

Original Research Article

Perceptions of pregnancy, labour, and post-partum difficulties related with the adoption of focused antenatal care services among women of reproductive age in Sirisia Sub-County, Bungoma County, Kenya

Tobias Makunja^{1*}, John Kariuki², Taratisio Ndwiga³

¹Department of Community, Epidemiology and Biostatistics, Mount Kenya University (MKU), Thika, Kenya

²School of Public Health, Mount Kenya University (MKU), Thika, Kenya

³Department of Public Health, South Eastern Kenya University (SEKU), Kitui County, Kenya

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*Correspondence:

Tobias Makunja,

E-mail: tobymakunja@gmail.com

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ABSTRACT

Background: Focused antenatal care (FANC) adoption is significantly influenced by women's perceptions of pregnancy, labour, and post-partum difficulties. Cultural beliefs, personal experiences, and social norms shape these perceptions, affecting whether women seek FANC services. Fear of medical procedures and privacy concerns also deter FANC adoption. These perceptions contribute to FANC underutilization, potentially compromising maternal and neonatal health outcomes.

Methods: Analytical cross-sectional study design was used and 323 participants in the selected wards in Sirisia subcounty, Bungoma County, Kenya. Data was collected using interviewer administered structured questionnaire, and focus group discussion. Quantitative data analysis was conducted using statistical package for the social sciences (SPSS) version 29.0 and involved univariate and bivariate analysis. Bivariate analysis was done through logistic regression was used to test the significance of the association between the dependent and independent variables ($p < 0.05$). Qualitative data was analyzed by thematic content analysis.

Results: More than half 183 (56.7%) had initial prenatal care attendance between 4-6 months and 17 (5.3%) between 7-9 months. Further, 202 (62.5%) had four or more ANC visits with 5 (1.5%) and 85 (26.3%) had one and three visits respectively. Significant relationships were found between FANC uptake and positive perceptions of well-being ($OR = 5.810$), worry alleviation ($OR = 2.425$), complication reduction ($OR = 5.011$), birth preparedness ($OR = 4.551$), service access ($OR = 3.005$), and risk detection ($OR = 5.847$). Barriers included fatigue (66%), permission requirements (67%), and transportation issues (65%). Factors like clinic distance, terrain, waiting times, and staffing shortages significantly influenced FANC uptake ($p = 0.0001$).

Conclusions: FANC uptake influenced by perceived benefits and demographics. Logistical challenges remain. Recommendations include mobile clinics and community health worker education to improve access and awareness.

Keywords: Pregnancy, Safe child birth, Focused antenatal care, Postnatal care, Skilled birth attendant

INTRODUCTION

The adoption of focused antenatal care (FANC) services among women of reproductive age is significantly influenced by their perceptions of pregnancy, labour, and post-partum difficulties. These perceptions, shaped by cultural beliefs, personal experiences, and social norms,

play a crucial role in determining whether women seek and adhere to FANC services throughout their pregnancy journey. In many communities, pregnancy is viewed as a natural process that doesn't necessarily require medical intervention, leading to a reluctance in accessing antenatal care.¹ This perspective is often reinforced by traditional practices and the advice of elder women who may not have

benefited from modern healthcare during their own pregnancies. Additionally, the fear of medical procedures, misconceptions about the purpose of antenatal visits, and concerns about privacy and confidentiality can deter women from fully embracing FANC services. Labour, often perceived as a test of a woman's strength and endurance, may be approached with a mix of anticipation and anxiety.² Some women may believe that preparing for labour through medical means is unnecessary or even detrimental to their ability to give birth naturally. This can result in a preference for traditional birth attendants over skilled birth attendants in healthcare facilities. Post-partum difficulties, while acknowledged as potential risks, are sometimes underestimated due to a lack of awareness about the range and severity of complications that can occur after childbirth. The perception that post-partum care is less critical than care during pregnancy can lead to neglect of essential follow-up visits and adherence to post-natal recommendations. These perceptions collectively contribute to the underutilization of FANC services, potentially compromising maternal and neonatal health outcomes.³

