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ASSESSMENT OF KNOWLEDGE, ATTITUDE AND PRACTICE TOWARDS ANC SERVICES AMONG REPRODUCTIVE AGE GROUP WOMEN AT DR KHALID MCH, IN 26 JUNE DISTRICT, HARGEISA-SOMALILAND

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ABSTRACT: Background: Antenatal care is the health care services given to a mother during Pregnancy, also known as prenatal care, is the complex of interventions that a pregnant woman receives from organized health care services. In short it is the care that a woman receives during pregnancy that helps to ensure healthy outcomes for women and new-born.
Objective: The overall objective of the study to assess the knowledge, attitude and practice to ward antenatal care services among reproductive age Group women at Dr Khalid MCH, in 26 June district, Hargeisa-Somaliland.
Methods: This research is based on Descriptive cross-sectional research design that identifies the knowledge, attitude and practice toward antenatal care services among reproductive age group women at Dr Khalid MCH, in 26 June district Hargeisa Somaliland. A sampling technique of the study was simple random sampling and its easy method, therefore the households was selected by probability sampling method. The sample size of this study was 112. The questionnaire written English language then we translated into Somali language since most of the population did not know English language.
Result: The analysis of this study revealed that, Majority of mothers 86(66.2%) had Good knowledge about ANC services where 26(20.0%) they had poor knowledge about ANC services. The most of the respondents of 72.3% had positive attitude while 23.4% of the respondents had negative attitude.
Conclusion and recommendation: Majority of mothers 86(66.2%) had Good knowledge about ANC services where 26(20.0%) they had poor knowledge about ANC services. The health care workers should also inform pregnant women about the advantage of antenatal care and its benefits. The pregnant women with relatives and friends as well as ANC providers share the responsibility for a positive development. Community health practitioners, public health educators and social workers should plan appropriate technique to modify the attitude of some pregnant women on the concept of antenatal services.

I. INTRODUCTION

1.1. Background

Antenatal care is the health care services given to a mother during Pregnancy, also known as prenatal care, is the complex of interventions that a pregnant woman receives from organized health care services. In short it is the care that a woman receives during pregnancy that helps to ensure healthy out comes for women and new-born. (1)
ANC is given different meanings by different scholars, among others the meaning that says," Antenatal Care means care before birth and includes education, counselling, screening and treatment to monitor and to promote the well - being of the mother and fetus. (2)
ANC is the key entry point of a pregnant woman to receive broad range of health promotion and preventive services

