

ASSESSMENT OF ANTENATAL CARE SERVICES AVAILABILITY AND ACCESSIBILITY IN THREE MAIN MCH AT HARGEISA CITY-SOMALILAND

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Abstract: Antenatal care, also known prenatal care as is a type of preventive healthcare, with the goal of providing regular check-ups that allow doctors or midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefit both mother and child. Current models of antenatal care originated in the early decades of the 20th century. The pattern of visits recommended at that time (monthly until 30 weeks, then fortnightly to 36 weeks and then weekly until delivery) is still recognizable today. It has been said that antenatal care has escaped critical assessment.

Objective: To assess Antenatal care services availability and accessibility in three main MCH, Hargeisa-Somaliland.

Methods: cross-sectional study design was used to assess the antenatal care services availability and accessibility in three main MCH, Hargeisa-Somaliland. Simple random sampling technique was applied to identify sample population. The data was entered in to SPSS version 20 and excel 2007 for further analysis.

Result: A total of 138 were incorporated in the study of which majority of ANC attendees age were 20-25(31%) while 54% of them are illiterate and 79% were married. It shows that the majority of them 70% did not plan where they were going to deliver while 41% of them had late antenatal checkup. It also showed that about 24% of the respondent deliver their past pregnancies at home.

Conclusion: The study findings revealed that greater part of antenatal care attendees 54% of them were illiterate in which lack of knowledge and low antenatal care attendance goes hand in hand almost all, 79% of them were currently married. The study showed that out of 67(48.6%) who had difficulty in attending the MCH stated their reason which, 16(11.6%) was due to too much responsibility, 45(32.6%) was due to lack of transportation while 6(4.3%) was due to lack of money. While the 51% indicates those who have not had any difficulty in attending the MCH.

Keywords: Antenatal care accessibility and availability.

1. INTRODUCTION

Antenatal care, also known prenatal care as is a type of preventive healthcare, with the goal of providing regular check-ups that allow doctors or midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefit both mother and child. ^[1]

Antenatal care is a critical opportunity for health providers to deliver care, support and information to pregnant women. This includes promoting a healthy lifestyle, including good nutrition; detecting and preventing diseases; providing family planning counseling and supporting women who may be experiencing intimate partner violence. ^[2]

"If women are to use antenatal care services and come back when it is time to have their baby, they must receive good quality care throughout their pregnancy," says Dr Ian Askew, Director of Reproductive Health and Research, WHO. "Pregnancy should be a positive experience for all women and they should receive care that respects their dignity." ^[2]

Current models of antenatal care originated in the early decades of the 20th century. The pattern of visits recommended at that time (monthly until 30 weeks, then fortnightly to 36 weeks and then weekly until delivery) is still recognizable today. It has been said that antenatal care has escaped critical assessment. ^[3]

Almost one-fifth of the world's population constitutes women of reproductive age who are repeatedly exposed to pregnancy and childbearing. Many are often at high risk of illness and mortality during pregnancy and require maternal healthcare services for early detection of complications. ^[4]

Globally, while 85% of pregnant women access antenatal care with skilled health personnel at least once, only six in ten (58%) receive at least four antenatal visits. In regions with the highest rates of maternal mortality, such as sub-Saharan Africa and South Asia, even fewer women received at least four antenatal visits 49% and 42%, respectively. ^[5]

Internationally, women in the richest 20% of the population are also more likely to receive antenatal care than poorer women, especially in the most deprived regions. In South Asia (excluding India), for instance, women in the richest quintile are five times as likely as women in the poorest quintile to receive four or more antenatal care visits, which is the minimum recommended (68% versus 14%). Large disparities in coverage based on wealth are also found in sub-Saharan Africa, particularly in West and Central Africa. ^[6]

Pregnancy-related deaths and diseases remain unacceptably high. In 2015, an estimated 303,000 women died from pregnancy-related causes, 2.7 million babies died during the first 28 days of life and 2.6 million babies were stillborn. While substantial progress has been made over the past two decades, increased access to and use of higher-quality health care during pregnancy and childbirth can prevent many of these deaths and diseases, as well as improve women and adolescent girls' experience of pregnancy and childbirth. Globally, however, only 64% of women receive antenatal care four or more times throughout their pregnancy. ^[6]

Maternal mortality is unacceptably high. About 830 women die from pregnancy or childbirth-related complications around the world every day. Almost all of these deaths occurred in low-resource settings, and most could have been prevented. ^[4]

In sub-Saharan Africa, an estimated 900,000 babies die as stillbirths during the last twelve weeks of pregnancy. It is estimated that babies who die before the onset of labor, or antepartum high stillbirths, account for two-thirds of all stillbirths in countries where the mortality rate is greater than 22 per 1,000 births – nearly all African countries. Antepartum stillbirths have a number of causes, including maternal infections – notably syphilis – and pregnancy complications, but systematic global estimates for causes of antepartum stillbirths are not available. ^[7]

1.2 BACKGROUND

Historically, the traditional antenatal care service model was developed in the early 1900s. This model assumes that frequent visits and classifying pregnant women into low and high risk by predicting the complications ahead of time, is the best way to care for the mother and the fetus. The traditional approach was replaced by focused antenatal care (FANC) — a goal-oriented antenatal care approach, which was recommended by researchers in 2001 and adopted by the World Health Organization (WHO) in 2002. ^[8]

The social, family, and community context and beliefs affect health during pregnancy either positively or negatively. Some cultures promote special foods and rest for pregnant women, but in others, pregnancy is not to be acknowledged. In these cases, women continue to work hard, and nutritional taboos may deprive them of essential nutrients, adding to nutritional deficiencies, particularly iron, protein, and certain vitamins. ^[7]

In Bangladesh antenatal care seeking was strongly determined by knowledge about, and thus beliefs in the importance of ANC. Husbands and mothers-in-law were usually the decision makers about ANC. Some women found the idea of ANC to be shameful, especially if they felt that they would be examined by male health workers. Financial charges for ANC, unofficial but universally expected to be paid by families, were commonly cited as barriers to ANC. ^[9]

Despite advances in the last 20 years, the report says that there has been too little progress in preventing adolescent pregnancies, abortions, maternal deaths, sexually-transmitted infections and HIV. There are also significant gaps in availability, quality and access to comprehensive sex education and services for young people, especially in low-income countries.^[10]

Maternal mortality statistics underscore how societies have failed women, especially young women in developing countries. As many as 529,000 women die each year from complications of pregnancy and childbirth.] Pregnancy is the leading cause of death for young women ages 15 through 19.^[11]

Unsafe abortion can have devastating consequences, including cervical tearing, perforated uterus, hemorrhage, chronic pelvic infection, infertility, and death. Infants of adolescents are at increased risk for death. In fact, the infants of adolescent mothers are more likely to die before their first birthday than are the infants of older mothers.^[11]

2. LITERATURE REVIEW SUMMARY

Antenatal care (ANC) is the care that a woman receives that promotes a healthy lifestyle that improves long-term health outcomes for the woman, her unborn child and possibly her family (Glasier et al., 1996).^[18]

ANC also contributes to improving the care and health of newborns and children in the future (Zuniga de Nuncio et al., 2003). Also informs women and their families about the possibility of unexpected events, how to deal with them and seek help when appropriate (Whitford & Hillan, 1998; Pasinlioglu, 2004).^[18]

The rationale for providing ANC is to screen predominantly healthy pregnant women to detect early signs of, or risk factors for, abnormal conditions or disease and to follow this detection with effective and timely intervention (Lumbiganon et al., 2004). In short, ANC helps to build a healthy family environment that is responsive to the mother's and the child's needs.^[18]

Most life threatening obstetric complications can be prevented through antenatal care. Moreover, there is sufficient evidence that care during pregnancy is an important opportunity to deliver interventions that will improve maternal health and survival during the period immediately preceding birth and after birth. Furthermore, if the antenatal period is used to inform women and families about danger signs and symptoms and about the risks of labor and delivery, it may ensure that pregnant women deliver with the assistance of a skilled health care provider.^[19]

Globally, developing countries still face a challenge of poorly implemented ANC programs with irregular clinical visits and long waiting times plus poor feedback to the women.^[20]

Nearly 99% of death happens in low-income countries especially in Sub-Saharan Africa and South Asia. Rural and poor communities are even more vulnerable to maternal deaths because they do not have access to adequate quality health services on time. Furthermore, only one third of all pregnant women in developing countries receive at least four antenatal care visits. There is also a huge disparity of maternal health status between urban and rural Settings.^[1]

In South Sudan, the prolonged conflict, which has lasted over two decades, has destroyed much of the health services with currently over 40% of health facilities not operative. As a result, pregnant women in South Sudan have limited access to, and availability of maternal health services.^[21]

Women, particularly in Kenya and Malawi, reported that they would not attend ANC until the sixth or seventh month to minimize the number of journeys and therefore the total cost of ANC. As women viewed the scheduled appointments as compulsory, attending in the third month of pregnancy could potentially result in eight journeys to the health facility.^[22]

While in Uganda, the ANC services are characterized by poor attendance, poor counseling services and poor client-provider relations, with the quality being worse in rural areas. The quality of ANC is critical in enabling women and health workers identify risks and danger signs during pregnancy which should lead to appropriate action. Whether or not women can identify danger signs during pregnancy and act appropriately depends on quality aspect such as depth of the information and counseling given during an ANC visit.^[23]

Mothers' level of education influenced the use of ANC for which Mothers with primary educational level were more likely to attend ANC than women who are unable to read and write. Studies further revealed that availability of women's time is important as women spend more time on their multiple responsibilities for care of children, collecting water or fuel, cooking, cleaning, and trade than on their own health.^[24]

Inadequate resources influence in most developing countries, where there is gross shortage of doctors, midwives and maternity units. The few medical workers available tend to practice in urban areas, leaving rural areas without access to care.^[25]

