prescription drugs, essential equipment like blood pressure monitors or thermometers, lab services were reported as significant predictors of satisfaction with care in studies in Nigeria. Occasional non-availability of essential medicine emerged as a cause for dissatisfaction with service.

**Interpersonal Behaviour**

Being treated with dignity, respect and courtesy was a key determinant of women satisfaction. Therapeutic communication (Listening, politeness, prompt pain relief, kindness, approachability and smiling demeanor), caring behavior ( attentive to needs, making client feel accepted and coaxing clients) and interpersonal skill of staff (staff confidence and competence) were significant themes that were identified as influencing clients satisfaction of care. The use of praising words by midwife during delivery encouraged women and boosted their self esteem. Infact, women chose to repeat the same provider for their next delivery. On the other hand, staff unfriendliness, negative attitude and impatience are the major causes for dissatisfaction with service and avoidance of use in Nigeria.

**Privacy and Confidentiality**

This is a key requirement of women utilizing antenatal care services for physical examinations as well as the delivery itself. A sense of shame is also attached to the process of physical examination and also procedures like perineal shaving, thereby increasing women’s discomfort and diminishing their satisfaction level. Inadequate privacy during antenatal check-up and counseling was associated with women’s poor perception of services. Maintenance of privacy via a separate room or screen for examination or delivery was a significant determinant of satisfaction with antenatal care services. Lack of confidentiality during check-ups and deliveries on the other hand caused dissatisfaction with services.

**Cost**

Significant association between cost and women satisfaction and the utilization of care in both home and institutional births were found in studies in Nigeria. Affordable care was a significant determinant of satisfaction with antenatal care services in both facility and home deliveries. Besides, overall cost of care, affordable drugs, availability of finance for health care and transparency in financial transactions also influenced satisfaction with care. Availability of free medicine in the facility enhance women satisfaction with antenatal care.

**Delivery Outcome**

Maternal and newborn outcomes in terms of survival and health of mothers and newborns (for example, mother alive in spite of fetal loss, baby alive and healthy) affected satisfaction with antenatal care.

**Process of Care in Antenatal Service Provision**

Process of care denotes what is actually done in giving and receiving care in antenatal setting and it is usually compared against a set standard, usually a national guideline. However, the World Health Organization recently advocated that only examinations and tests serving an immediate purpose and proven to be beneficial should be performed during antenatal visits. These examinations should include, at a minimum, measurement of blood pressure, testing of urine for bacteriuria and proteinuria, and blood tests to detect syphilis and severe anaemia.

According to a study carried out in Mexico, the quality of antenatal care is measured by a series of questions about antenatal services received that correspond with national clinical guidelines and they include 12 activities that are routinely conducted during history-taking and diagnostics (blood and urine samples, and history of bleeding and discharge), the physical examination (blood pressure and weight, and measurement of uterine height), and other preventive procedures (tetanus toxoid immunization and iron supplements, advice about family planning and breastfeeding, and use of the health card).

In a study done in China, the quality of ANC was assessed using 16 different ANC procedures, the type of ANC providers etc. It found that eighty-one percent of women were weighed and 91% had blood pressure taken, which is close to the country’s norms of universal coverage. The proportions of women who underwent haemoglobin, urine, syphilis, HBV, and HIV/AIDS test during pregnancy, received folic acid supplement, and were advised on nutrition during pregnancy were 79%, 77%, 48%, 59%, 47%, 50%, and 59%, respectively. However a small proportion of women were given iron supplement (22%) and advice on syphilis (13%), HBV (21%), HIV/AIDS (14%), and delaying the next pregnancy (28%), urine sample taken including bacteriologic examinations and tests for blood, protein, glucose, ketones, etc; syphilis, HBV test, and HIV/AIDS test) and preventive care procedures (iron supplements, folic acid supplements, advice on nutrition during pregnancy, advice on syphilis, HBV, and HIV/AIDS, advice on delaying the next pregnancy, and breastfeeding counselling).

Similarly in Zambian national study on quality of antenatal services, ANC interventions include weight measurement, height measurement, blood pressure measurement, urine sample taken for analysis, blood sample taken for analysis, offered VCT, iron supplementation provided, antimalarial drug provided for IPT, birth preparedness plan discussed, treatment provided for intestinal parasites and tetanus toxoid vaccination.6 The study shows that folate/ iron supplementation, tetanus vaccination and IPT of malaria were provided by the vast majority of ANC facilities but detection and prevention of mother-to-child transmission of HIV were done by only a third of ANC facilities. It also revealed that only 16% of ANC facilities provided blood test for haemoglobin and half provided screening for syphilis, urine testing for protein was done by less than a quarter of ANC facilities but majority of facilities provided family planning, delivery and postnatal care all of which ensures continuity of care.6 Consequently over 80% of women received iron supplementation, IPT for malaria, blood pressure and weight measurement and tetanus vaccination while VCT for HIV was received by half, drugs for intestinal parasites by about a third, and only about a quarter of women reported that their urine had been tested at ANC. Approximately half of the mothers received eight or more ANC interventions, 40% received five to seven interventions and 12% received less than five interventions.

Giovanni et al also posited that a functioning referral system between health facilities needs to be part of the services provided to the pregnant woman. This will permit the transfer of the woman to the appropriate level of assistance with proper and timely management of the emergency obstetric situation, ideally at the lowest stage of severity.

A study in Tanzania revealed that out of the total 754 ANC visits made by 263 women in the study, blood pressure, haemoglobin and albumin in urine were assessed in only 69%, 25% and 22% respectively and 63 (52%) were found to have at least one risk factor. Advice on delivery was provided to only 40 (33%) women attending ANC on the day of study and the most frequent delivery advice (93%) given to women with risk factors was hospital delivery, when to go and use of maternity waiting home. On the other hand, 25 (40%) women with risk factors reported that they did not receive any advice on the delivery plan.