The majority of maternal deaths (66%) happened in Sub-Saharan Africa, while 99% occurred in low- and middle-income countries, with the majority of them preventable.⁴ Hemorrhage, hypertensive illnesses of pregnancy, and sepsis were the leading causes of these maternal deaths, with indirect causes resulting from the interaction of pre-existing medical problems and pregnancy.⁵ FANC requires pregnant women to attend at least four scheduled ANC consultations and receive all of the WHO-recommended comprehensive packages from experienced healthcare practitioners.⁴ This new approach is based on the quality of services rather than the amount of services provided to pregnant mothers. Focused prenatal care replaced traditional risk evaluations in favor of assisting women in maintaining normal pregnancies.¹ According to latest estimates in Kenya, the maternal mortality ratio is 362 deaths per 100,000 live births, much exceeding the sustainable development goals (SDG) target of less than 70 per 100,000 live births by 2030.⁶ A lack of access to quality maternal health services, including as antenatal, delivery, and postnatal care, contributes to the problem of high maternal mortality.⁷

Effective utilization of FANC services can enhance mother health. The call to adopt a prenatal care paradigm known as FANC arose from a desire to improve the inadequate implementation of traditional ANC in underdeveloped nations. FANC is complete, tailored care for a pregnant woman that focuses on her overall health, birth preparation, and problem prevention.⁸ More resources injected into the health system are expected to improve healthcare service delivery, resulting in increased uptake. A well-functioning health system provides healthcare services that fulfil minimal quality standards and ensure population adoption.⁹ Strengthening healthcare service delivery is essential to realize SDG #3, including interventions to reduce maternal-child mortality.¹⁰

METHODS

This was an analytical cross-sectional design using both quantitative methods (issuing interviewer-administered questionnaires to women of reproductive age who gave birth in the last two years in Sirisia Sub-County) and qualitative methods (use of focus group discussion from the selected women groups in order to create a diverse group in terms of age, domicile, and education levels) from selected household with the data collection done between May 2024 to June 2024 after ethical approval from MKU, permit from National Council of Science and Technology (NACOSTI) and permission from Bungoma County's Ministry of Health. Systematic random sampling method was used among 323 respondents from Namwela and Malakisi/South Kulisiru wards. The study included women of reproductive age in Sirisia Sub-County within two years of post-delivery who consent to participate in the study or whose guardians' consent to their participation. Further, it excluded women of reproductive age in Sirisia Sub-County who did not consent to participate in the study or whose guardians did not consent, mothers whose pregnancy was classed as high risk, necessitating additional antenatal follow-up, and those who were more than two years post-delivery were also excluded from the study. Interviewer-administered structured questionnaires were used to collect quantitative data while focus group discussion guide was used to collect qualitative. Quantitative data was analyzed using statistical package for social science (SPSS) version 29.0. Descriptive data was presented using frequencies, percentages, means and standard deviation while inferential statistics used Chi-square test to measure association between independent and dependent variables. P values less than 0.05 were considered statistically significant.

RESULTS

Socio-demographic characteristics of study respondents

Out of 323 respondents, 103 (31.9%) were between 21-30 years, 60 (18.6%) were 20 years and below, and 63 (19.5%) were 41 years and above. More than half 185 (57.3%) and 276 (85.4%) were in marital union (Table 1). Approximately 4% of respondents had no formal education with most 185 (57.3%) had secondary level of education and 77 (23.8%) had tertiary level of education. Most of respondents 112 (34.7%) were self-employed with 67 (20.7%) being formally employed and 80 (24.8%) were unemployed (Table 1).

Initial attendance of prenatal clinic

More than half 183 (56.7%) had initial prenatal care attendance between 4-6 months and 17 (5.3%) between 7-9 months (Figure 1).

ANC booklet is one other facilitating factor for women to visit the clinic, during the first and second trimesters and to some still during the last trimester.

“When I go to the clinic, I get a book (ANC booklet) which is required for me to have before delivery and for progress of my pregnancy” (FGD 2).