In some places and in rural areas in particular, the population may be widely dispersed because villages are far apart, the people are nomadic in nature, or because many women spend a great part of the year in farms assisting their husbands and cannot easily reach maternity centers, especially where roads are bad or impassable.^[25]

Illiteracy and poverty are important factors which contribute to the poor prenatal and preconception care in many developing countries. A study in 47 countries in Africa, the Middle East and Asia showed that infant mortality rates associated far more with literacy rates than with gross national products.^[25]

The care of women during pregnancy is determined to a large extent by the influence of cultural and traditional factors. Many communities tend to adhere to the traditional belief that pregnancy and delivery is the province of traditional birth attendants.^[26]

The use of traditional birth attendants has generated a lot of heated debate over the decades, especially among health professionals. But the facts strongly support their use.^[27]

TBAs are highly respected in African communities. They perform cultural rituals and provide essential social support to women during childbirth. Their clients trust them and share their secrets with them. Without modern training on how to attend to pregnant women, however, TBAs are unable to recognize and respond appropriately to complications of pregnancy. For this reason, deliveries attended by untrained TBAs are risky for women and their babies, leading to poor health outcomes and even death.^[28]

According to Kruske and Barclay approximately half of all births in developing countries are attended by traditional birth attendants (TBAs) and as many as 95% of women are attended by TBAs.^[29]

No prenatal care is performed in many of these cases. One study about the care of pregnant women in northern Nigeria showed that this influence is so strong in the population that even some educated patients do not go to the maternity centers during their pregnancy, preferring to remain at home and adopt traditional methods.^[30]

Over 200 million women become pregnant each year and 130 million bear children. Each year nearly 500,000 women die as a result of complications of pregnancy or childbearing. Ninety-nine percent of these deaths would be prevented if the lowest mortality rates in developed countries were achieved worldwide.^[11]

Maternal mortality is an avoidable tragedy since most causes of maternal deaths can be prevented with timely and appropriate medical care. Several factors restrict women's access to medical care. The three delay model by Thaddeus and Maine that lead to maternal deaths were described as: delays in seeking care; reaching care; and providing care. The first two delays are related to care seeking practices including making the decision to seek care and reaching the health facility in time. The third delay occurs at the health facility, and is due to factors including the shortage of personnel, drugs and equipment, administrative delays and clinical mismanagement of patient.^[13]

All-inclusive, over 200 million women have no access to modern, effective contraception. In the developing world, lack of access to family planning results in some 76 million unintended pregnancies each year. Experts say that contraceptive use could prevent up to 35 percent of maternal deaths and when contraceptive use increases, countries' infant mortality rates go down. In countries where less than 10 percent of women use contraception, the infant mortality rate is 100 deaths per 1,000 live births compared to 52 per 1,000 in countries where over 30 percent of women use contraception.^[11]

About 16 million girls aged 15 to 19 years and two million girls under the age of 15 give birth every year. Worldwide, one in five girls has given birth by the age of 18. In the poorest regions of the world, this figure rises to over one in three girls. Almost all adolescent births – about 95% – occur in low- and middle-income countries. Within countries, adolescent births are more likely to occur among poor, less educated and rural populations.^[31]

Many factors influence pregnancy-related health outcomes. It is important for all women of reproductive age to adopt healthy lifestyles (e.g., maintain a healthy diet and weight, be physically active, quit all substance use for good, prevent injuries) and address any health problems before getting pregnant.^[31]

The leading causes of maternal death are classified as direct or indirect. **Direct causes** are those related to obstetric complications of pregnancy, labor and delivery, and the post-partum periods. Direct causes account for 80% of maternal death.^[32]

And indirect causes are those relating to pre-existing medical conditions that may be aggravated by the physiologic demands of pregnancy. Many factors influence pregnancy-related health outcomes. It is important for all women of reproductive age to adopt healthy lifestyles (e.g., maintain a healthy diet and weight, be physically active, quit all substance use for good, prevent injuries) and address any health problems before getting pregnant. ^[32]

According to the World Health Organization (WHO) Statistical analyses estimation about causes of maternal shows those 417 datasets from 115 countries comprising 60,799 deaths in the analysis. About 73% (1,771,000 of 2,443,000) of all maternal deaths between 2003 and 2009 were due to direct obstetric causes, While the Deaths due to indirect causes accounted for 27.5% of all deaths. ^[33]

Only 66% of births were attended by a skilled health care worker. Many rural villages do not have access to clean water or to electricity, and women often must travel great distances to seek medical attention, a common problem throughout sub-Saharan Africa. Weak public transport and road infrastructure has added to the problem of delayed referrals, Dr. Okello said. ^[34]

In 2009, in Zimbabwe the maternal mortality rate stood at 960 deaths for 100,000 births. The main causes of death included postpartum hemorrhage, sepsis and malaria. Deaths were also attributed to delays in seeking health care, finding appropriate facilities and being treated at a clinic or hospital. Many women delivered their babies at home, and health care remained unaffordable for a large proportion of the population. ^[34]

About 80% of maternal deaths result from direct complications of pregnancy and childbirth. The five major direct causes are unsafe abortions, hemorrhage, sepsis, hypertensive disorders, and prolonged or obstructed labor. Most of these conditions can be prevented with proper medical monitoring, information and services. The rest arise from pre-existing conditions that are aggravated by pregnancy such as malaria, and HIV (22%) (WHO, 2010b). ^[35]

Pregnant adolescents are more likely than adults to have unsafe abortions. An estimated three million unsafe abortions occur globally every year among girls aged 15–19 years. Unsafe abortions contribute substantially to lasting health problems and maternal deaths. ^[31]

Maternal Mortality rates in Somalia are amongst the highest in the world; one out of every seven Somali children dies before seeing their fifth birthday (137 deaths/1,000 live births) with a higher number in south and central Somalia. One out of every 12 women dies due to pregnancy related causes (Maternal Mortality Rate is 732 deaths of mothers for 100,000 live births – down from 1210 in 1990). ^[36]

The average fertility rate is 6.6 children per woman. Access to maternal health services is low with 44 and 38 per cent of births in Somaliland and Punt land being attended by skilled birth attendants. Somalia is also drought prone and faces food insecurity, which is exacerbated by poor healthcare, lack of access to safe drinking water and safe sanitation facilities. ^[36]

Somaliland has one of the worst maternal mortality ratios in the world, estimated to be between 10,443 and 14,004 per 100,000 live births," said Ettie Higgins, head of the UN Children's Fund (UNICEF) field office in Hargeisa, capital of Somaliland. Maternal mortality is the leading cause of death among women of reproductive age; it is caused mainly by hemorrhage, puerperal sepsis, eclampsia and obstructed labor," Higgins said, adding that women in Somaliland had a one in 15 risk of dying of maternal-related causes. ^[37]

Over 200 million women become pregnant each year and 130 million bear children. Each year nearly 500,000 women die as a result of complications of pregnancy or childbearing. Ninety-nine percent of these deaths would be prevented if the lowest mortality rates in developed countries were achieved worldwide. Moreover, all regions of the World Health Organization (WHO) give high priority to lowering maternal mortality to achieve 'Health for All' by the year 2000. Even in developed countries with low maternal mortality, such as the United States, an estimated 50 percent or more of maternal deaths are preventable—and lowering the rate to five per 100,000 live births is among the United States' stated public health priorities. ^[38]

2.1 QUALITY OF CARE

Quality of care is considered as one of the major public health concerns of this century. Patient perceptions of the quality of services are widely recognized as a useful tool to improve health services in many developed countries. Such perceptions are considered as one of the best measures of quality in healthcare. ^[39]

Maternal perception of antenatal care quality is an important attribute in understanding the relationship between quality and utilization of antenatal care services. However, measuring this in a developing country is a significant challenge due to non-availability of valid and reliable instruments. ^[40]

Most women who utilize antenatal care (ANC) services in sub-Saharan Africa (SSA) do not receive adequate attention; as care providers are overwhelmed by the number of pregnant women seeking ANC. Consequently, some have argued for the adoption of focused ANC, in which case a woman attends ANC four times during pregnancy at specific intervals for uncomplicated pregnancies. This allows for adequate attention to be given to each pregnant woman and provides opportunity for monitoring of high risk pregnancies. ^[41]

Quality Care in ANC should ultimately do what is right, acceptable to and good for the pregnant adolescents and should adhere to professional ethics. Quality ANC has to be imbued with the concept of caring including the humanistic attributes of competence, confidence, commitment, compassion and conscience and should be based on knowledge, skills and values (Van der Wal). Focused ANC promotes quality care. ^[42]

The JHPIEGO stipulates the following general principles on the provision of quality care ^[42]

Individualized services:-This is an approach to ANC that emphasizes individualized care, client centered, fewer but comprehensive visits, disease detection not risk management and the care is by a skilled provider. Individualized services, privacy/confidentiality is assured, continuous care is provided by the same person to national protocols and referral is facilitated Pregnant women have reported negative attitudes of health care providers (Matua).

Culturally appropriate ANC services:-Pregnancy and childbirth are individual, family and community events, rich in spiritual significance and power, cultural awareness, competency and openness are therefore essential in entering into a care relationship with a woman during this important time in her life. When a specific cultural practice has been identified as harmful and violation of human rights, skilled providers must carefully assess the usefulness of the practice in their area and with other skilled providers and local influential people to develop a plan to advocate a change.