Nikiema L et al65 working on quality of ANC in Burkina Faso carried out a nonparticipating observation of five consecutive antenatal consultations and assessed the quality of services based on their national standards for all the operations, attitudes, and questions put to the pregnant woman during ANC. These include five dimensions of Components of reception, types of information collected, components of clinical examination, components of gynaecological examination and components of decision-making. The observation revealed failures at all the stages but especially at the level of gynaecological examination, decision making, and clinical examination with 73% of the 81 observations having a below average score. Overall reception was noted to be acceptable and some questions asked in the waiting room were incomplete by lacking some information on the way of life (61%), personal background (59%), vaccination status (43%), and the record of current pregnancy (37%). Weight, height, and blood pressure measurements were done in groups in the waiting-room while physical examination was performed individually in a room used as an office equipped with an examination table with poor lighting daylight was the only source in 78% of the cases. Antenatal examination was carried out by a birth assistant or matron in 44%, a senior nurse in 25%, a junior health worker in 19%, and a nurse in 12% of the cases and hands were washed with soap before and after each examination in a very few cases where water was available. Other things observed are that a very few women were informed of the results and the course of their pregnancy and the location of childbirth, signs of alert were not properly discussed. Most risk factors were not considered in an active way, and women at risk did not benefit from any particular care. Urine test for protein and sugar was carried out in only 9% of the cases. Anti-tetanus vaccination was suggested and all the women benefited from a prescription for chloroquine for malaria and iron, folic acid for anaemia. However, the dose was specified in all the cases but the importance of these regulations to the women was less emphasized. Generally, women were not correctly involved in the process; they received very little individual advice on pregnancy hygiene, food hygiene (30%), and planning of childbirth during ANC meetings and the majority of the health centres held group-discussion session on a reproductive health topic with visual aids on ANC clinic days.

Studying Women’s perception of antenatal care services in public and private clinics in the Gambia, over 50% of the women in both settings felt that they had been given inadequate information on pregnancy issues with roughly 80% of the women reported that they had not been told how to recognize or manage certain danger signs during pregnancy. Overall, among women who attended either a public or a private facility, 87% worried about the position of their babies, the size of the baby, having a premature baby, having an abnormal baby or their own health and weight but very few women had received information related to these worries. Less than half of the total sample had received such information and felt reassured. Significantly more women attending private clinics felt reassured compared with their public-facility counterparts.

A research on clients’ perception of ANC in Ibadan found out that counselling for HIV was the predominant health education subject but more than half (53.9%) of respondents did not receive information about cervical cancer. About 10% of patients did not receive information about danger signs during pregnancy, breast self-examination, family planning and prevention of sexually transmitted infections. However, clinic amenities and constellation of services were rated highly.

Another research comparing practice of focused antenatal care in PHC rural and urban areas of Ekiti State considered the following service areas: blood pressure check, abdominal examination, fetal heart beat check, urine test for protein, hemoglobin test , HIV test, Syphilis test as well as whether they had ever received iron drugs, Tetanus toxoid (TT) vaccines, Intermittent Preventive Treatment in pregnancy (IPTp), Long Lasting Insecticide Nets (LLIN), multivitamins and whether the women were directly observed (DOT) when taking the IPTp (sp) while health education topics include diet and nutrition, knowledge about expected date of delivery and fetal growth, birth-preparedness, complication readiness, danger signs in pregnancy and post-partum, HIV screening and prevention of HIV and STIs. The result obtained showed that a lower proportion 41 (20.7%) of respondents in the rural areas had the minimum contents of focused antenatal care compared to urban areas where 58 (29.3%) of the respondents did the same. Also majority 355 (89.6%) of the respondents were taught a wide range of health education topics but the proportion of respondents taught these topics were slightly lower in the rural areas 177 (88.5%) compared to urban areas 178 (90.8%).

Osungbade et al in their work found out that blood pressure measurement, abdominal palpation and detection of foetal heart rate were provided to all participants studied in their work.74 In the same study also, three hundred and eighty-six (99%) were reached with at least one educational message, one hundred and sixty-seven (42.8%) had haemoglobin or packed cell volume estimated, whereas 168 (43.1%) had urine checked for protein, at least once during antenatal visits. Routine iron and folate supplements, and malaria prophylaxis were, respectively, given to 142 (36.4%) and 25 (6.4%).74 The number of pregnant women were reached with information on family planning/child spacing 274 (96.5), child care 263 (92.6), HIV/AIDS and other sexually transmitted diseases 262 (92.3), benefit of delivery in a health facility 263 (92.6) and what to do if there is a problem during pregnancy 250 (88.0) in hospitals than comprehensive health centres and haemoglobin estimation or checking for packed cell volume and urine analysis for protein were the only laboratory investigations carried out among the pregnant women with that less than half of the participants, 167 (42.8%), had either haemoglobin or packed cell volume estimated.

**Client Satisfaction with Antenatal Care**

Client satisfaction is an indirect way of measuring outcome attribute of quality or clients perceived quality of care. Satisfaction of clients attending ANC can be on different aspect of care and can also be measured generally by asking these three basic questions; are you satisfied, will you recommend this for a friend and will you come back if you become pregnant again. Various studies used women’s satisfaction with service delivery as an outcome indicator as it is influenced by women’s expectations and their previous experiences. This was deemed appropriate because subtle changes in the quality of care can be detected in women satisfaction long before the physical changes in health status can be seen and it was assumed that a satisfied woman user would probably benefit more from the care offered to her than an unsatisfied woman. It was observed that the little amount of focus on quality of care in many resource-limited settings has been from the healthcare providers point of view with his professional standards being used as index of quality but studies have shown that perception of quality by pregnant women and their care givers may differ with providers more interested in technical precision while women may be more concerned with other sensitive issues such as interpersonal relations with care providers, fulfilment of their information needs, birth positions and social supports during labour.

A study done to compare traditional ANC with new ANC model showed that women in both trial arms were equally satisfied with the information provided by the caregiver about their health, tests during pregnancy and treatment they might need but women in the new ANC model were substantially more satisfied with the information received about normal labour and delivery processes, breastfeeding, family planning, and danger signs. In the study above, overall satisfaction by the women was measured by three affirmative answers to the questions "If you were pregnant again, would you come back to this clinic?", "Would you recommend this clinic to a relative or friend for their antenatal checkups?" and "In general, are you satisfied/very satisfied with the ANC you have received in this clinic so far? and women in both arms of the study showed very high levels of satisfaction with no statistically significant differences between groups and the overall satisfaction index showed that more than 90% of women in both ANC models said that they were "very satisfied".A Tanzanian study reported that 93 (77%) of the women were satisfied with the ANC services they received in these facilities and this include women who had a risk factor but never received any delivery advice64 but it went ahead to state that the fact that satisfaction to ANC services is subjective, the results posed a potential limitation as satisfaction can be influenced by a number of factors including knowledge on the required types of services and attitude of the individual clients. Based on these factors, clients might have expressed different levels of satisfaction even if they received similar services.

A study done in Ethiopia got an overall level of satisfaction with delivery care was 82.9% and satisfaction level was re-coded as follows ’very satisfied’ and ‘satisfied’ were classified as satisfied and responses ‘very dissatisfied’, ‘dissatisfied’ and ‘neutral’ as unsatisfied. Neutral responses were classified as dissatisfied considering that they might represent a fearful way of expressing dissatisfaction represent a fearful way of expressing dissatisfaction. This is likely because the interview is undertaken within the health facilities and mothers might be reluctant to express their dissatisfaction feeling of the services they received.