Table 1: Socio-demographic characteristics of study respondents.

Characteristics	Frequency	Percent
Age group (years)		
11-20	60	18.6
21-30	103	31.9
31-40	97	30.0
41-50	63	19.5
Marital status		
Single	111	34.4
Married	185	57.3
Divorced/separated	20	6.2
Widowed	7	2.2
Religious affiliation		
Christian	276	85.4
Muslim	35	10.8
Traditional beliefs	12	3.7
Level of education		
No formal education	14	4.3
Primary	47	14.6
Secondary	185	57.3
Tertiary	77	23.8
Employment status		
Self-employed	112	34.7
Employed	67	20.7
Casual labourer	64	19.8
Unemployed	80	24.8

Frequency of focused antenatal care visits

Almost two third of respondents 202 (62.5%) had four or more ANC visits with 5 (1.5%) and 85 (26.3%) had one and three visits respectively (Figure 2). The timing of the initial FANC visit ultimately affects the actual number of FANC visit by pregnant women. Pregnant women who complete the four FANC visit are mostly the ones who start their FANC visit in the first trimester.

“I was only able to go to the hospital two times to have my baby checked by the doctor because I delivered before the next visit that I had been told to come back” (FGD 8).

Perceptions of pregnancy, labour and post-partum complications in women

Perceived susceptibility

Most of respondents 103 (67.3%), 75 (64.1%), 99 (65.6%) disagreed that they are likely to encounter challenges related to pregnancy, it is likely that they will encounter challenges related to childbirth and the postpartum period, and they had a good chance of having pregnancy-related issues utilized FANC services respectively. Further, 60

(61.9%), 145 (64.4%), and 103 (60.9%) agreed that they had a higher likelihood than the average woman of experiencing adverse pregnancy outcomes, feel confident in my health and believe unlikely to experience any pregnancy, delivery, or postpartum complications, and worry that they might have problems during pregnancy, during delivery, or after delivery if they don't receive FANC services utilized FANC services. However, these variables were not significantly associated with uptake of FANC services (Table 2).

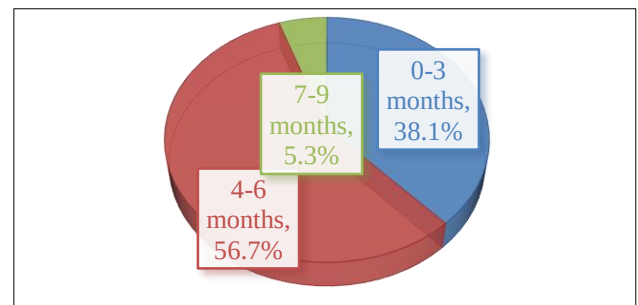


Figure 1: Initial attendance of prenatal clinic.

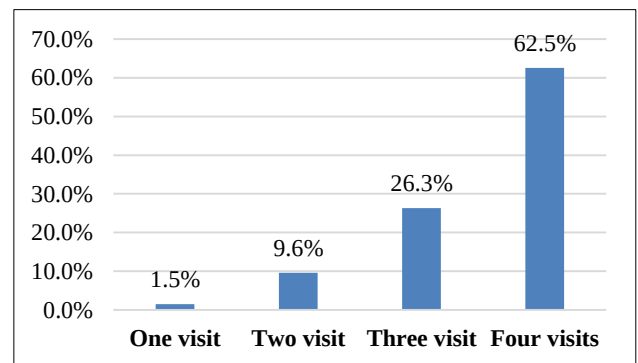


Figure 2: Frequency of focused antenatal care visits.

Perceived severity

Most of respondents utilized recommended four FANC services were neutral that challenges they might face during pregnancy and delivery would have long-lasting effects 25 (65.8%) and fear the pregnancy would not progress to full term 50 (71.4%). Additionally, 130 (64.7%), 64 (67.4%), and 161 (65.2%) of respondents disagreed that pregnancy complications could strain their relationship with their partner, pregnancy-related issues could result in permanent life changes, and scared of their baby would not survive the pressure that comes with labour and delivery utilized recommended four FANC services respectively. However, these variables were not significantly associated with uptake of FANC services (Table 3).