Adolescent friendly services inclusive of a partner: - Provide services that are acceptable to the women by doing the following;

- Respect beliefs, traditions and culture
- Include family, partner or other support persons in care
- Provide relevant and feasible advice
- Empower the woman and their family to become active participants in care
- Ensure that all health staff uses good interpersonal skills.
- Consider the emotional, psychological and social wellbeing of the woman

3. METHODS AND TECHNIQUES

3.0 INTRODUCTION

This chapter discussed most significant parts in the study including research design, the location of the study, the target population of study, sampling technique and sample size, the method of sampling, the tools or instruments used for collecting data, as well as the criteria for selecting eligible subjects under study. This chapter in addition, discusses ethical issues of the research as well as illustrating dependent and independent variables and their definitions.

3.1 STUDY DESIGN

The study design was cross-sectional study design to assess the antenatal care service availability and accessibility in three main MCH, Hargeisa-Somaliland. This method was used because, it is certain to get all the necessary data with in short period of time to complete the project.

3.2 STUDY AREA

The study was carried out in three main MCH which are located at Jig jiga yar, Hawadle, Mohamed Moge at Hargeisa city, Somaliland.

Hargeisa is a city situated in the north-west region of the self-declared but internationally unrecognized Republic of Somaliland in the Horn of Africa. It is the capital and largest city of the Somaliland. ^[43]

Hargeisa is located in the northwest of Somaliland in a valley of the Galgodon highlands. It is the capital and the largest city in Somaliland with a population of approximately 1,300,000. ^[43]

Somaliland has one of the most homogenous populations in Africa, practically the entire population speaking Somali as their first language. Somaliland are united by language, culture, Islamic religion and tradition primarily based on pastoral nomadic.

In Hargeisa there are many health centers and hospitals and twelve MCH which are recognized by the ministry of health.

3.3 STUDY PERIOD

This study was carried out the period between May 2017 and July 2017.

3.4 STUDY POPULATION

The study populations were all population age group (15-49) years old female in Sahardid MCH, Mohamed Moge MCH and Hawadle MCH area at time of data collection.

3.5 SAMPLING METHOD

Sample size was calculated based on the assumption of the distribution according to age group for Somaliland people in the range 15-49 year. The sample size was calculated by using the following.

Formula = $n = Z^2pq/d^2$

Where: n= minimum sample size

z- Confidence interval of 95 % (1.96)

q= the non-occurrence of variable

d= degree of freedom 5%

$n = (1.96)^2 * 0.1 (1-0.1) / (0.05)^2$ n=138

3.6 SAMPLING PROCEDURE

The sampling procedure of the study was simple random sampling, because this method is easy. Each person had equal chance of being selected in each MCH, which it was selected by lottery method in each MCH by selecting 46 respondents in each MCH, therefore, the 3 Main MCH was selected by a total of 138. Then every person who was selected and qualified and was present at the time of data collection were interviewed by using questionnaire.

3.7 DATA COLLECTION INSTRUMENT

The study was designed in questionnaire for the target population who live in the study area. Data was collected by questionnaire.

The questions was written in uncomplicated English language and the interviewer was translated the questionnaire and guide the interviewee to respond all the questions in the questionnaire paper.

Data collected with respect of target population; information were obtained by recording the socio demographic of the target population and as well as the antenatal service availability and accessibility. The questionnaire was translation to Somali language so that it is easy to understand.

3.8 INCLUSION AND EXCLUSION CRITERIA

3.8.1 Inclusion criteria:

- ✓ All age group (15-49) years old female at the time of data collection
- ✓ People who are member of the selected MCH'S and who were present at the time of data collection
- ✓ People who accepted to participate in the study

3.8.2 Exclusion criteria

- ✓ All age group who are less than 15 and older than 49 year old
- ✓ People who are not member in the selected MCH's
- ✓ People who are not willing to participate in the study at the time of data collection

3.9 DATA ANALYSIS

Data analyzing was processed by using (SPSS) software version 24 and result were analyzed by using graphics table and charts statistical analysis Microsoft Excel statistical 2007.

3.10 ETHICAL CONSIDERATION

In this study, research ethics were upheld. Informed consent was transmittal for every administration of the questionnaire to ensure full informed permission of the participants. The consent form was translated into Somali and confirmed consent orally from the study participants.

For the voluntary participation their participation in the research survey was entirely voluntary. There would not be any disciplinary measure taken against those who declined to participate and neither was there any prize for participation.

And for Confidentiality: all information obtained in the course of this study was treated with all most confidentiality and was not be used outside the scope of the study.

This is done in compliance with the requirement for confidentiality through providing brief descriptions of the part and excluding their names or any other identifiers. It was made clear at the beginning of every interview that some of the question could have been uncomfortable and that all the information provided was completely voluntary and that the interview could be stopped at any time or a question skipped.

3.10 Limitation

Although the research has reached its aims there were some unavoidable limitations Such us shortage of time because the time was limited, the research was conducted on a small number of people and since the time of the research data collection was on the month of Ramadan, it was hard to get participant attention and participation which was difficult for the questionnaire to be conducted within this shortage of time.

3.12 DEFINITION OF OPERATIONAL TERMS

- **Ante partum hemorrhage:** - is defined as **bleeding** from or in to the genital tract, occurring in second half of pregnancy or prior to the birth of the baby.
- **Maternal mortality:** - is the **death** of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO) definition.
- **Maternal morbidity:** any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman's wellbeing.
- **Preeclampsia** is a syndrome unique to pregnancy characterized by the new onset of hypertension and proteinuria in the latter half of gestation.
- **postpartum period** is the **time** beginning immediately after the birth and extending for about six weeks
- **Stillborn:** - is the death or loss of a baby before or during
- **Traditional birth attendants:** - is a community lady who is primary care provider during pregnancy, birth and postpartum and is recognized as such by the community and jurisdiction.

3.13 VALIDITY AND RELIABILITY OF DATA

The content validity and the reliability were ensured by using different types of methods such pre-testing the questioner before administrating the questioner to the respondent as well as using the test-retest technique and also translation of the

questioner was done for reliability. Those questions that were not clear were modified in order to improve on the validity of the responses later obtained through the questionnaires.

And also the purpose of the study was also fully explained to the respondents so that they did not hold back essential information due to fear of victimization.

4. RESULTS

4.0 Introduction

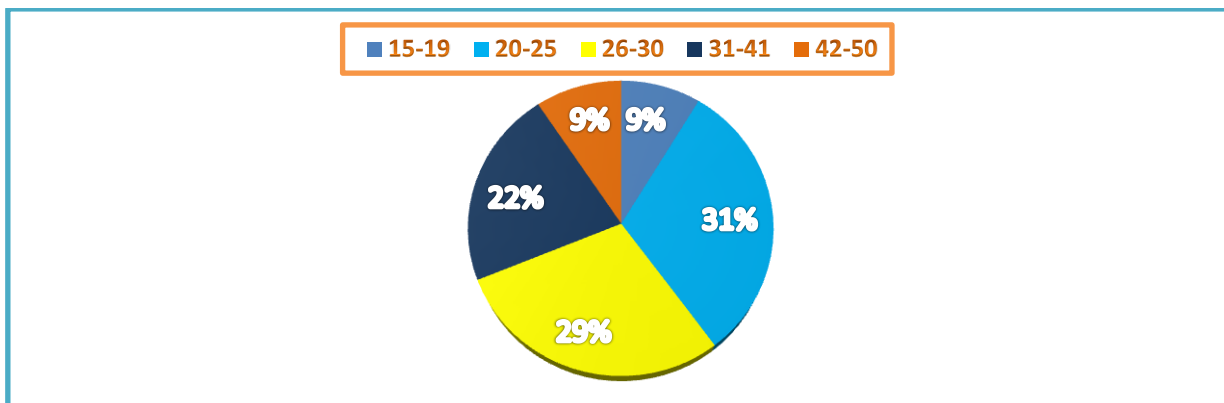
This chapter presents the analysis and discussion of findings. The chapter also presents the characteristics of the sample that was used in the collection of the primary data. Further still, the presentation has been done in line with the study objectives.

Statistical package for social sciences (SPSS) and Microsoft Excel was used to aggregate and analyze the data presented in this chapter. The presentation of this data is in line with the aim of the study which was assessment of antenatal care service availability and accessibility in three main MCH, Hargeisa-Somaliland.

4.1 Socio-demographic characteristics of the respondents

The sample characteristics were summarized in terms of age group, sex structure and position at the work place. This is explained below.

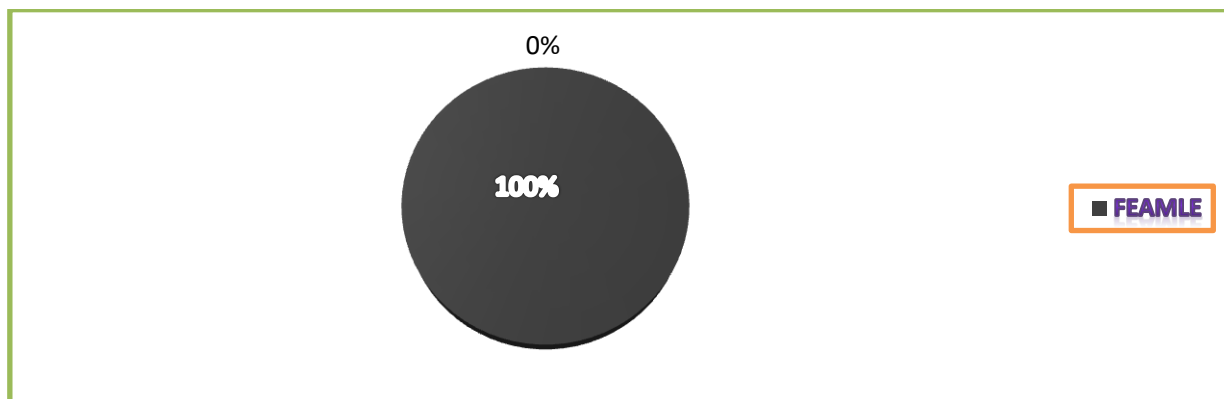
Figure-1 age of the respondents



Source: primary data

In figure-1, the age groups of the respondents showed that age 15-19 were 12(9%), 20-25 were 43(31%), 26-30 were 40(29%), 31-41 were 30(22%) while age 42-50 of the respondent were 13(9%).