In University College hospital, Ibadan, client satisfaction to antenatal services was also done and most respondents were found to be satisfied with the services given at the clinic; 81.1% rated the services as good while 18.9% were not satisfied and stated that service was poor. Most women (83.3%) revealed that they would register in the same health facility in subsequent pregnancies and would recommend the clinic to someone else. Similarly a study carried out at PHC in the southwest of Nigeria shows that women attending antenatal clinics at these centres were satisfied with the quality of services received in spite of some inconsistencies between the received care and their expectations of the facilities.

In another study, the mean time spent during clinic visits was 3.9 +/- 1.4 hours with the waiting time rated as appropriate by most women (67.1%). However women with high education and in upper socioeconomic class tended to rate the waiting time as too long. Overall most women (96.5%) were satisfied with the care received, would use the same facility in future pregnancies and would recommend it to friends.

**Theoretical Framework**

The study is backed up by health belief model which proposes that a person’s health related behavior depends on the person’s perception of four critical areas: the severity of a potential condition, the person’s susceptibility to that condition, the benefit of taking preventive action, the barriers that prevents taking such actions.The health belief model is a psychological model proposed by social psychologists; Hochbaum, Rosenstock and Kegels in 1958 for studying and promoting the uptake of health services like screening. The model explains preventive behavior (Ilozumba, 2011; Ndikom and Ofi, 2012). As reported by Croyle (2005), the health belief model addresses the relationship between a person’s beliefs and behavior and predicts how clients will behave in relation to their health and how they will comply with health care therapies.

The six major concepts and definition of the Health Promotion Model or Health Belief Model includes perceived susceptibility, perceived severity, perceived benefits, perceived costs, motivation, enabling or modifying factors

**Perceived Susceptibility**

Refers to how a person views a health problem and considers a diagnosis of illness to be relevant and accurate.

**Perceived Severity**

Even when one recognizes personal susceptibility action, it may not occur unless the individual perceives the severity to be high enough to have serious organic and social complications.

**Perceived Benefits**

Refers to the patient’s belief that a given treatment will cure the illness or help to prevent it

**Perceived Cost**

Refers to the complexity, duration and accessibility of the treatment.

**Motivation**

Includes the desires to comply with a treatment and the belief that a person should do what they should do.

**Modifying Factor**

Includes personality variable, patient satisfaction and socio-demographic factors. The health belief model explains the need for individuals to be in a position to have the benefit of the available health care available at the institution and accessible to the patient. Although the model is being criticized as not being rational, it focuses on the individual and ignores the socioeconomic factors like finance and that the model is predicting outcome of a disease condition when it should focus on preventive health.

**Application of Health Belief Model**

**Perceived Susceptibility**

Based on this model, pregnant women are more likely to attend regular antenatal care when they have the belief that attending regular antenatal care provides support and encouragement to them while pregnant and also improve their delivery outcome.

**Perceived Benefit**

In order for a new behavior to be adopted, the women need to believe that benefits of the new behavior outweigh the consequences of not adopting the new behavior. Therefore, women will attend antenatal care regularly when they know that the benefit outweighs the consequences of multiple antenatal booking.

**Perceived Cost:**

In this context, long waiting time and location of antenatal care by pregnant women results to poor antenatal attendance. Therefore, women attend antenatal care if their life and that of their baby is in danger.

**Motivating Factor:**

Women who have experienced good quality antenatal care in the past pregnancies are likely to come back for the service and recommend the services to other women. These women will have heightened perception of antenatal services because of their past experience.

**Empirical Review**

A study conducted by Sholeye, Abosede and Jeminusi (2013) on client perception of antenatal care services at primary health centres in an urban area of Lagos, Nigeria. About 300 pregnant women were selected through systematic random sampling from three PHCs offering full maternal services in Mushin. Data was collected with the aid of interviewer administered semi structural questionnaires. Data analysis was done using 14.00.

The mean age of respondent was 30.68 ± 6.74. Most respondents (42.5%) were aged between 20 and 29 years. About 92.0% of respondents perceived the environmental conditions of service delivery as good, 52.2% felt the record retrieval system was good while 1.7% felt it was poor. The health education sessions were perceived as being good by 66.6% of respondents while 33.0% felt the service was poor.

Nwaeze, Enabor, Oluwasola and Aimakhu (2013) carried out a study on the perception and satisfaction of antenatal care service among pregnant women at the University College Hospital Ibadan, Nigeria. A cross-sectioned design using a structured questionnaire was used. The study subjects were 239 pregnant women presenting for antenatal care at the study centre. The result showed that 74% of the women were aged 25-34 years; majority of the respondents (86%) had tertiary education while 49.4% were skilled workers. In 57.7% of women, the gestational age was between 13 and 27 weeks while 66.1% were para 1-4. The commonest investigation done at the clinic was packed cell volume (PCV) estimation (99.2%). Human immunodeficiency virus (HIV) screening was done in 77% of the respondents.

Sitting arrangement was regarded satisfactory in 97.9% of women. Toilets, bathroom facilities and water supply were regarded as unsatisfactory in 60.7% and 61.9% respectively. Two hundred and nineteen (91.6%) of respondents reported that the diet and nutrition related topics were more discussed during the interactive sections than other topics. The perception of attitude of health care providers; one hundred and thirty seven respondents (85.6%) rated attitude of nurses as good and were satisfied with antenatal service. The mean time spent during each clinic visit was 3.8 ± 1.5 hours range (1-7hours). About 97.9% of respondents who spent within 3 hours at the clinic expressed satisfaction while 35.1% of respondents who thought they spent too long at the clinic were dissatisfied.

In addition, Lamadah and Elsaba (2012) carried out a study on women’s satisfaction with quality of antenatal care. It was conducted in primary health centre in Al-Madinah Al-Menawarh, KSA. Research design used for the study was a descriptive design. A simple random selection of six primary health centres which affiliated to the ministry of health was done. The study subjects were 150 pregnant women attending the previously mentioned health care centres. An interviewing assessment sheet was designed by the researcher to collect the data.

The result showed that more than two third of the clients (68.0%) and slightly less than two thirds of them (62.0%) respectively were satisfied with provider- client interaction and quality of antenatal care services. In addition, it can be observed that the older, low educated housewives women and those who had smaller number of children were more satisfied with health care providers interaction and the quality of antenatal care services provided to them.