which promote the health of the mother and health of the baby. (3)
ANC is care provided by skilled health-care professionals to pregnant women and adolescent girls in order to ensure the best health conditions for both mother and baby during pregnancy. The components of ANC include: risk identification; prevention and management of pregnancy- related or concurrent diseases; and health education and health promotion. (3)
ANC reduces maternal and perinatal morbidity and mortality both directly, through detection and treatment of pregnancy-related complications, and indirectly, through the identification of women and girls at increased risk of developing complications during labor and delivery, thus ensuring referral to an appropriate level of care. (3)
It is a key entry point for pregnant women to receive a multiple range of health services such as nutritional support and prevention or treatment of anemia, prevention, detection and treatment of malaria, tuberculosis and sexually transmitted infections. (4)
Antenatal Care is an opportunity to promote the benefits of skilled attendance at birth and to encourage women to seek postpartum care for themselves and their new born. It is also an ideal time to counsel women about the benefits of child spacing. (5)
The main reasons that hinder the use of Antenatal Care are different from Country to Country. But the reason experienced in developing countries are nearly similar such as; hemorrhage, eclampsia, infection, abortion complications, obstructed labor and lack of knowledge and preparedness about reproductive health in the family, community and health provider. (6)
Antenatal Care is the most important method for detecting pregnancy problems in the early period Because Antenatal care is the best mechanism to minimize maternal mortality, and give a good information for pregnant women about their birth and how to prevent related problems. The best and most advantage of Antenatal Care is to protect the health of women's and their infants as well as indicating the danger signals that will be occurred and needs to be further treated by advanced health professionals. (7)
A number of studies indicate that the Antenatal Care utilization rate is still low due to many factors that need to be examined such as socio demographic factors, knowledge of social support. They conclude that eliminating such factors is important to increase the women's participation in Antenatal Care. (8)
Antenatal Care utilization rate is still low due to many factors that need to be examined such as socio demographic factors, knowledge of social support. They conclude that eliminating such factors is important to increase the women's participation in Antenatal Care. (9)
However, Antenatal Care have such attractive benefits and strategies, according to the United Nations (UN) Millennium Development Goals, every year, at least half a million women and girls die as a result of complications during pregnancy, childbirth or the six weeks following delivery. Almost all (99%) of these deaths occur in developing countries. This shows that the Antenatal care activity is very weak in developing country. (9)
Annually, WHO an estimated 529,000 women die every year from complications of pregnancy, childbirth and abortion, 99% of these deaths are from the developing countries , Less than 1% of these deaths occur in more developed countries making maternal mortality the health indicator with the greatest disparity between developed and developing countries. (10)
Seventy percent (70%) of maternal deaths due to five major complications (which are direct obstetric complications): hemorrhage (25%), infection (15%), and complication of unsafe abortion (13%), hypertension (12%), and obstructed labor (8%). This complication can occur at any time during pregnancy and childbirth, often without fore warding and often requiring immediate access to emergency obstetric care for their management. (11)
Antenatal care (ANC) coverage is a success story in Africa, since over two-thirds of pregnant women (69 %) have at least one ANC contact. In sub-Saharan Africa, a number of countries halved their levels of maternal mortality since 1990. (12)
In 2015, 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. (12)
East Africa maternal mortality ratios are among the highest on the continent at 740, 410, and 400 deaths per 100,000 live births in Burundi, Tanzania and Kenya, respectively. (12)
Ethiopia is one of the Sub-Saharan African countries that experience the highest maternal mortality ratios in the world; that is, 673 per 100,000 live births and more than fourteen thousand mothers die as the result of pregnancy and related causes each year. In addition, more than 400,000 suffer long-term disabilities due to complications during pregnancy, delivery, or postpartum periods. The use of ANC, delivery, and postnatal services by Ethiopian women is one of the lowest in the world. (13)
Somalia, women of Somali descent often have the perception that labor is a vulnerable time. Childbirth in Somalia is

often fraught with the risk of maternal or neonatal mortality. The maternal mortality rate is 1,600 per 100,000 live births which contrast to a maternal mortality rate of 12 per 100,000 in the United States. The rates of child morbidity and mortality in Somalia remain among the highest in the world. (14)

Somaliland has one of the worst maternal mortality ratios in the world, estimated to be between 1,500 per 100,000 live births. Life expectancy at birth is between 47 and 57 years. (15)

Somalia is the highest maternal mortality rate and children death rate in the world because of lack of health system since in 1991 when the local government collapsed and this led to collapsed all the social service. However, there is no available data about the antenatal care service. Poverty, low levels of female literacy and lack of female empowerment are factors that correlate strongly to poor ANC outcomes in different countries. (16)

Somaliland has one of the highest maternal mortality ratios in the world at 1,044 deaths per 100, births multiple indicator cluster survey. According to MICS, 2006, only thirty-two percent of women received antenatal care (ANC) from skilled health personnel's Whereas ANC coverage is only 26 %. (17)

When we come to our study aims, to promote access to health care services, the country has faced challenges in increasing health care utilization and the proportion of women who give birth with the assistance of skilled attendants is the lowest in Sub-Saharan Africa.

Also the aims of our study is to prevent or identify and treat conditions that may threaten the health of the fetus or the mother, and to help a woman approach pregnancy and birth as positive experiences.

Quality of ANC has been designated one of the four Pillars of Safe Motherhood, along with clean and safe delivery, essential obstetric care and family planning which could 2 contribute to reduction of maternal mortality.

However, the knowledge about ANC views is still very limited, especially in developing countries. It is necessary to promote a better access of antenatal care in Somaliland.