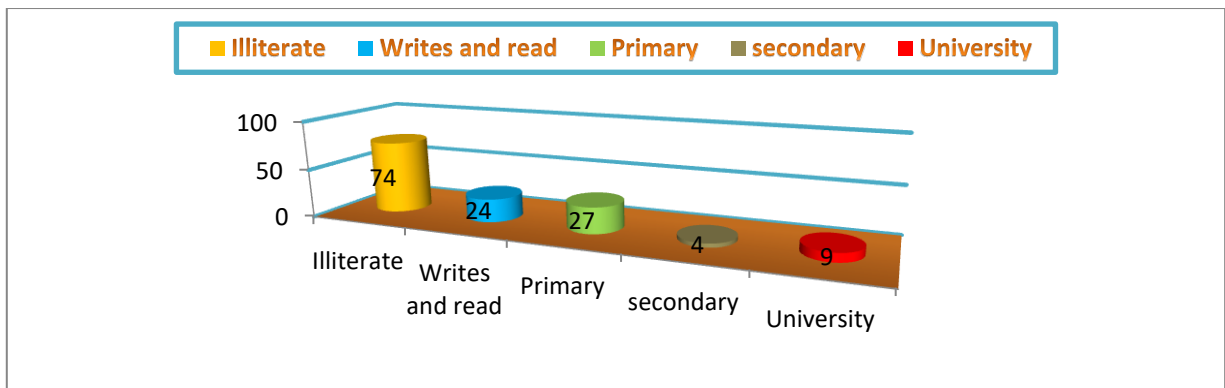
Figure. 2 Gender of the respondents



Source: primary data

In figure 2: The gender of the respondents showed that the entire respondents were 138 (100%) female.

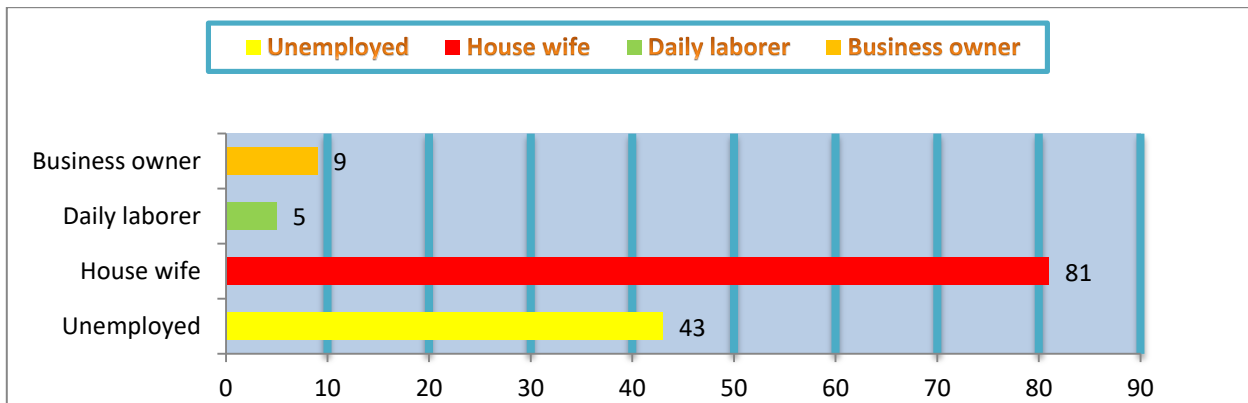
Figure-3 Educational status of the respondents



Source: primary data

In figure 3: The educational status of the respondents showed that majority 74(54%) were illiterate, 24(17%) of the respondent could write and read, 27(20%) were primary school, 4(3%) were secondary school while 9(6%) of the respondent were university level.

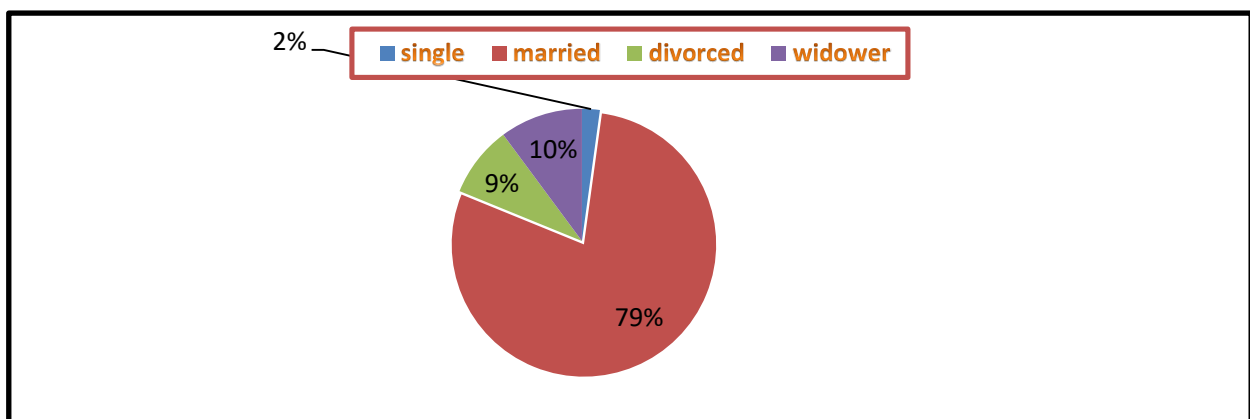
Figure- 4 Occupation of the respondents



Source: primary data

In figure 4: The occupational status of the respondents showed that 81(59%) were house wife’s, 43(31%) were unemployed, 9(6%) were business owners, while 5(4%) were daily laborers.

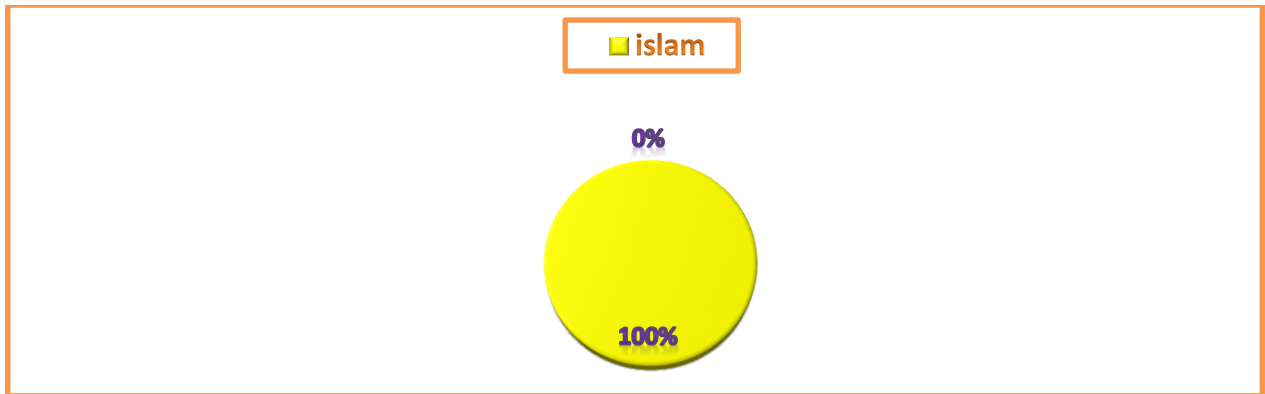
Figure-5 Marital status of the respondents



Source: primary data

In figure 5: The marital status of the respondents indicated that majority 109(79%) were married, while 14(10%) were widowed, 12 (9%) were divorced and 3(2%) were single.

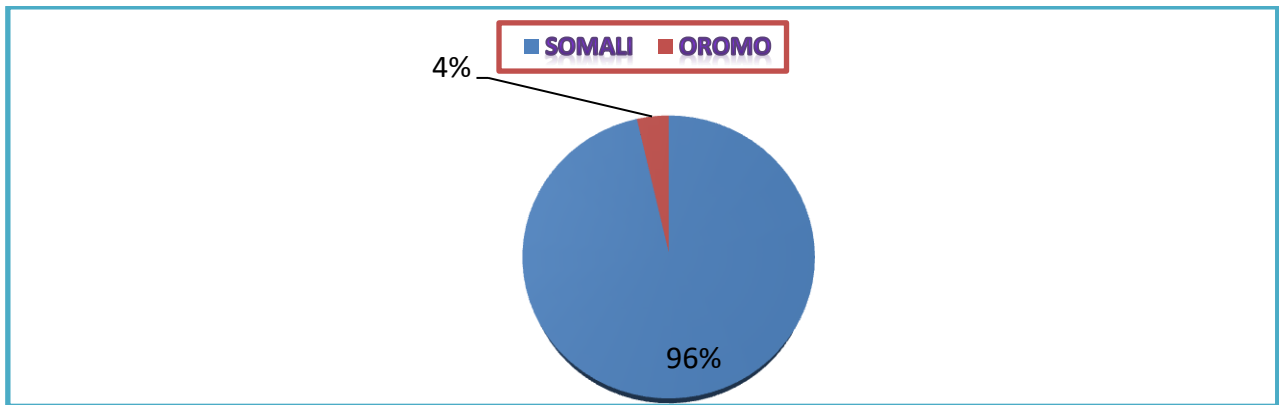
Figure- 6 Religion of the respondents



Source: primary data

In figure 6: The religion of the respondents indicated that 138(100%) were Islam and there were no other religion in the population of the three main MCH.