Perceived benefits

The uptake of recommended FANC services was higher 146 (62.7%) among respondents who agreed that there is a

sense of well-being experienced when attending FANC, further analysis showed that likelihood was 5.8 times likely to utilize recommended FANC services.

Likewise, respondents agreed FANC visits alleviates worries about pregnancy and its outcome, completing FANC visits reduces risk of pregnancy-related complications, completing FANC visits allows to learn about individual birth preparedness and reduces the likelihood of delaying seeking care during labor, completing my FANC visits enables me to access a wide range of services (such as PMTCT, TTV immunizations, iron and vitamin A supplementation, SP, ITNs, and hookworm treatment) for a favourable pregnancy outcome, and attending FANC clinic enhances the chances of early detection of risk conditions associated with pregnancy were 2.4, 5.0, 4.6, 3.0, and 5.8 times more likely to utilize the recommended FANC services.

There was a significant relationship between agreeing there is a sense of well-being experienced when attending FANC (OR=5.810; 95% CI=1.921-36.674; $p=0.017$), FANC visits alleviates worries about pregnancy and its outcome (OR=2.425; 95% CI=1.165-9.623; $p=0.041$), completing FANC visits reduces risk of pregnancy-related complications (OR=5.011; 95% CI=2.001-10.210; $p=0.003$), completing FANC visits allows to learn about individual birth preparedness and reduces the likelihood of delaying seeking care during labor (OR=4.551; 95% CI=2.345-10.170; $p=0.015$), completing my FANC visits enables me to access a wide range of services (such as PMTCT, TTV immunizations, iron and vitamin A supplementation, SP, ITNs, and hookworm treatment) for a favourable pregnancy outcome (OR=3.005; 95% CI=0.944-8.033; $p=0.033$), and attending FANC clinic enhances the chances of early detection of risk conditions associated with pregnancy (OR=5.847; 95% CI=3.421-12.658; $p=0.004$) (Table 4).

Typically, the women were ambiguous on the specific ailments they would be checked for, simply mentioning things like 'getting blood tested to determine if they have a sickness' or alluding to a blood examination. Only malaria and HIV were mentioned as illnesses. The women recognized the need of being aware of their HIV status for the purpose of receiving treatment and preventing transmission of the illness to their child. Nevertheless, HIV testing was perceived as an obstacle to seeking medical attention.

"When we go to the clinic, we are happy because our blood is tested so we know our status and this is something good that a TBA would not do" (FGD 3).

Checking the position of the foetus was also a reason to access FANC – although some women acknowledged the TBA also performed this task so would visit them instead. Women reasoned this would determine whether their birth

would be straightforward, or thought that the doctor would then be able to turn a malpresentation around.

"Whether it is the child that is in a bad position, the doctor is there, you will leave that place when you have been helped totally" (FGD 5).

Perceived barriers

All respondents who utilized recommended FANC services disagreed they struggle to make it to FANC clinics 133 (85.3%), considerable distance to the health facility during pregnancy hinders my access to FANC services 97 (78.2%), and the poor terrain makes traveling to the FANC clinic uncomfortable 138 (85.2%). At least 49 (81.7%) and 132 (85.2%) of respondents were neutral that they are uneasy waiting in such a huge line at the FANC clinic and disagreed to skip some of the clinics because of the FANC clinic's staffing shortage respectively. Further, 64 (66.0%), 67 (67.0%), and 160 (65.0%) of respondents agreed that the fatigue from attending every FANC visit is intense, in order to visit the FANC clinic, they must obtain permission first, and when it comes to using FANC services, transportation is an issue respectively.