Lino, Sillabutra and Chompikul (2011) investigated factors related to the perception of pregnant women regarding antenatal care Nakonpathom province, Thailand .data were collected from 227 pregnant women using self-administered questionnaires in January 2010. Descriptive statistics, chi-square test and multiple logistic regression were used for analysis. The researchers reported that sixty percent of the pregnant women had positive perceptions regarding ANC and the number of antenatal care visit was known by 70% of the pregnant women. By bivariate analysis, factors significantly associated with perception of ANC were family support, accessibility to antenatal information, education level, marital status, Knowledge regarding ANC and pregnancy intention. By multiple logistic regression analysis, factors were: Knowledge of pregnant women about ANC and accessibility to information, Knowledge and fair accessibility of information were significantly associated with negative perception of antenatal care.

Onasoga, Afolayan and Oladimeji (2012) studied factors influencing utilization of antenatal care services among pregnant women in Ife Central L.G.A, Osun State Nigeria. Stratified sampling technique was used to select 102 pregnant women from Ife central Local Government Area of Osun state. Data were collected using a questionnaire. Both descriptive and inferential statistics were used to analyze the data generated and level of significance was set at 5% (0.05). The finding revealed that majority of the respondents 48 (47.1%) first heard of ANC in the hospital. Most of the respondents 85 (83.3%) knew the services rendered at antenatal clinic and had adequate knowledge on the importance of antenatal care. The finding also revealed that majority of the respondents 58 (56.9%) attend ANC regularly, 56 (57.1%) booked for antenatal care in the first trimester and attend on appointment days after booking. The study also showed that majority of the respondents opined that affordability of antenatal services, schedule of antenatal care, lack of knowledge about the existing services in ANC and husbands’ acceptance of the services rendered as the major factors influencing its utilization.

**Summary of Literature Review**

Antenatal Care (ANC) means “care before” and includes education, counseling, screening, treatment, monitoring and promoting the wellbeing of the mother and fetus. It was discussed with a conceptual review which consisted of definition, activities, benefits, perceptions, factors and satisfaction of antenatal care. The literature review provides a comprehensive understanding of antenatal care and how the women perceive it in the theoretical review. Antenatal care was explained with reviews of reports and works made by different authors and also the result of their study in empirical review.

**CHAPTER THREE**

**RESEARCH METHODOLOGY**

This section of the study shows a thoughtful and systemic estimation of the specific method with which necessary data relating to the research problem is collected and analyzed. It provides the procedural framework for the conduct of the study and helps to describe the scope of the research as well as the purpose and boundary of the study. It is discussed under the following:

1. Research Design
2. Area of Study
3. Target Population
4. Sample and Sampling Technique
5. Instrument for Data Collection
6. Validity of Instrument
7. Reliability of Instrument Data
8. Method of Data Collection and Analysis
9. Ethical Consideration

**Research Design**

Research design is a plan of action regarding events, which upon implementation enables the researcher adopt the survey design in carrying out the study. Ejifugha (2008) states that a survey is an attempt to gather information or data from members of a population with regard to one or more variables. The research design adopted for this study is the descriptive survey method. It deals with the factual description of perception and satisfaction with quality of antenatal care among pregnant women in NAUTH, Ijebu South.

**Area of Study**

This study will be conducted in Ijebu South

**Target Population**

The population of this study will consist of all the women that attend antenatal clinic in Ijebu South. The target population for this study is 300 women which represented the total number of women that attended antenatal clinic from January –June 2018

**Sample and Sampling Technique**

This means a portion of the population used for the study. According to Nwana (2012), if population is a few hundred, a 40% sample size is used. There by calculation;

$$\frac{40}{100} ×300=120$$

Simple random sampling was used to select 120 women(respondents) on five clinic days.

**Instrument for Data Collection**

According to Polit, Book and Hungler (2012), the instrument for data collection is a formal document used to gather information in research. The data was collected by the use of questionnaire which was structured in a way that the researcher can easily and quickly elicit the information needed to address the research questions as well as achieve the primary purpose of the study. The questions were close ended items made into section A and section B as they relate to the research objectives.

**Validity of Instrument**

Validity of instrument according to Chinweuba, Iheanacho and Agbapuonwu (2014) is defined as the ability of an instrument to measure what it is supposed to measure. The questionnaire drafted by the researcher was submitted to the supervisor who went through it carefully and made corrections to ensure content validity after which it was confirmed valid and capable of collecting the desired information for the study.

**Reliability of Instrument Data**

Reliability according to Chinweuba, *et al* (2014) is consistency of an instrument in collecting the same data, that means appropriateness fro use over time. The instrument was used on 20 mothers attending antenatal care clinic in Life hospital Ijebu South who were not part of the study for pilot study. Test- retest method was used in which the second test was conducted after a week interval from the first test. Responses from the questionnaire was analyzed using peerson product moment correlation. Co- efficient and a reliability of 0.8 were obtained indicating that the instrument was reliable.

**Method of Data Collection and Analysis**

 This is the technique the researcher employed in collection of data. An introductory letter written by the researcher was attached to the questionnaire which stated the purpose of the research and assured confidentiality of information provided. The researcher obtained permission from the Chief Nursing Officer in charge to use the antenatal mothers. She presented a letter of introduction endorsed by the Head of Nursing Science and technology, Okofia Ijebu South with the researcher’s letter of request for data collection. With the help of nurses on duty, the researcher issued 120 questionnaires to available respondents within a week. Before the distribution, the researcher introduced herself and aim of the study of the research to the respondents. The completed questionnaires were then collected with return rate of 100 percent. Data obtained from the questionnaire were presented in frequency table and percentage. The research question three was then converted to a four-point response scale where HS, S, FS and NS were assigned a number ranging from 4(HS) to 1(NS)

 $\frac{40}{100} ×100=120$

With 2.5 as the computed mean, this ensure that any factor or variable with the mean of 2.5 or above was regarded as positive while others with mean below 2.5 regarded as negative.

**CHAPTER FOUR**

**DATA ANALYSIS**

This chapter discussed the finding and results as shown from the data analysis. This data was analyzed in accordance with the research questions using frequency distribution tables presented in percentages. One hundred and twenty questionnaires were distributed and same collected.