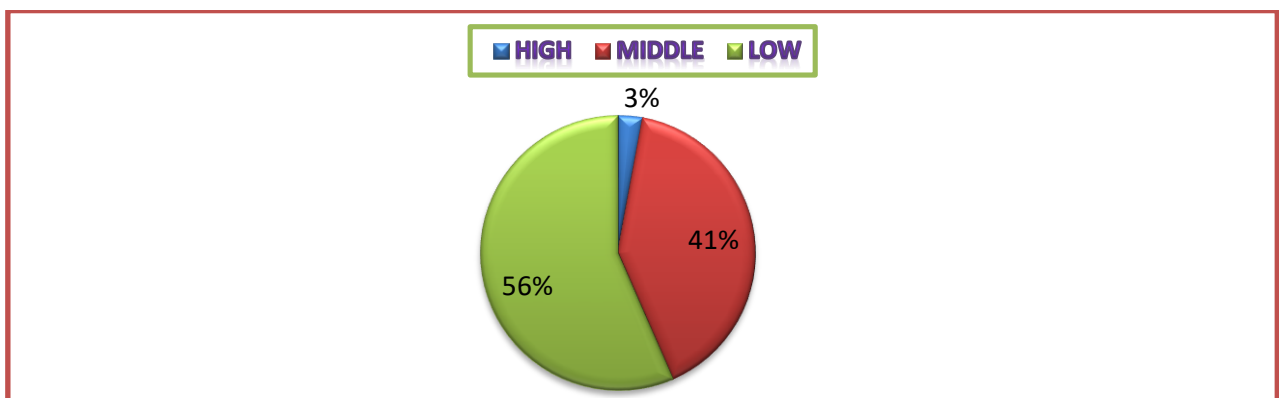
Figure-7 Ethnicity of the respondents



Source: primary data

In figure 7: The ethnicity of the respondents indicated that 133 (96%) were Somali while 5(4%) of the respondent were Oromo.

Figure-8: Average income of the respondents

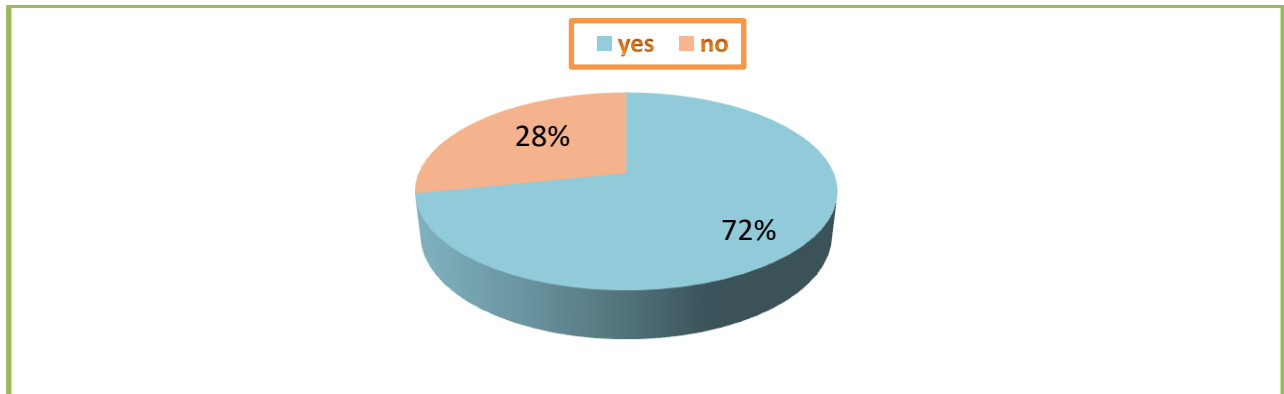


Source: Primary data.

In figure 8: The average income of the respondent indicated that 78(56%) of the respondent were low income, 56(41%) were middle class while 4(3%) were in high class in terms of income.

4.2 Results regarding antenatal care service

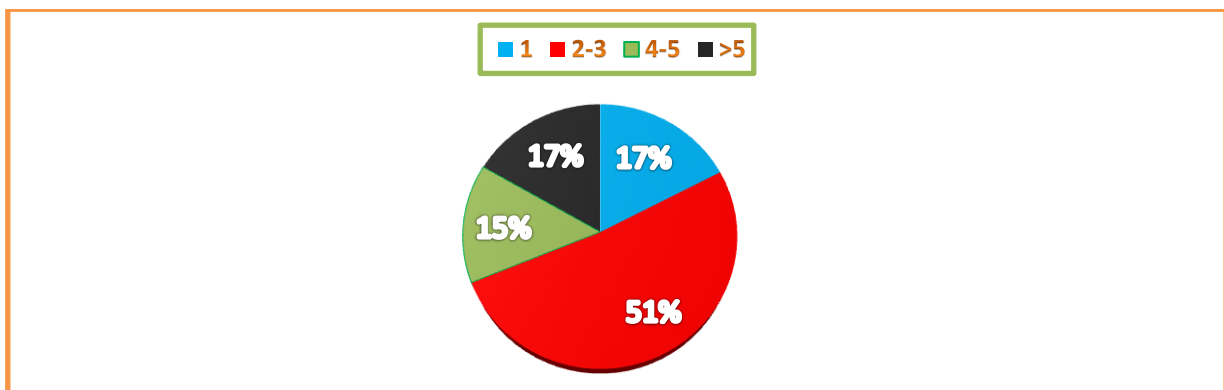
Figure-9: The importance of attending ANC on media



Source; primary data

In figure 9: The respondents were asked if they ever heard the importance of attending ANC service on the media, 99(72%) of the participants heard it from media while 39(28%) of respondents did not hear it.

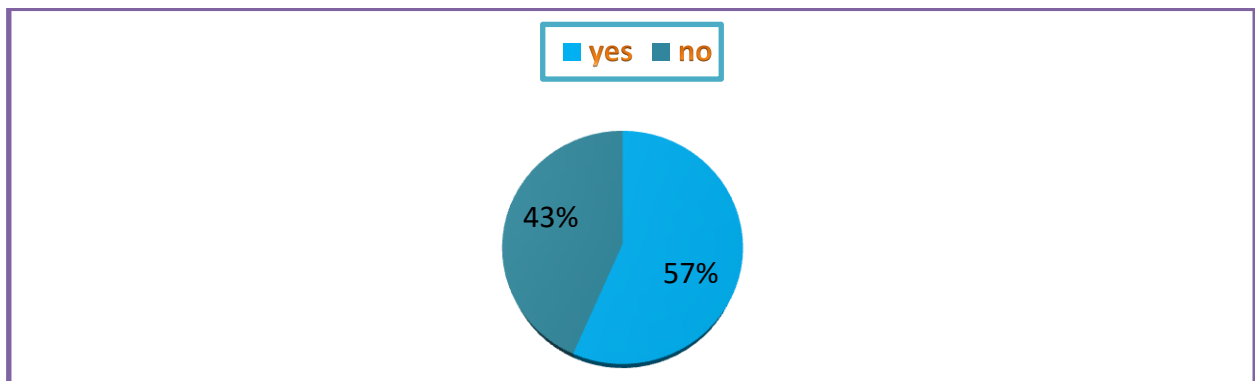
Figure-10: Number of pregnancy of the respondents



Source: Primary data

Figure 10: Indicated that the number of pregnancy of the respondents 24(17%) have been pregnant one time, 71(51%) have been pregnant 1-2 times while 20(15%) have been pregnant 4-5 times while 23(17%) been pregnant more than five times.

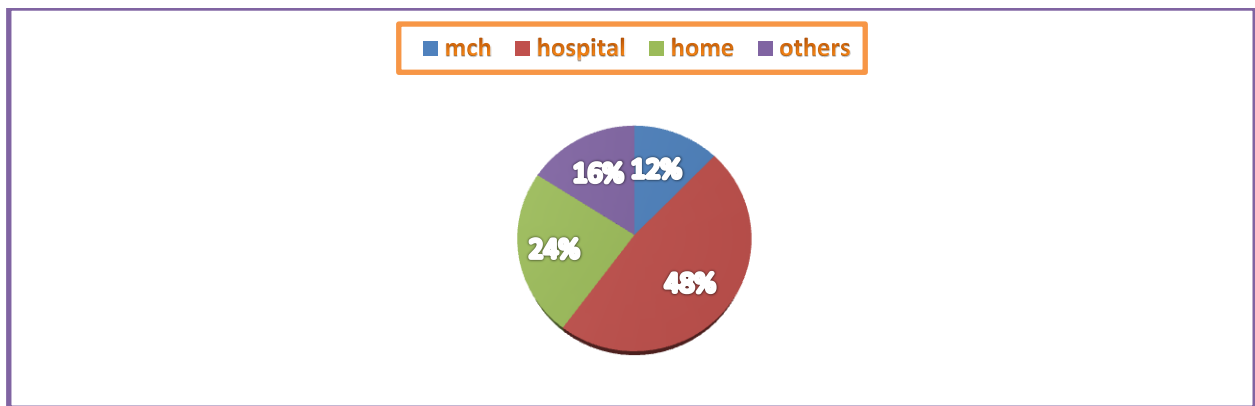
Figure-11: Support of the husbands of the respondents



Source: Primary data

Figure 11: Indicates that if the respondent husbands support them in attending to the MCH or not, 78(57%) have got support from their husband while 60(43%) did not get support from their husband when attending the MCH.