However, struggle to make it to FANC clinics ($\chi^2=75.212$, $df=2$, $p=0.0001$), the considerable distance to the health facility during pregnancy hinders my access to FANC services ($\chi^2=56.109$, $df=2$, $p=0.0001$), the poor terrain makes traveling to the FANC clinic uncomfortable ($\chi^2=77.610$, $df=2$, $p=0.0001$), being uneasy in waiting in such a huge line at the FANC clinic ($\chi^2=14.698$, $df=2$; $p=0.0001$), and skipping some of the clinics because of the FANC clinic's staffing shortage ($\chi^2=69.812$, $df=2$; $p=0.0001$) were influencing the uptake of FANC services (Table 5).

Many of the women in the various groups identified four primary obstacles to attending a health facility for FANC. These were HIV testing, attitudes of clinic personnel, which were associated with another barrier, long clinic waiting times, and cost. Participants also discussed the dread of others (rather than their own) of discovering their HIV status, despite the fact that some women considered it significant to be aware of their status. This appeared to be partially due to an apprehension of not wanting to disclose their HIV status or having others discover it.

"And there are some people who if they hear about VCT they would rather die even if they are positive. They would die without taking the drugs" (FGD 2).

"If you tell her that you have given birth to eight kids, she would quarrel you and ask you if you still intend to give birth to more children. And maybe some of the children that she is talking about some had died. So, you come from the clinic upset" (FGD 7).

Table 2: Perceived susceptibility.

Variables	FANC (%)		Statistics
	Four visits	<Four visits	
Encounter challenges related to pregnancy			
Agree	66 (58.4)	47 (41.6)	$\chi^2=2.841$, df=2, p=0.242
Neutral	33 (57.9)	24 (42.1)	
Disagree	103 (67.3)	50 (32.7)	
Anxious about-facing challenges during pregnancy			
Agree	117 (60.3)	77 (39.7)	$\chi^2=1.178$, df=2, p=0.555
Neutral	26 (68.4)	12 (31.6)	
Disagree	59 (64.8)	32 (35.2)	
Encounter challenges related to childbirth and the postpartum period			
Agree	69 (63.9)	39 (36.1)	$\chi^2=0.677$, df=2, p=0.713
Neutral	58 (59.2)	40 (40.8)	
Disagree	75 (64.1)	42 (35.9)	
Good chance of having pregnancy-related issues			
Agree	60 (60.0)	40 (40.0)	$\chi^2=1.108$, df=2, p=0.575
Neutral	43 (59.7)	29 (40.3)	
Disagree	99 (65.6)	52 (34.4)	
Higher likelihood of experiencing adverse pregnancy outcomes			
Agree	60 (61.9)	37 (38.1)	$\chi^2=2.204$, df=2, p=0.332
Neutral	47 (70.1)	20 (29.9)	
Disagree	95 (59.7)	64 (40.3)	
Feel confident in health even without FANC			
Agree	145 (64.4)	80 (35.6)	$\chi^2=1.589$, df=2, p=0.452
Neutral	31 (55.4)	25 (44.6)	
Disagree	26 (61.9)	16 (38.1)	
Worry of pregnancy outcome or after delivery without FANC			
Agree	103 (60.9)	66 (39.1)	$\chi^2=0.552$, df=2, p=0.759
Neutral	32 (66.7)	16 (33.3)	
Disagree	67 (63.2)	39 (36.8)	

Table 3: Perceived severity.

Variables	FANC (%)		Statistics
	Four visits	<Four visits	
Challenges in pregnancy and delivery have long-lasting effects			
Agree	151 (62.7)	90 (37.3)	$\chi^2=0.396$, df=2, p=0.820
Neutral	25 (65.8)	13 (34.2)	
Disagree	26 (59.1)	18 (40.9)	
Pregnancy complications could strain relationship			
Agree	36 (57.1)	27 (42.9)	$\chi^2=1.233$, df=2, p=0.540
Neutral	36 (61.0)	23 (39.0)	
Disagree	130 (64.7)	71 (35.3)	
Pregnancy-related issues could result in permanent life changes			
Agree	84 (60.4)	55 (39.6)	$\chi^2=1.341$, df=2, p=0.511
Neutral	54 (60.7)	35 (39.3)	
Disagree	64 (67.4)	31 (32.6)	
Fear the pregnancy would not progress to full term			
Agree	59 (62.8)	35 (37.2)	$\chi^2=3.476$, df=2, p=0.176
Neutral	50 (71.4)	20 (28.6)	
Disagree	93 (58.5)	66 (41.5)	
Scared baby would not survive the pressure that comes with labour and delivery			
Agree	20 (54.1)	17 (45.9)	$\chi^2=3.432$, df=2,
Neutral	21 (53.8)	18 (46.2)	

Continued.