1.2. Problem statement

Maternal Mortality a Global Tragedy Annually, 600,000 women die of pregnancy related complications, 99% in developing world while 1% in developed countries and every minute one maternal death occur. (18)

Maternal Health Scope of Problem, 180–200 million pregnancies per year, 75million unwanted pregnancies, 50 million induced abortions, 20 million unsafe abortions and 600,000 maternal deaths (1 per minute) while neonatal health scope of problem, 3 million neonatal deaths (first week of life) and 3 million stillbirths death. (19)

Maternal Watch that occurs every Minute, 380 women become pregnant, 190 women face unwanted pregnancy, 110 women experience a pregnancy related complication, 40 women have an unsafe abortion and 1 woman dies from a pregnancy related complication. (19)

The lifetime risk of maternal death, 1 in 8000: The lifetime risk of maternal death in Europe as compared to 1 in 94 in Asia, The sub-Saharan Africa where one in every 13 women dies of pregnancy related causes compared to only one in women in developed countries. (20)

Over a Somali woman's lifetime risk of maternal death, where will face one in every 11 women dies from causes related to pregnancy or childbirth - the highest lifetime maternal death risk in the world. The situation is grim for children, as well: Somalia has the world's fourth highest maternal mortality rate and child mortality rate (21).

the reason priority that we are conducting this research is Somaliland have the highest maternal mortality rate, the mothers that are dying the complications related from pregnancy, at the same time the utilization of ANC service is not very high.

Antenatal Care related problem parameters are very sensitive because it have directly related with maternal morbidity and mortality, and loss of fetus. It is a necessary component of maternal health in order to identify complications. (22)

Therefore the aim of this study is to Assessment knowledge, attitude and practice to ward antenatal care services among reproductive age group women at Dr Khalid MCH, in 26 June district Hargeisa Somaliland.

1.3.0 Objectives of study

1.3.1. General Objective

To assess the knowledge, attitude and practice towards antenatal care services among reproductive age Group women at Dr Khalid MCH, in 26 June district, Hargeisa-Somaliland.

1.3.2. Specific Objectives

- To identify the reproductive age group women's knowledge about antenatal care service.
- To determine reproductive age group women's attitude towards of antenatal care service.
- To assess reproductive age group women's practice about of antenatal care service.

1.4. RESEARCH QUENTIONS

1. What is the knowledge level of their reproductive age group women towards antenatal care?
2. What are attitudes of reproductive age group women towards antenatal care?
3. What is the practice of reproductive age group women towards antenatal care?

1.5. SCOPE OF THE STUDY

Geographical scope: Geographically, the study was select by Dr Khalid MCH 26 June districts Hargeisa Somaliland. The main objective of this study was to review the current assessment of KAP to ward ANC services among reproductive age group and propose to reducing the high maternal mortality ratio of Dr. Khalid MCH 26 June districts, Hargeisa- Somaliland.

Time scope: the period of this study was started on march-06-2019 up to August-16-2019

1.6. JUSTIFICATION FOR THE STUDY

Antenatal care helps prevent complications and inform women about important steps they can take to protect their infant and ensure a healthy pregnancy. Lack of antenatal care service cause high maternal, fetal and neonatal mortality rate but Access to adequate ANC to have a good or safe pregnancy and a healthy baby. This study sought to establish the knowledge, attitude and practice influencing reproductive age women's attendance to antenatal care services among reproductive age group women at Dr Khalid MCH, in 26 June district Hargeisa Somaliland.

1.7. Significance of the study

Having positive attitude and good knowledge is the most valuable precondition for any healthy behavior including ANC service. Different studies have shown that women who had a positive attitude towards ANC had a higher proportion of ANC visits than those with a negative attitude.

Therefore knowing about prevalence of women who has positive attitude and good knowledge and identifying the associated factors in a given society has important contribution in addressing maternal health need of the women.

This study is intended to extract out the knowledge and attitude of pregnant women on the benefits of ANC utilization during antenatal visit. The findings of this study will serve as a reference for giving intervention accordingly by the health care providers and others who concerned; for conducting further researches; the findings of this study will have special importance for health care providers because it will serve as base line for filling gaps of the actual practices on antenatal care. The findings with relevant recommendations will be also submitted to the:

Firstly, **Ministry of Health (MOH**) of Somaliland will benefit from this research because we access antenatal care services of pregnant women in all the Somaliland district.

Secondly, **Health Centers (HC)** will benefit from it to give mothers more health care support for pregnancy mothers and to prevent any kind of complications that women develops.