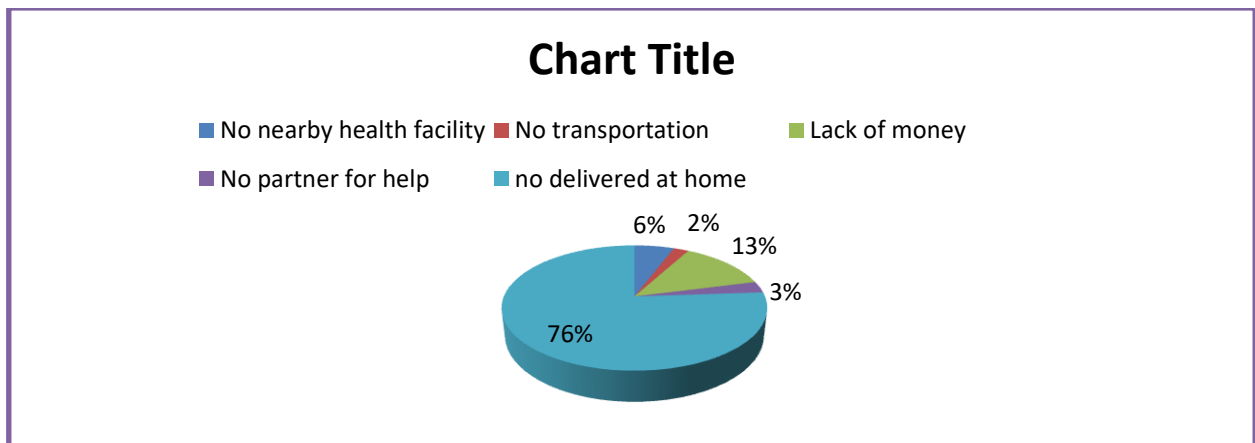
Figure-12: Place of the respondents past delivery



Source: Primary data

Figure 12: Indicates that where the respondent delivered their past pregnancies, 17(12%) of them delivered in MCH, 66(48%) delivered in hospital, 33(24%) delivered at home while 22(16%) delivered other than the places mentioned.

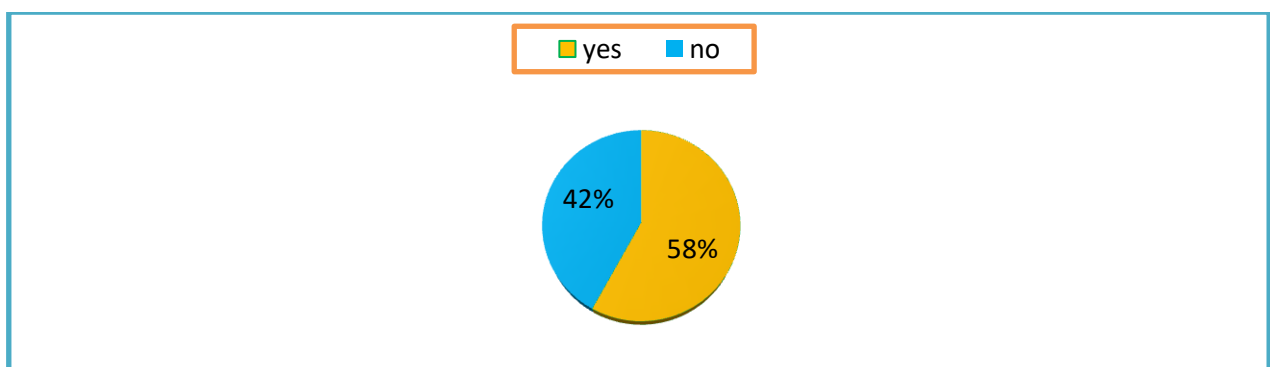
Figure-13: Reasons for delivering at home



Source: Primary data

Figure 13: Indicates the reasons for delivering at home, out of the 33 respondent who delivered at home, 8(6%) responded due to no nearby health facility, 3(2%) due to lack of transportation, 18(13%) due to lack of money while 4(3%) due to no partner for help. While the other 76% indicates those respondents who did not delivered at home.

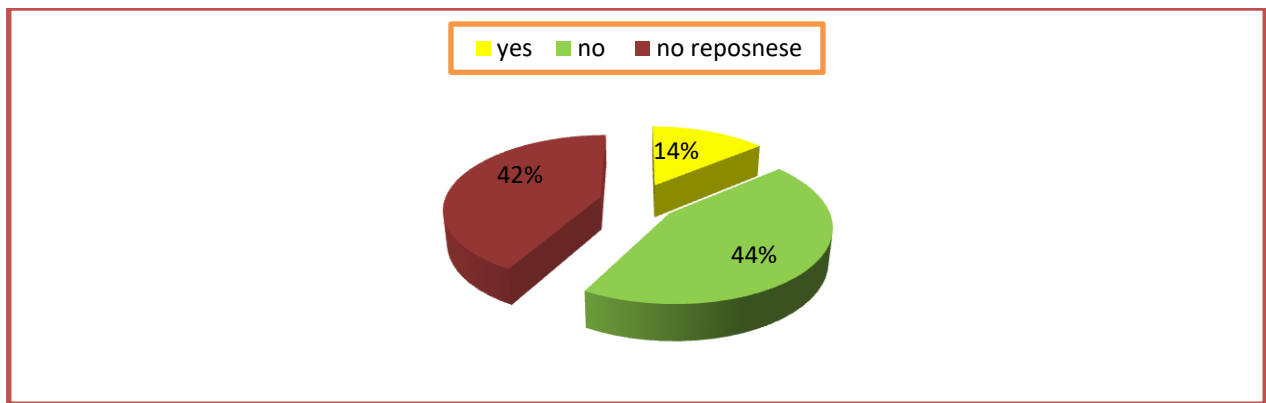
Figure-14: Pregnant women ANC check-up



Source: Primary data

In figure 14: The respondent were asked if they think pregnant women need ANC Check-up, 80(58%) responded that they need ANC checkup while 58(42%) did not need ANC checkup.

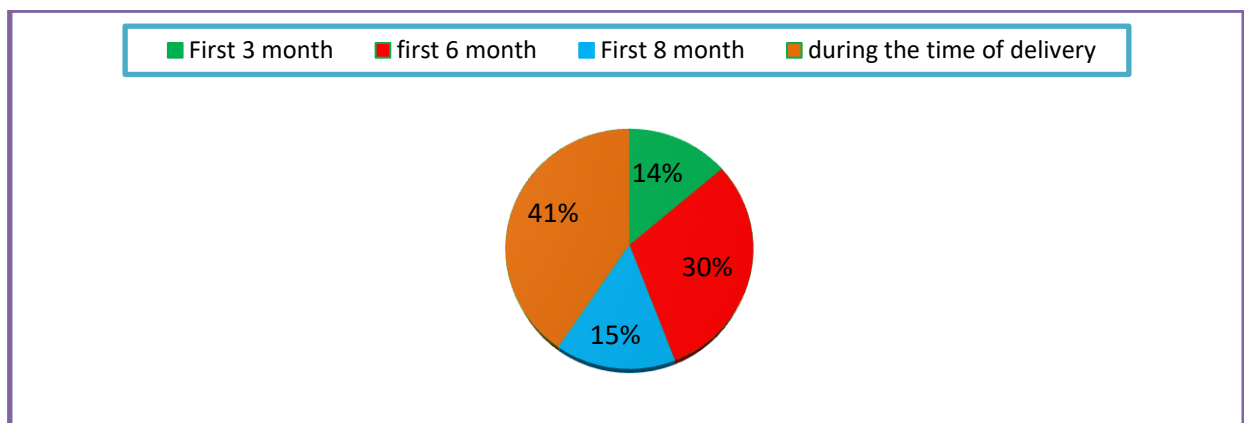
Figure-15: Does ANC check-up without complication requires



Source: Primary data

Figure 15: Indicates out of the 80(58%) respondent who said pregnant women need ANC check-up they were asked if it require to go for ANC check-up without complication 18(14%) responded yes while 66(44%) said it do not require to go for check-up. while the rest 42% indicated the respondent who had no complication.

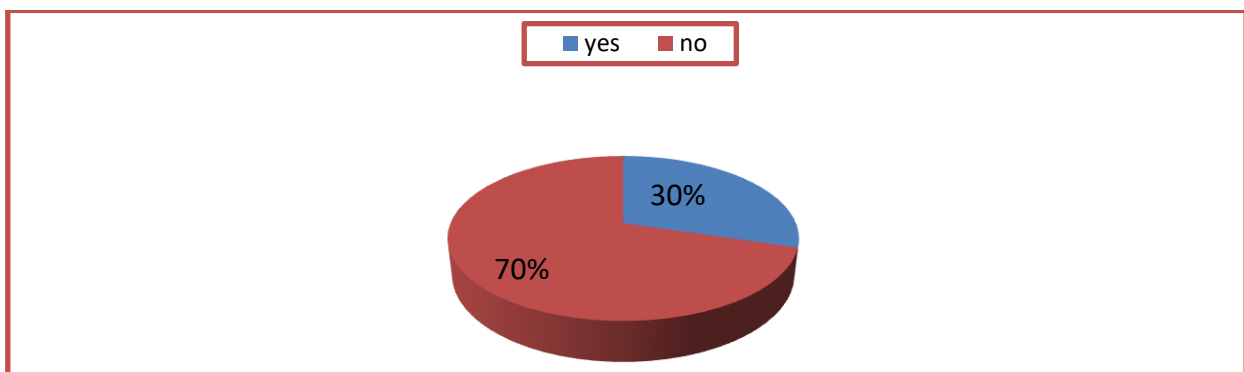
Figure-16 First antenatal check-up



Source: primary data

Figure 16: Indicates the respondents first antenatal check-up 19(14%) had their first check-up on the first three month while 42(30%) had on the first six month also 21(15%) had it on the first 8 month while 56(41%) of the respondents had their first check-up during the time of delivery.