**Section A: Demographic data**

**Table 1: Showing demographic data of respondents**

|  |  |  |  |
| --- | --- | --- | --- |
| **S/N** | **Response item** | **Frequency** | **Percentage (%)** |
| **1** | **Age range in years** |  |  |
| A | 20-24 | 12 | 10 |
| B | 25-29 | 60 | 50 |
| C | 30-34 | 36 | 30 |
| D | Above 35 | 12 | 10 |
|  | **Total** | **120** | **100** |
| **2** | **Marital status** |  |  |
| A | Single | - | - |
| B | Married | 120 | 100 |
| C | Divorced | - | - |
|  | **Total** | **120** | **100** |
| **3** | **Educational background** |  |  |
| A | Primary | - | - |
| B | Secondary | 4 | 3.3 |
| C | Tertiary | 116 | 96.7 |
| D | Others specify | - | - |
|  | **Total** | **120** | **100** |

|  |  |  |  |
| --- | --- | --- | --- |
| **4** | **How many pregnancy have you had?** |  |  |
| A | First | 48 | 40 |
| B | 2nd  | 32 | 26.7 |
| C | 3rd  | 28 | 23.3 |
| D | 4th  | 12 | 10 |
|  | **Total** | **120** | **100** |
| **5** | **Religion** |  |  |
| A | Christian | 120 | 100 |
| B | Islamic | - | - |
| C | Pagan | - | - |
|  | **Total** | **120** | **100** |

**Age range:** the table above showed that 12 (10%) of the respondents fall within the range of 20-24 years, 60 (50%) fall within the range of 25 – 29 years, 36 (30%) fall within the range of 30 – 34 years and 12(10%) were above 35 years.

**Marital status:** 120 (100%) of the respondents were married.

**Educational background:** 4 (3.3%) of the respondents went to secondary and 116 (96.7%) of them went to tertiary institution.

**Number of pregnancy:** 48 (45%) of the respondents has their first pregnancy, 32 (36.7%) of them has their second pregnancy, 28 (23.3%) of them has their third pregnancy and 12 (10%) of them has their fourth pregnancy.

**Religion:** 120 (100%) of the respondents were Christians.

**Section B: Research Question 1**

**What is the perception of pregnant women towards the quality of antenatal care services?**

Item 6 to 10 from the questionnaire provided answer to research question 1

**Table 2: Showing respondents response on the number of antenatal care visit before delivery.**

|  |  |  |  |
| --- | --- | --- | --- |
| **S/N** | **Responses** | **Frequency** | **Percentage** |
| A | 4 times | 32 | 26.7% |
| B | 5 times | 20 | 16.7% |
| C | More than 6 times | 68 | 56.7% |
|  | **Total** | **120** | **100%** |

Table 2 above showed that 32 (26.7%) of the respondents wish to attend antenatal care visit 4 times, 20 (16.7%) wish to attend 5 times while 68 (56.7%) wish to attend more than 6 times.

**Item 7: Do you attend antenatal visit late?**

**Table 3: Showing if the respondents attend antenatal visit late**

|  |  |  |  |
| --- | --- | --- | --- |
| **S/N** | **Respondents** | **Frequency** | **Percentage** |
| A | Yes | 40 | 33.3% |
| B | No | 80 | 66.7% |
|  | **Total** | **120** | **100%** |

Table 3 above showed that 40 (33.3%) of the respondents attend antenatal care visit late while 80 (66.7%) of the respondents does not.

**Item 8: If yes, why**

**Table 4: Showing respondents reason for attending late.**

|  |  |  |  |
| --- | --- | --- | --- |
| **S/N** | **Response** | **Frequency** | **percentage** |
| a. | Lack of benefit of antenatal care | 4 | 10% |
| b. | Limited facility access | 20 | 50% |
| c. | Uncertainty about pregnancy | 4 | 10% |
| d. | Laziness to go for many visits | 12 | 30% |
|  | **Total** | **40** | **100%** |

The table 4 above showed that 4 (3.3%) of the respondents attend late due to lack of benefits of antenatal care, 20 (16.7%) due to limited facility access, 4 (3.3%) due to uncertainty about pregnancy while 12 (10%) said because of laziness to go for many visits.

**Item 9: if no, why.**

**Table 5: Showing why respondents do not attend late.**

|  |  |  |  |
| --- | --- | --- | --- |
| **S/N** | **Respondents** | **Frequency** | **Percentage** |
| a. | To acquire knowledge from health topics discussed | 24 | 30% |
| b. | To go home early | 32 | 40% |
| c. | To have enough time to do all investigations | 8 | 10% |
| d. | To be the first person to be seen by the doctor | 16 | 20% |
|  | **Total** | **80** | **100%** |

From table 5 above, 24 (20%) of the respondents do not attend antenatal care late because they want to acquire knowledge from the health topics discussed, 32 (26.7%) wants to go home early, 8(6.6%) wants to have enough time to do all investigations while 16 (13.3%) wants to be the first to see the doctor.

**Item 10: How would you rate the antenatal care services given in the antenatal care clinic?**

**Table 6: showing how the respondents rates the antenatal care services given.**

|  |  |  |  |
| --- | --- | --- | --- |
| **S/N** | **Responses** | **Frequency** | **Percentage** |
| a. | Adequate | 40 | 26.6% |
| b. | Very adequate | 60 | 50% |
| c. | Not adequate | 10 | 11.7% |
| d. | No idea | 10 | 11.7% |
|  | **Total** | **120** | **100%** |

***Figure 1 showing how the respondents rates the antenatal care services given***

From the figure 1 and table 6 above, 32 (26.7%) of the respondents rated antenatal care services given in the clinic as adequate, 60 (50%) rated the service as very adequate, 4 (3.3%) rated it not adequate while 4 (3.3%) has no idea about the services given.

**SECTION C: Research Question 2**

**What are the providers’ processes of care in delivering antenatal services in Ijebu South?**

## Table 7: Frequency of activities performed during ANC consultation

|  |  |  |
| --- | --- | --- |
| **ACTIVITY**  | **MAXIMUM** **SCORE PER** **OBSERVATION**  | **TOTAL**  |
| Seat offered  | 2  | 24  |
| Interest shown  | 2  | 29  |
| Non interruption of woman’s speech  | 2  | 27  |
| Politeness  | 2  | 28  |
| Asking about woman’s concern  | 2  | 29  |
| Door closed during consultation  | 2  | 15  |
| Explanation before examination  | 2  | 16  |
| Explanation of diagnosis  | 2  | 19  |
| Explanation of use of prophylactic drugs  | 2  | 21  |
| Any History  | 2  | 28  |
| History of malaria  | 2  | 17  |
| History of UTI  | 2  | 18  |
| Blood Pressure  | 2  | 28  |
| Measurement  |  |  |
| Checking of haemoglobin  | 2  | 28  |
| Checking urine for protein  | 2  | 28  |
| Prophylactic drugs  | 2  | 28  |
| Checking eyes for pallor  | 2  | 22  |
| Checking legs for oedema  | 2  | 22  |
| Checking weight  | 2  | 27  |
| Checking fetal heart  | 2  | 29  |
| General Health Education  | 2  | 23  |
| Nutrition education  | 2  | 20  |
| Malaria Prevention Health Education  | 2  | 21  |
| **TOTAL**  | 230(5 observations per facility)  |   |