Thirdly, **Undergraduate Student** that are willing to conduct a research about antenatal care.

Fourthly, **Somaliland Government** in general may benefit the findings of this study and may address effective policies that help and promote ANC and to achieve the gap in Somaliland and also it helps pregnant woman to have a successful delivery and healthy baby.

Fifthly, **Nongovernmental Organization** (**NGO)** which helps to know the benefit the findings of this study especially those focus to prevent maternal mortality, still birth and other pregnancy related morbidity and complication because they always support health community.

Sixthly, **Local community** in Somaliland may also benefit the findings of this study and they will know the advantage of ANC on mothers and babies as well as health benefits of ANC.

II. LITERATURE REVIEW

2.1. Introduction

Antenatal care is a medical and general care that is provided to pregnant women during pregnancy. It is goal oriented provided with the aim of meeting both psychological and medical needs of pregnant women within the context of health care delivery system, culture and religion in which the women live. It is based on local situation and addresses risk assessment, health promotion and care provision. It has been found to be effective in the treatment of anemia, hypertension and sexually transmitted diseases. (23)

Pregnancy and child birth is a natural process which in most cases comes to good end even without any intervention; however in a relatively high proportion of pregnancies there are complications. (24)

To combat the major maternal health problem and tackle unwanted outcomes of pregnancy, ANC is the only and most important method in detecting and treating pregnancy problems in its earliest period. ANC is a critical element for reducing maternal mortality, and for providing pregnant women with a broad range of health promotion and preventive health services. One of the most important functions of ANC is to offer health information and services that can significantly improve the health of women and their infants. ANC is also an opportunity to inform women about the danger signs and symptoms for which immediate assistance should be sought from a health care provide.

ANC is an important determinant of safe delivery. Although certain obstetric emergencies cannot be predicted through antenatal screening, women can be educated to recognize and act on symptoms leading to potentially serious conditions (25).

ANC coverage is a success story in Africa, since over two-thirds of pregnant women 69% have at least one ANC contact. However, to achieve the full life-saving potential that ANC promises for women and babies, four visits providing essential evidence based interventions – a package often called focused antenatal care – are required. Essential interventions in ANC include identification and management of obstetric complications such as preeclampsia, tetanus toxoid immunization, intermittent preventive treatment for malaria during pregnancy, and identification and management of infections including HIV, syphilis and other STIs .(26)

2.2. Problem Related to Antenatal care services

Good care during pregnancy is important for the health of the mother and the development of the unborn baby. Pregnancy is a crucial time to promote healthy behaviours and parenting skills. Good ANC links the woman and her family with the formal health system, increases the chance of using a skilled attendant at birth and contributes to good health through the life cycle. Inadequate care during this time breaks a critical link in the continuum of care, and affects both women and babies. (27)

Effects on mothers: It has been estimated that 25 percent of maternal deaths occur during pregnancy, with variability between countries depending on the prevalence of unsafe abortion, violence, and disease in the area. (27)

1 Between a third and a half of maternal deaths are due to causes such as hypertension (pre- eclampsia and eclampsia) and antepartum haemorrhage, which are directly related to inadequate care during pregnancy. 2 In a study conducted in six West African countries, a third of all pregnant women experienced illness during pregnancy, of which three percent required hospitalization. 3 Certain pre-existing conditions become more severe during pregnancy. (28)

Every minute a woman dies during delivery. The highest MMR are in Africa, with a lifetime risk of 1 in 16; the lowest rates are in Western nations (1:2800), with a global ratio of 400 maternal deaths per 100,000 live births. The main causes of death are postpartum haemorrhage (24%); indirect causes such as anemia, malaria, and heart disease (20%); infection (15%); unsafe abortion (13%); eclampsia (12%); obstructed labour (8%); and ectopic pregnancy, embolism, and anesthesia complications (8%). 45% of postpartum deaths occur within the first 24 hours and 66% occur during the first week. Of the estimated 211 million pregnancies, 46 million result in induced abortions. 60% of these abortions are unsafe and cause 68,000 deaths annually. (29)