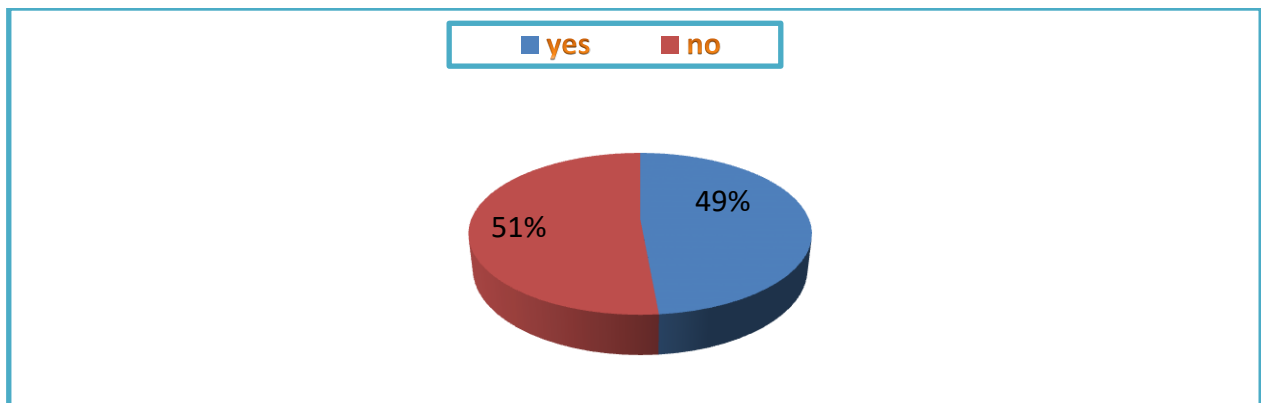
Figure-17: Delivery plan of the respondent



Source: Primary data

Figure-17: Indicates if the participant planned their delivery or not, 41(30%) of the respondents were planed their delivery while 97(70%) were not planned on where they are going to deliver their baby.

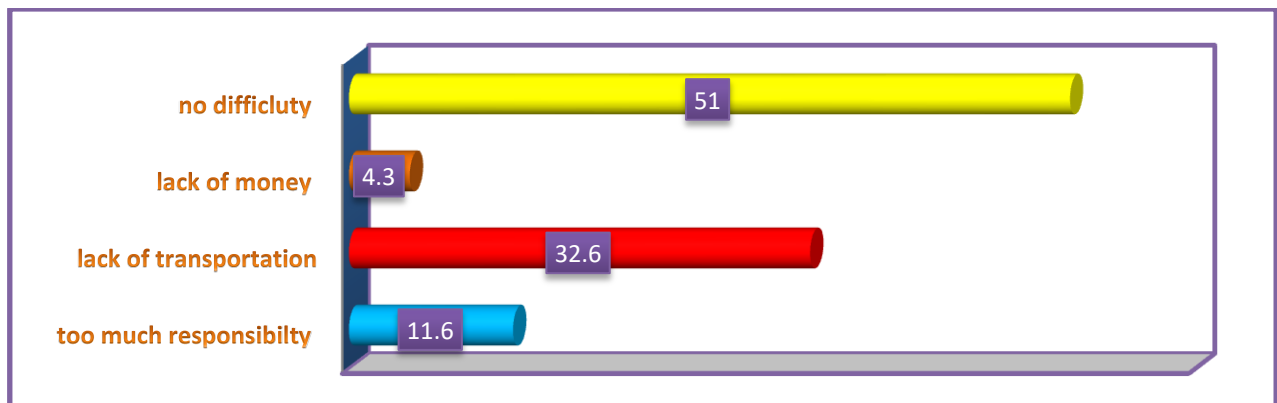
Figure-18 : Difficulty in attending the MCH



Source: Primary data

Figure 18: Indicates that the respondents were asked if it is difficult for them to attend the MCH, 67(49%) responded yes while 71(51%) responded no.

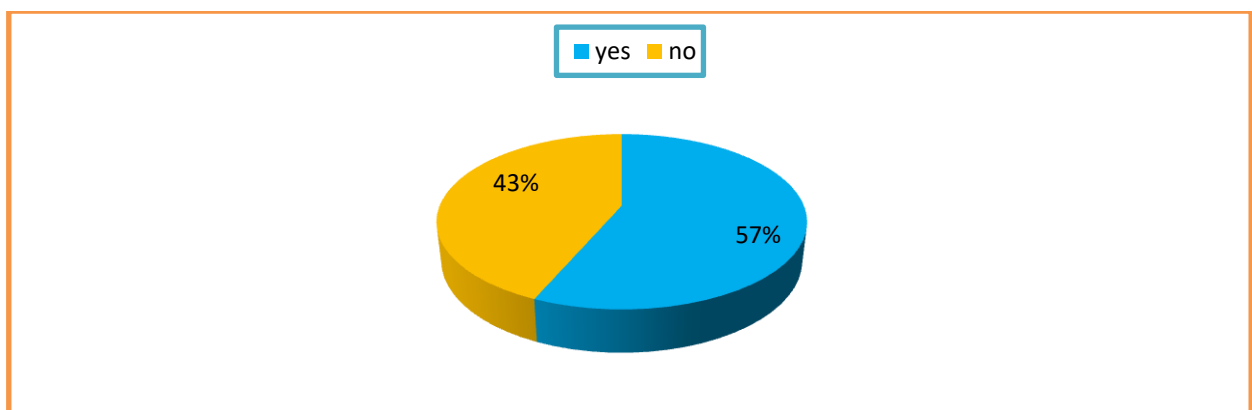
Figure-19: Reasons why it's difficult to attend the MCH



Source: Primary data

Figure 19: Indicates that out of 67(48.6%) who had difficulty in attending the MCH stated their reason which, 16(11.6%) was due to too much responsibility, 45(32.6%) was due to lack of transportation while 6(4.3%) was due to lack of money. While the 51% indicates those who have not had any difficulty in attending the MCH.

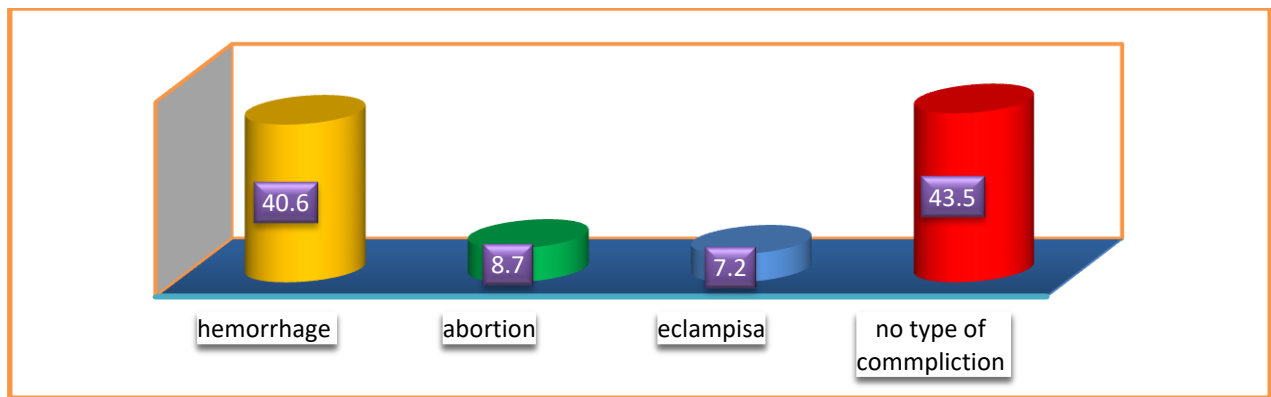
Figure-20: Complications for not seeking health service



Source: Primary data

Figure 20: Indicates if the respondent had a complication for not seeking health service or not, 78(57%) had a complication while 60(43%) had no complication.

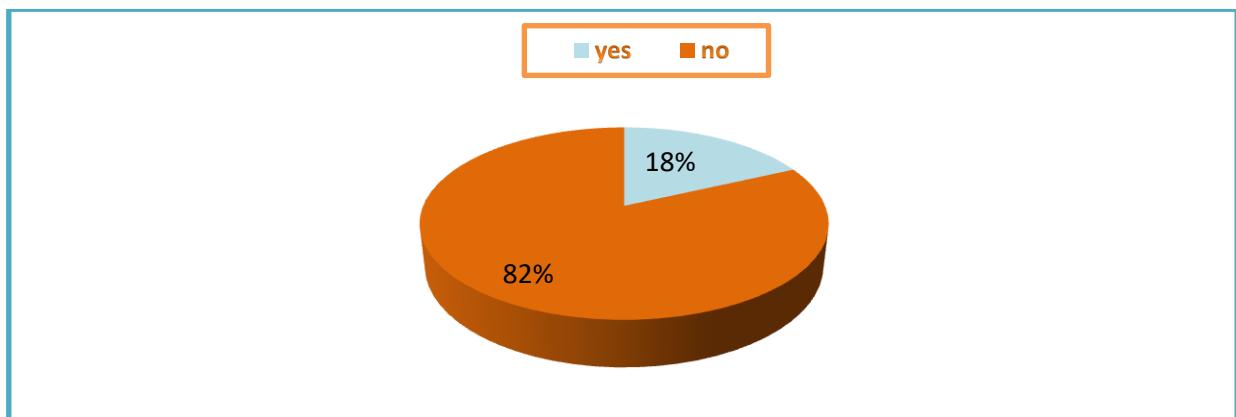
Figure-21: Type of complication for not seeking health service



Source: Primary data

Figure 21: Indicates that out of 78(57%) who had complication stated their type of complication which, 56(40.6%) had hemorrhage, 12(8.7%) had abortion while 10(7.2%) had eclampsia. While the other 60(43.5 %) were those respondent who had no complication.