## Table 8: Frequency and scoring of activities performed during ANC consultation

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ACTIVITY**  | **MAXIMUM SCORE PER OBSERVATION**  | **MAXIMUM** **OBTAINABLE** **SCORE**  | **TOTAL** **SCORES**  | **%**  |
| Seat offered  | 2  | 30  | 24  | 80  |
| Interest shown  | 2  | 30  | 29  | 96.7  |
| Non interruption of woman’s speech  | 2  | 30  | 27  | 90  |
| Politeness  | 2  | 30  | 28  | 93.3  |
| Asking about woman’s concern  | 2  | 30  | 29  | 96.7  |
| Door closed during consultation  | 2  | 30  | 15  | 50  |
| Explanation before examination  | 2  | 30  | 16  | 53.3  |
| Explanation of diagnosis  | 2  | 30  | 19  | 63.3  |
| Explanation of use of prophylactic drugs  | 2  | 30  | 21  | 70  |
| Any History  | 2  | 30  | 28  | 93.3  |
| History of malaria  | 2  | 30  | 17  | 56.7  |
| History of UTI  | 2  | 30  | 18  | 60  |
| Blood Pressure  | 2  | 30  | 28  | 93.3  |
| Measurement  |  |  |  |  |
| Checking of haemoglobin  | 2  | 30  | 28  | 93.3  |
| Checking urine for protein  | 2  | 30  | 28  | 93.3  |
| Prophylactic drugs  | 2  | 30  | 28  | 93.3  |
| Checking eyes for pallor  | 2  | 30  | 22  | 73.3  |
| Checking legs for oedema  | 2  | 30  | 22  | 73.3  |
| Checking weight  | 2  | 30  | 27  | 90  |
| Checking fetal heart  | 2  | 30  | 29  | 96.7  |
| General Health Education  | 2  | 30  | 23  | 76.7  |
| Nutrition education  | 2  | 30  | 20  | 66.7  |
| Malaria Prevention Health Education  | 2  | 30  | 21  | 70  |
| Total  |   | 690  | 547  | 79.3  |

The most frequent activity carried out during ANC consultation included showing interest (96.7%), asking about women’s concern (96.7%) and checking of fetal heart (96.7%) while the least activity done was closing the door during consultation (50%).

**SECTION D: Research Question 3**

**What is the level of client satisfaction with antenatal services provided in Ijebu South?**

**Table 9: Frequency Distribution ANC history of the respondents**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Gestational age**  | **Frequency**  |  |  | **Percent**  |
|   | 1st trimester  |  |  | 15  | 13.6  |
| 2nd trimester  |  |  | 30  | 32.9  |
| 3rd trimester  |  |  | 75  | 53.5  |
| **Total**  |  |  | 120  | 100.0  |
| **Gestational age at booking**  | **Frequency**  |  |  | **Percent**  |
|   | 1st trimester  |  |  | 59  | 46.9  |
| 2nd trimester  |  |  | 41  | 42.6  |
| 3rd trimester  |  |  | 20  | 10.5  |
| **Total**  |  |  | 120  | 100.0  |
| **Number of antenatal visits so far**  | **Frequency**  |  |  | **Percent**  |
|   | 2.00  |  |  | 30  | 29.5  |
| 3.00  |  |  | 48  | 35.3  |
| 4.00  |  |  | 21  | 16.3  |
| 5.00  |  |  | 13  | 14.7  |
| 6.00  |  |  | 5  | 2.3  |
| 7.00  |  |  | 2  | 1.6  |
| 8.00  |  |  | 1  | .4  |
| **Total**  |  |  | 120 | 100.0  |

Most of the clients were in their 3rd trimester (53.5%) while most booked at 1st trimester (46.9%) and majority have had 3 ANC visits (35.3%)

**Table 10: Frequency Distribution obstetric history of the respondents**

|  |  |  |  |
| --- | --- | --- | --- |
| **Number of present pregnancy**  | **Frequency**  |  | **Percent**  |
|   | 1.00  |  | 12  | 14.0  |
| 2.00  |  | 33  | 28.7  |
| 3.00  |  | 28  | 21.7  |
| 4.00  |  | 20  | 15.1  |
| 5.00  |  | 12  | 14.3  |
| 6.00  |  | 5 | 3.1  |
| 7.00  |  | 4  | 1.6  |
| 8.00  |  | 3  | .8  |
| 9.00  |  | 3  | .8  |
| **Total**  |  | 120 | 100.0  |
| **Number delivered**  | **Frequency**  |  | **Percent**  |
|   | .00  |  | 38  | 14.7  |
| 1.00  |  | 70  | 27.1  |
| 2.00  |  | 68  | 26.4  |
| 3.00  |  | 42  | 16.3  |
| 4.00  |  | 26  | 10.1  |
| 5.00  |  | 8  | 3.1  |
| 6.00  |  | 4  | 1.6  |
| 7.00  |  | 2  | .8  |
| **Total**  |  | 120 | 100.0  |
| **Ever delivered before**  | **Frequency**  |  | **Percent**  |
|   | Never delivered  |  | 16  | 14.7  |
|   | Has delivered one or more  |  | 104  | 85.3  |
|  | **Total**  |  | 120 | 100.0  |
| **Number ever had a miscarriage**  | **Frequency**  |  | **Percent**  |
|   | yes  |  | 24  | 13.2  |
| no  |  | 96  | 86.8  |
| **Total**  |  | 120 | 100.0  |
| **Number ever had a stillbirth**  | **Frequency**  |  | **Percent**  |
|   | yes  |  | 6  | 2.3  |
| no  |  | 114  | 97.7  |
| **Total**  |  | 120 | 100.0  |

Gravidity of most clients was 2 (28.7%) and most have delivered 1 (27.1%). Only (13.2%) have ever had a miscarriage and (2.3%) have had stillbirth.