Variables	FANC (%)		Statistics
	Four visits	<Four visits	
Disagree	161 (65.2)	86 (34.8)	p=0.209
My baby might be born prematurely			
Agree	38 (66.7)	19 (33.3)	$\chi^2=1.250$, df=2, p=0.535
Neutral	24 (55.8)	19 (44.2)	
Disagree	140 (62.8)	83 (37.2)	

Table 4: Perceived benefits.

Variables	FANC (%)		OR	95% CI		P value
	Four visits	<Four visits		Lower bound	Upper bound	
Experience a sense of well-being at FANC						
Agree	146 (62.7)	87 (37.3)	5.810	1.921	36.674	0.017
Neutral	29 (60.4)	19 (39.6)	1.100	0.047	2.215	0.062
Disagree	27 (64.3)	15 (35.7)	Ref			
FANC clinics enables to monitor the progress of pregnancy						
Agree	166 (61.3)	105 (38.7)	1.272	1.067	1.996	0.067
Neutral	14 (77.8)	4 (22.2)	2.319	2.106	6.959	0.051
Disagree	22 (64.7)	12 (35.3)	Ref			
FANC visits alleviates worries about pregnancy and its outcome						
Agree	102 (66.7)	51 (33.3)	2.425	1.165	9.623	0.041
Neutral	39 (62.9)	23 (37.1)	1.000	0.546	3.857	0.088
Disagree	61 (56.5)	47 (43.5)				
FANC visits reduces risk of pregnancy-related complications						
Agree	123 (63.4)	71 (36.6)	5.011	2.001	10.210	0.003
Neutral	53 (65.4)	28 (34.6)	2.767	1.490	7.644	0.037
Disagree	26 (54.2)	22 (45.8)	Ref			
FANC reduces the likelihood of delaying seeking care during labor						
Agree	139 (64.4)	77 (35.6)	4.551	2.345	10.170	0.015
Neutral	33 (56.9)	25 (43.1)	1.994	0.300	3.261	0.045
Disagree	30 (61.2)	19 (38.8)	Ref			
FANC visits enables favourable pregnancy outcome						
Agree	179 (63.5)	103 (36.5)	3.005	0.944	8.033	0.033
Neutral	11 (47.8)	12 (52.2)	1.776	1.052	4.230	0.049
Disagree	12 (66.7)	6 (33.3)	Ref			
FANC clinic enhances early detection of risk conditions associated with pregnancy						
Agree	129 (60)	86 (40)	5.847	3.421	12.658	0.004
Neutral	30 (66.7)	15 (33.3)	2.369	1.109	5.866	0.028
Disagree	43 (68.3)	20 (31.7)	Ref			

Table 5: Perceived barriers.

Variables	FANC (%)		Statistics
	Four visits	<Four visits	
Struggle to make it to FANC clinics			
Agree	48 (35.8)	86 (64.2)	$\chi^2=75.212$, df=2, p=0.0001
Neutral	21 (63.6)	12 (36.4)	
Disagree	133 (85.3)	23 (14.7)	
Interacting with doctors and nurses at the FANC clinic unsettles me			
Agree	73 (60.8)	47 (39.2)	$\chi^2=0.712$; df=2, p=0.700
Neutral	57 (66.3)	29 (33.7)	
Disagree	72 (61.5)	45 (38.5)	
Distance to the health facility during pregnancy hinders access to FANC services			
Agree	33 (32.7)	68 (67.3)	$\gamma^2=56.109$, df=2,

Continued.