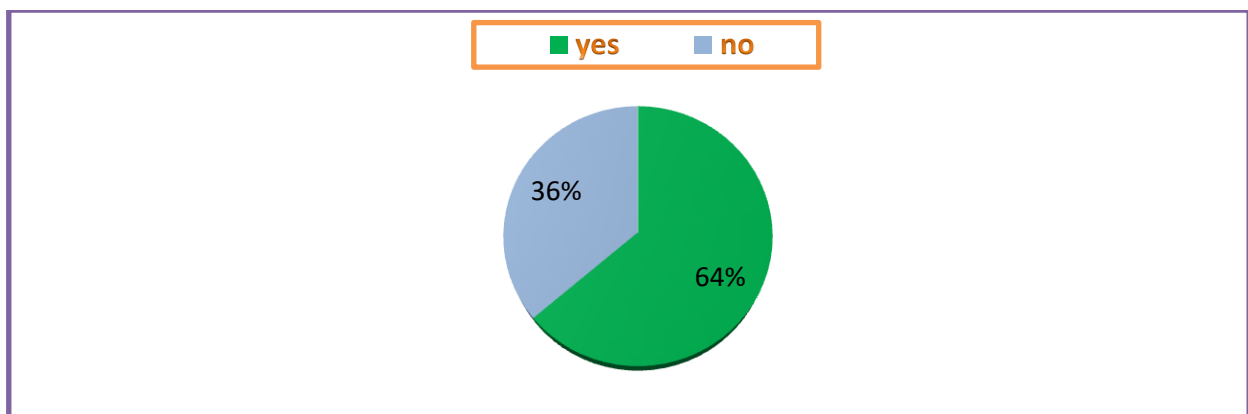
Figure-22: Do people discourage pregnant woman to attend the MCH



Source: Primary data

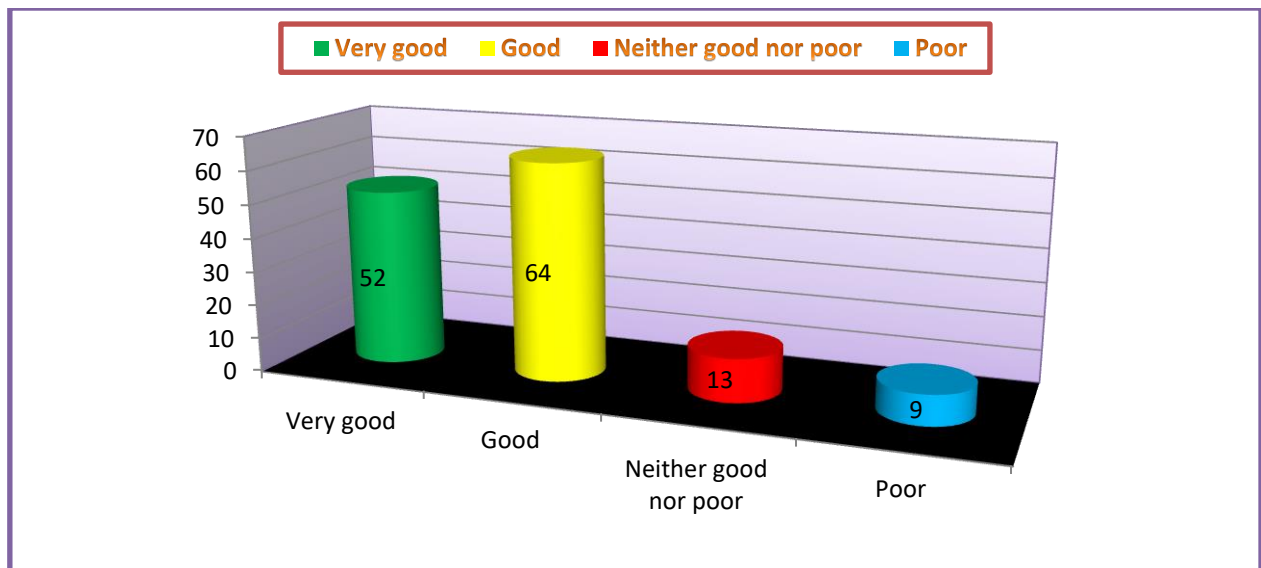
Figure 22: Indicates that the respondent was asked whether the people in their locality discourage to attend to the MCH, 25(18%) responded yes while 113(82%) responded no.

Figure-23 Experience or witness having complication by giving birth at home



Source: Primary data

Figure.23 Indicates that the respondent were asked if they ever experienced or witness on having complication by giving birth at home, 88(64%) responded yes while 50(36%) responded no.

Figure-24 : Respondent rate on ANC service

Source: primary data

Figure 24: Indicates that the resident rate on ANC service showed that 62(46%) said it was good, 52(38%) rated very good, 13(9%) rated neither good nor poor while 9(7%) rated poor.

5. DISCUSSION

5.0 INTRODUCTION

This chapter looks at the discussion conclusions drawn from data analysis and results in the study and forward recommendation. A cross Sectional Descriptive study design was conducted to assess antenatal care service availability and accessibility in three main MCH, Hargeisa-Somaliland.

5.1. DISCUSSIONS

This study shows that (31%) of ANC attendees age were 20-25 while 54% of them were illiterate and 79% were married.

While another study done in south Sudan showed that, (72%) were aged between 20–34 years; nearly all of the women (90%) were illiterate while 77% were currently married. ^[44]

This study showed that majority 56% of the respondents had low income while another study conducted in Ethiopia in Ari Woreda, South Omo Zone were 280 interviewees stated that 65.6% had low income. ^[45]

This is because of lack education in which 31% of the respondents are unemployed which makes them economically low leaving the quality of health service to lack accesses.

This study showed that the respondents have late antenatal checkup and mostly majority, 70% of them did not plan where they were going to deliver while 41% of them had late antenatal checkup.

While another study conducted in Mekelle City, Northern Ethiopia shows that 4.7% not planed their delivery while 67.3% of women who attend the health survive had late antenatal check-up.

This study also shows that about 24% of the respondent deliver their past pregnancies at home, out of them, 13% of them delivered at home because of lack of money while 2.2% are due to lack of transportation, and 2.9% are due to no partner help.

While study conducted in Kenya on December 2002. Of the 730 women (83%) delivered outside of a health facility. Of these, 80% delivered in their own house, 18% in the house of a TBA and 3% on their way to a health facility. The most frequent reason for not attending a health facility for delivery was lack of means of transport, in particular at night (49%). Other important barriers were fast progression of labor (47%), and expense (28%). ^[48]

This study showed that 57% of them had complication for not seeking the health service which 40.6% had hemorrhage, 8.7% had abortion while 7.2% had eclampsia.

While another study conducted in Hospital in Uganda showed that the leading cause followed by post-partum hemorrhage (21.6 %). The abortion complications included post-abortion septic shock and hemorrhage and these constituted 10.8 % while hypertensive disorders contributed 14.4 %. Majority of the mothers with hypertensive disorders had eclampsia and pre-eclampsia. ^[49]

6. CONCLUSIONS

In this study it showed that 54% of the antenatal care attendee's participants were illiterate, 31% of them were age group between 20-25 in which 79% of them were currently married. Also 56 % of the participant had average low income. Lack of knowledge and low income had effect on the usage of health service in which the study shows that 41% of the respondent had their first antenatal check-up during the time of their delivery.

This study showed that 70% of the participants have not planned their place of delivery also 44% of them did not think they need antenatal check-up without complication. This study showed that lack of knowledge cause to delay antenatal care.

Also the study showed that 24% of the participants delivered their past pregnancies at home and about 13% of the 24% reasons for delivering at home were due to lack of money also there were other reasons for delivering such as transportation 2% and 3% lack of support of partner respectively.

This study shows that 57% of the respondent had complication for not seeking the health service. 40.6% had hemorrhage for not seeking health care while 8.7% had abortion and 7.2% had eclampsia. this because of the lack of knowledge women have regarding antenatal care and the barrier women face to seek health service which 49% have difficulty in attending the MCH which 32.6% of them had difficulty because of lack transportation

7. POLICY RECOMENDATIONS

Based on the study result we recommended the following measurements to resolve the problem of the research.

- The government should make free of payment for those women who cannot afford to use the MCH.
- The Ministry of health should train the traditional birth attendance since some of the woman in the study still delivered their past pregnancies.
- The ministry of education should offer an educational program opportunity for the illiterate women.
- The health workers should educate on the conscious of home delivery and the complication a women face without medical assistance.
- The health care workers should also inform pregnant women about the advantage of antenatal care and its benefits.
- The health workers should educate pregnancy women about healthy eating and keeping physically active during pregnancy to stay healthy and to prevent excessive weight gain during pregnancy.
- Prominent International/LNGOs which are in engaged in health sector should advocate for the fund raising to the allocation of the required drugs, supplies and other facilities required by the health centers,
- Experienced LNGOs should transfer their knowledge and skills to the health staff and provide on job training and other capacity building needs.
- The community should support pregnant women and encourage them to seek health service.
- The community should be educated on the care of pregnant women and the complication they could face without medical assistance.

ACKNOWLEDGMENT

Firstly, In the name of Allah, the Most Gracious and the Most Merciful Alhamdulillah, all praises due to Allah for the strengths and His blessing in completing this thesis. And again praise is to Allah who gives us the ability and power to complete this Achievement efficiently and successfully. Without Allah nothing would have been possible.

Second, we will like to send our deep gratitude to our parents for their untiring efforts, their wonderful encouragement, support and motivation from the beginning of our education to where we are today and we are so grateful for what they have done for us.

Thirdly, our appreciation goes to our Supervisor, **Sa'ad Ahmed Abdiwali**, for his supervision and continuous support. His priceless help supervision on the comments and suggestions throughout our field in thesis, which his works have contributed to the success of this research.

Likewise would like to state our appreciation to our lecturers for their great encouragement and self-motivated lessons they thought us also we like to send our acknowledgment to all the managerial persons and office staffs of Gollis University for their co-operations.

Lastly we will like to sincerely thanks to all respondents in the MCH'S for their kindness and great support during our study. Not forgotten all our class friends for their kindness and moral support during our study. Thanks for the friendship and memories.

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