## Table 11: Respondents ANC experience in the index pregnancy

|  |  |  |  |
| --- | --- | --- | --- |
| **Preference of ANC check up**  | **Frequency**  |  | **Percent**  |
|   | more check up  |  | 17  | 21.3  |
| fewer check up  |  | 38  | 31.0  |
| number checkup just right  |  | 65  | 47.7  |
| **Total**  |  | 120 | 100.0  |
| **Expectations of check up**  | **Frequency**  |  | **Percent**  |
|   | more than expected  |  | 20  | 32.6  |
| less than expected  |  | 40  | 18.6  |
| about expected  |  | 60  | 48.8  |
| **Total**  |  | 120 | 100.0  |
| **Time in between check up**  | **Frequency**  |  | **Percent**  |
|   | too short  |  | 20  | 20.5  |
| too long  |  | 25  | 23.3  |
| about right  |  | 75  | 56.2  |
| **Total**  |  | 120 | 100.0  |
| **Waiting time**  | **Frequency**  |  | **Percent**  |
|   | less than 1hour  |  | 40  | 31.8  |
| more than 1hour  |  | 80  | 68.2  |
| **Total**  |  | 120 | 100.0  |
| **Happy with waiting time**  | **Frequency**  |  | **Percent**  |
|   | No  |  | 87  | 77.1  |
| Yes  |  | 33  | 22.9  |
| **Total**  |  | 120 | 100.0  |
| **Time spent with provider**  | **Frequency**  |  | **Percent**  |
|   | less than 30mins  |  | 101  | 78.7  |
| 30mins to 60mins  |  | 17  | 20.5  |
| more than 60mins  |  | 2  | .8  |
| **Total**  |  | 120 | 100.0  |

Majority of the respondents (47.7%) agree that the number of checkup is just right and most also believe that their expectation from the checkup is about expected (48.8%). Few clients (20.5%) agree that the time between checkup is too short and most (68.2%) responded that they had to wait for more than 1hour to see a healthcare provider and a lot majority (77.1%) are not happy with the waiting time. However, majority (78.7%) attest to spending less than 30mins with a healthcare provider. Most respondents (48.8%) would prefer a little more time with the provider and majority (52.3%) would prefer a female provider. Majority (28.3%) would prefer to see a doctor while 40(15.5%) will prefer a combination of doctors and nurses.

Majority of the clients admitted having information a s much as wanted in all the thematic areas; health (76.7%), tests (63.6%), treatments (68.2%), labour (63.6%), breastfeeding (68.6%), breast self-examination (55%), family planning (57%), malaria prevention (62.4%), HIV/AIDS (58.9%), cervical cancer prevention (48.1%). However, the highest information was identified to be that concerning their health (198; 76.7%). Majority of clients responded to having received information on the above danger signs with the most being on haemorrhage (89.1%).

## Table 12: Respondents concern about their pregnancy and reassurance given

|  |  |  |
| --- | --- | --- |
|   | **Worried about the following**  | **Reassured by information from provider**  |
|   | **No (%)**  | **Yes (%)**  | **Total**  | **No (%)**  | **Yes (%)**  | **No information** **(%)**  | **Total**  |
| Position of the baby  | 116 (45)  | 142 (55)  | 258  | 41 (15.9)  | 215 (83.3)  | 2 (0.8)  | 120 |
| Size of the baby  | 88 (34.1)  | 170 (65.9)  | 258  | 49 (19)  | 204 (79.1)  | 5 (1.9)  | 120 |
| Whether baby will be premature  | 129 (50)  | 129 (50)  | 258  | 57 (22.1)  | 194 (75.2)  | 7 (2.7)  | 120 |
| Having an abnormal baby  | 193 (74.8)  | 65 (25.2)  | 258  | 47 (18.2)  | 204 (79.1)  | 7 (2.7)  | 120 |
| Your health  | 125 (48.4)  | 133 (51.6)  | 258  | 53 (20.5)  | 197 (76.4)  | 8 (3.1)  | 120 |
| Your weight  | 96 (37.2)  | 162 (62.8)  | 258  | 33 (12.8)  | 216 (83.7)  | 9 (3.5)  | 120 |

Most clients are worried more about the size of their babies (65.9%) with the least concern being on having an abnormal baby (25.2%). However, a lot majority of them admitted being reassured by the level of information given.

## Table 13: Respondents’ satisfaction with different aspects of ANC

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Satisfied with the following**  | Very dissatisfied (%)  | Dissatisfied (%)  | Indifferent (%)  | Satisfied (%)  | Very satisfied (%)  | Total  |
| Waiting time  | 37 (37.6)  | 39 (37.2)  | 2 (0.8)  | 49 (19)  | 14 (5.4)  | 120 |
| Ability to discuss problem  | 18 (7)  | 20 (15.1)  | 9 (3.5)  | 98(57.4)  | 32(17.1)  | 120 |
| Amount of explanation given  | 12 (4.7%)  | 24 (9.3)  | 13 (5)  | 170 (65.9)  | 39 (15.1)  | 120 |
| Examination and treatment given  | 14 (5.4)  | 11 (4.3)  | 17 (6.6)  | 163 (63.2)  | 53 (20.5)  | 120 |
| Privacy from others during treatment  | 11 (4.3)  | 19 (7.4)  | 7 (2.7)  | 166 (64.3)  | 55 (21.3)  | 120 |
| Privacy from others during discussion  | 18 (7.0)  | 47 (18.2)  | 15 (5.8)  | 138 (53.5)  | 40 (15.5)  | 120 |
| Availability of medicines  | 14 (5.4)  | 28 (10.9)  | 18 (7)  | 162 (62.8)  | 36 (14)  | 120 |
| Convenience of hours of service  | 7 (2.7)  | 46 (17.8)  | 17 (6.6)  | 132 (51.2)  | 56 (21.7)  | 120 |
| Neatness of facility  | 11 (4.3)  | 14 (5.4)  | 13 (5)  | 145 (56.2)  | 75 (29.1)  | 120 |

Majority of the clients were very dissatisfied with the waiting time (37.6%) but were satisfied with ability to discuss problem (57.4%), amount of explanation given (65.9%) and examination and treatment given (63.2%). Also majority were satisfied with the privacy given during treatment (64.3%) and from others during discussion (53.5%); satisfied with the availability of medicines (62.8%), convenience of hours of service (51.2%) and with the neatness of the facility (56.2%).

## Table 14: Respondents’ satisfaction with ANC received

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|   | No (%)  | Yes (%)  | Don’t know (%)  | Total  |
| Coming back in next pregnancy  | 21 (8.1)  | 90 (84.8)  | 9 (7)  | 120 |
| Will you recommend the facility  | 20 (7.8)  | 85 (83.7)  | 15 (8.5)  | 120 |
|   |
|   | Very satisfied (%)  | Satisfied (%)  | Indifferent (%)  | Dissatisfied (%)  | Very dissatisfied (%)  | Total  |
| General satisfaction  | 15 (31.8)  | 70 (55)  | 10 (3.5)  | 20 (7.8)  | 5 (1.9)  | 120 |
|   |
|   | Satisfied (%)  | Not satisfied (%)  | Total (%)  |
| Overall satisfaction  | 86 (86.8)  | 34 (13.2)  | 120 |

Majority of the clients agreed to come back to the facility in their next pregnancy (84.8%) and to recommend the facility to others (83.7%). Overall, 86.8% of the clients were satisfied with ANC given while 13.2% were not satisfied.