Variables	FANC (%)		Statistics
	Four visits	<Four visits	
Neutral	71 (73.2)	26 (26.8)	p=0.0001
Disagree	97 (78.2)	27 (21.8)	
Poor terrain makes traveling to the FANC clinic uncomfortable			
Agree	46 (35.1)	85 (64.9)	$\chi^2=77.610$, df=2, p=0.0001
Neutral	17 (58.6)	12 (41.4)	
Disagree	138 (85.2)	24 (14.8)	
Awkward to get examination by male workers at the FANC facility			
Agree	71 (62.3)	43 (37.7)	$\chi^2=1.454$, df=2, p=0.483
Neutral	65 (67.0)	32 (33.0)	
Disagree	66 (58.9)	46 (41.1)	
The fatigue from attending every FANC visit is intense			
Agree	64 (66.0)	33 (34.0)	$\chi^2=2.633$, df=2, p=0.268
Neutral	71 (65.7)	37 (34.3)	
Disagree	67 (56.8)	51 (43.2)	
Obtain permission to visits FANC			
Agree	67 (67.0)	33 (33.0)	$\chi^2=1.600$; df=2, p=0.449
Neutral	70 (62.5)	42 (37.5)	
Disagree	65 (58.6)	46 (41.4)	
Transportation is an issue to visit FANC			
Agree	160 (65.0)	86 (35.0)	$\chi^2=2.984$, df=2, p=0.225
Neutral	17 (51.5)	16 (48.5)	
Disagree	25 (56.8)	19 (43.2)	
Main obstacles to obtaining FANC services is money			
Agree	134 (62.6)	80 (37.4)	$\chi^2=1.937$, df=2, p=0.380
Neutral	24 (54.5)	20 (45.5)	
Disagree	44 (67.7)	21 (32.3)	
Lack of privacy in the FANC clinic			
Agree	55 (56.1)	43 (43.9)	$\chi^2=4.085$, df=2, p=0.130
Neutral	64 (61.0)	41 (39.0)	
Disagree	83 (69.2)	37 (30.8)	
Uneasy waiting in such a huge line at the FANC clinic			
Agree	91 (54.2)	77 (45.8)	$\chi^2=14.698$, df=2, p=0.0001
Neutral	49 (81.7)	11 (18.3)	
Disagree	62 (65.3)	33 (34.7)	
Skip some of the clinics because of the FANC clinic's staffing shortage			
Agree	48 (37.2)	81 (62.8)	$\chi^2=69.812$, df=2, p=0.0001
Neutral	22 (56.4)	17 (43.6)	
Disagree	132 (85.2)	23 (14.8)	

DISCUSSION

The study found that most of respondents utilized recommended four FANC services were neutral that challenges they might face during pregnancy and delivery would have long-lasting effects 25 (65.8%) and fear the pregnancy would not progress to full term 50 (71.4%). Similarly, studies by Konlan et al, Ngowi et al, and Nwabueze et al have recorded similar results regarding the fear of pregnancy complications, fear of survival of the infant and prematurity with a heightened recognition of the significance of ANC among women.^{5,11,12}

The uptake of recommended FANC services was higher 146 (62.7%) among respondents who agreed that there is a

sense of well-being experienced when attending FANC, further analysis showed that likelihood was 5.8 times likely to utilize recommended FANC services. Likewise, respondents agreed FANC visits alleviates worries about pregnancy and its outcome, completing FANC visits reduces risk of pregnancy-related complications, completing FANC visits allows to learn about individual birth preparedness and reduces the likelihood of delaying seeking care during labor, completing my FANC visits enables me to access a wide range of services (such as PMTCT, TTV immunizations, iron and vitamin A supplementation, SP, ITNs, and hookworm treatment) for a favourable pregnancy outcome, and attending FANC clinic enhances the chances of early detection of risk conditions associated with pregnancy were 2.4, 5.0, 4.6, 3.0, and 5.8 times more likely to utilize the recommended