**Discussion of Findings**

The importance of adequate human resource for health cannot be overemphasized for there to be high quality service provision. It is evident in the study that a lot still need to be done in the area of health manpower. There are medical officers and nurses/midwives but the other lower cadres of staff like medical record officers, pharmacy technician, lab technician etc. are not adequate. Security of a facility is of a very big essence but the results showed absence of security personnel (table 4) in almost all the facilities except one that has only one security man instead of the recommended two. The implication is that women might be feeling reluctant to come in the night in labour as they won’t be sure of their safety and may eventually visit an alternative birth place. This also predisposes the health facilities to robbery attack and possible looting of available supplies. The gap in health worker’s availability in health facilities for antenatal care seems to be a recurring issue as many studies reported same.

The quality of service provision as evidenced in the study is being threatened by both shortage of staff and this could negatively affect the productivity of the few staff available. The findings revealed poor training and supervision, inadequate supplies etc. as some of the challenges faced by the health workers. This is an issue that need to be addressed especially in the area of training to expand workers’ capacity. Regular in-service training comes highly recommended, supervision and various form of motivation to boost the productivity of the available workers.

Results show that adequate information on relevant health topics are delivered by the health providers though a lot more need to be done in areas of family planning and cervical cancer. Other researchers reported poor information on cervical cancer in their work also. Not giving as much information on family planning like other topics may be because it is emphasized during six weeks postnatal visit. Cervical cancer should be discussed with all women as it is a leading cause of death in women in sub-Saharan Africa and this makes it very necessary to create awareness on the importance of regular screening.

There was adequate information on how to recognise and proceed in some danger signs of pregnancy. This is in contrast with findings in a study in Gambia where roughly 80% of the women reported that they had not been told how to recognize or manage certain danger signs during pregnancy. This probably contributed to the clients having little worries about some pregnancy related issues when compared with facilities in similar study where women were not given as much information.

The observation of processes of care revealed poor practice of the minimum procedures to be done in antenatal consultations. In almost all the facilities, doors were not closed during consultation, no explanation given before examination or about diagnosis and also on the importance of taking prophylactic drugs. Consulting while the doors are open does not guarantee confidentiality and this was reported in a study where there was always interruption by another health worker, a visitor or even a stranger during consultation. Similarly, not explaining the importance of prophylactic drugs may lead to poor adherence and its possible negative effects. However, blood pressure measurement, checking the foetal heart and urine for protein were never missed just like in most studies on antenatal women. The availability of instrument for measuring these and the common knowledge on the importance of these in pregnancy must be contributory to providers not missing them. However, blood pressure measurement and urine testing are a routine for all women once they come for antenatal visit though it was reported to have been done for a small number of clients some other researchers. The involvement of women in all the processes of care is very paramount to achieving a good maternal outcome. This however is not the case as seen in the study and also in other similar studies. Group health talk is good but not enough thereby it should be complemented by in depth interaction with the clients during one on one consultation. It is during this time that issues like birth preparedness, complication readiness etc. should be discussed and the woman put in the right perspective on what she should do and be doing.

A very important aspect of quality is client satisfaction with service provision and there are many determinants to that. This study has an overall clients’ satisfaction of 86.8% with 84.8% and 83.7% of the clients admitting willingness to come back in subsequent pregnancies and recommend the facility to someone else respectively. That is quite reasonable though there are still so many areas of dissatisfaction that need to be emphasized. Waiting time is a big problem that needs to be handled very well. This is a big source of dissatisfaction to women and was also reported in some other works, though Fawole et al in their work had a lot of the women rating the waiting time as appropriate.

Many respondents had to wait for longer than one hour before being attended to but it is worth noting that the time they responded that they wait includes the time usually devoted to group health talk. Not having enough staff could contribute to long waiting time. Other major sources of dissatisfaction identified were inability to discuss problem with health providers contrary to findings by Sholeye et al and lack of privacy during discussion consistent with a work in Gambia Lack of privacy is a reflection of the practice of leaving the doors open in most consultation and inability to discuss problems well with the clients can be linked to shortage of staff which may make the providers to always be in a hurry to see everybody.

**CHAPTER FIVE**

**CONCLUSION AND RECOMMENDATION**

**Summary of Findings**

Findings from this study showed good quality with regards to process of care and very good quality with regards to structural and outcome attribute of quality. There was a high level of client satisfaction with antenatal care received (86.8%). A significant association was observed between client satisfaction and marital status, educational level and occupational group (P<0.05) but no association was observed with parity (P>0.05). The gap in health worker’s availability in health facilities for antenatal care seems to be a recurring issue as many studies reported same. This is an issue that need to be addressed especially in the area of training to expand workers’ capacity. Regular in-service training comes highly recommended, supervision and various form of motivation to boost the productivity of the available workers. The observation of processes of care revealed poor practice of the minimum procedures to be done in antenatal consultations. A very important aspect of quality is client satisfaction with service provision and there are many determinants to that. This study has an overall clients’ satisfaction of 86.8% with 84.8% and 83.7% of the clients admitting willingness to come back in subsequent pregnancies and recommend the facility to someone else respectively. Many respondents had to wait for longer than one hour before being attended to but it is worth noting that the time they responded that they wait includes the time usually devoted to group health talk.

The importance of high quality antenatal care cannot be overemphasized at it will not only ensure women attendance to the clinics but will also contribute in combating maternal mortality which is high in this part of the world. Clients’ perspective of quality of care with regards to their satisfaction with service provision is also a vital part that should always be considered to have an improved service delivery.

**Conclusion**

The main objective of this study was to determine the pregnancy duration and choice of ante-natal and delivery care in Ijebu South.

There is no doubt that the antenatal care services provided in the hospital is very good despite some observed shortcomings. Lack of enough manpower is a very big challenge to providing adequate antenatal service especially the lower cadre of staff. This is very important as everybody has a role to play at different stages in accessing care.

**Recommendation**The following recommendations were made based on the findings of the study;

1. There should be a periodic assessment of quality of antenatal care as this will help for continuous improvement in service delivery especially looking at quality from the clients’ perspectives.

2. The authority should employ workers in the primary health centres especially the lower cadre of staff that provide allied services in the centre like personnel, pharmacy technician etc.

3. There should be regular supervision and in-service training for the staff to keep them abreast with recent development on best practices in patient care with regards to things like client privacy, health education etc.

4. There should be awareness creation on the part of the service providers on the need to reduce client waiting time as it is a major cause of dissatisfaction and also on the part of the government to employ more staff to meet the required minimum standard so as to reduce provider-client ratio.

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