FANC services. This aligns with findings from Konje et al, who reported that positive experiences during antenatal care visits significantly increased the likelihood of continued attendance.¹³ Their study in Uganda showed that women who reported feeling respected and cared for during FANC visits were 4.2 times more likely to complete the recommended number of visits. A study by Ngowi et al in Tanzania, which found that women who perceived FANC as a means to reduce anxiety about pregnancy were 2.7 times more likely to attend all recommended visits, a research by Owusu et al in Nigeria, where women who participated in birth preparedness counselling during FANC were 3.8 times more likely to deliver in a health facility.^{3,11}

All respondents who utilized recommended FANC services disagreed they struggle to make it to FANC clinics 133 (85.3%), considerable distance to the health facility during pregnancy hinders my access to FANC services 97 (78.2%), and the poor terrain makes traveling to the FANC clinic uncomfortable 138 (85.2%). At least 49 (81.7%) and 132 (85.2%) of respondents were neutral that they are uneasy waiting in such a huge line at the FANC clinic and disagreed to skip some of the clinics because of the FANC clinic's staffing shortage respectively. Further, 64 (66.0%), 67 (67.0%), and 160 (65.0%) of respondents agreed that the fatigue from attending every FANC visit is intense, in order to visit the FANC clinic, they must obtain permission first, and when it comes to using FANC services, transportation is an issue respectively.

This contrasts with findings by Owusu et al in Nigeria, where 62% of women cited distance as a major obstacle to FANC utilization.³ The current study's results suggest potentially better infrastructure or transportation systems in the study area. However, 65% of respondents still identified transportation as an issue, aligning more closely with Ngowi et al, who found transportation challenges affected 58% of pregnant women in rural Tanzania.¹¹ The high percentage (85.2%) disagreeing that staffing shortages cause them to skip clinics is encouraging and differs from Konje et al, who reported staffing issues deterred 45% of women from FANC visits in Uganda.¹³ The fatigue associated with FANC visits, agreed upon by 66% of respondents, echoes findings by Muthingu et al where 61% of women across multiple African countries reported visit-related fatigue as a barrier.⁷

These comparisons suggest that while some common barriers persist, the study population may benefit from certain facilitating factors or interventions that have mitigated some typical obstacles to FANC access. Further research could explore these potential facilitators to inform strategies for improving FANC utilization in other contexts.

Limitations

The study was limited to the selected wards in Sirisia subcounty, due to socio-cultural attitudes, some

community members were hesitant to share and disclose sensitive information about their reproductive health difficulties. To address this constraint, the researcher reassured the respondents that the information they contribute were kept confidential and used only for the purposes of the study. Their identity was not revealed to any other party. Time was limited especially taking into consideration the whole process from proposal, data collection, analysis and production of the final report; and the fact that the researcher was also an employee and needed to deliver at work too. Also, the researcher was faced with some difficulties in meeting the costs related to the study especially printing and stationers as well transport costs and lunch allowance to the supporters/assistants considering that the researcher was a self-sponsored student.

CONCLUSION

It can be concluded from this study that 68.7% of pregnant women had ANC visits between 0-16 weeks, with 62.5% having four or more visits. WHO recommended four FANC services usage decreased with age, but was higher among married, Christian, formally employed, and those with 1-2 births. Further, marital status and level of education were significantly associated with uptake of FANC services. The study reveals that while various factors related to perceived benefits and experiences with FANC services significantly influence their uptake, logistical challenges such as travel distance, poor terrain, and staffing shortages also play a critical role in affecting whether individuals utilize these services. Respondents who recognize the benefits of FANC services, such as enhanced well-being, reduced pregnancy-related worries, and access to a range of services, are more likely to utilize them.

However, practical barriers like travel difficulties and clinic-related issues remain significant obstacles to accessing FANC services. The governments and relevant NGOs should try to come up with mobile clinics to offer FANC services to far places where they are not easily accessible, therefore, the Ministry of Health should equip the community health workers with relevant information to create awareness on importance of ANC services in reducing pregnancy related deaths in the districts.

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