Malaria, HIV/AIDS, anemia and malnutrition are associated with increased maternal and new- born complications as well as death where the prevalence of these conditions is high. So these women need to be identified during ANC.5 Some African societies believe that grieving for a stillborn child is unacceptable, making the death of a baby during the last trimester of pregnancy even harder to process and accept. (30)

Effects on babies: 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 labour, or antepartum stillbirths, account for two-thirds of all stillbirths in countries where the mortality rate is greater than per 1,000 births – nearly all African countries. Antepartum stillbirths have a number of causes, including maternal infections – syphilis – and pregnancy complications, but systematic global estimates for causes of antepartum stillbirths are not available. (31)

At the same time, we must confront the tragic fact that each year, 289 000 women still die while giving life and an estimated 18 000 children die every day from preventable diseases and circumstances. This is an appalling tragedy that demands an accelerated response. (31)

It is time to give new-borns a more prominent place on the global health agenda. We must do much more to save the 2.9 million new-borns dying during their first 28 days of life each year. The day of birth is the most dangerous day, when nearly half of maternal and new-born deaths and stillbirths occur. It is also the day babies face the greatest risk of disability. (32)

The number of child deaths worldwide has declined markedly in recent decades, largely through interventions to lower mortality after the first month of life. The mortality rate among children under-5 years of age has fallen globally by almost 50% (from 90 deaths per 1 000 live births in 1990 to 48 deaths per 1 000 live births in 2012), but the neonatal mortality rate decreased only 37% (from 33 deaths per 1 000 live births to 21 deaths per 1 000 live births) over the same period and represented, in 2012, 44% of the total child mortality. (32)

In addition to 2.9 million babies who die in the first month of life, it is estimated that 2.6 million babies are stillborn (die in the last three months of pregnancy or during childbirth) and some 289 000 women die each year from complications of pregnancy and childbirth. The global annual average rate of reduction in neonatal mortality since 1990 has been 2.0%, lower than that of maternal mortality (2.6%) and under-5-year old mortality (2.9%). (33)

New-borns are affected by problems during pregnancy including preterm birth and restricted fetal growth, as well as other factors affecting the baby's development such as congenital infections and fetal alcohol syndrome. (34)

2.3. The package and trends

Every year there are an estimated 200 million pregnancies in the world. Each of these pregnancies is at risk for an adverse outcome for the woman and her infant. While risk cannot be totally eliminated, they can be reduced through effective. To be most effective, health care should begin early in pregnancy and continue at regular intervals. Globally, UNICEF identifies women in the richest 20 percent of the population are also more likely to receive antenatal care than poorer women, especially in the most deprived regions. (35)

In the developing world: Nearly 70% of pregnant women have at least one antenatal care visit, and the majority of women presenting for any antenatal care have at least four visits. All age groups show similar rates of four or more visits. Rural and uneducated women are least likely to receive antenatal care. Women reporting at least four antenatal care visits are on average 3.3 times more likely than other women to give birth with a skilled provider. (36)

ANC in Africa has reached more than two thirds of pregnant women, with reported increases in the coverage of the recommended four ANC visits and increases in the coverage of a first trimester ANC visit. Multiple vertical programmes rely on ANC to deliver their interventions, representing both a challenge and an opportunity. As a critical link in the continuum of care, ANC offers tremendous opportunities to reach a large number of women and communities with effective clinical and health promotion interventions. However, inequity exists, and young, rural, poor, and less educated women may not benefit from ANC services or may drop out due to access barriers and low quality services. (37)

In sub-Saharan Africa, 69% of pregnant women have at least one ANC visit, more than in South Asia, at 54%. Coverage for ANC is usually expressed as the proportion of women who have had at least one ANC visit. However, Coverage of at least four ANC visits is lower at 44%, In Africa, 80% of women in the richest quintile have access to three or more ANC visits, while only 48% of the poorest women have the same level of access. (38)

In the case of Ethiopia, the 2005 EDHS showed that the MMR was 673 deaths per 100,000 live births, and infant mortality rate was 77 deaths per 1000 live births, Millions more women survive but suffer from illness and disability related to pregnancy and childbirth. (39)

ANC coverage in Somalia is 26 % Mothers and new-born babies in Somalia suffer from high levels of death and disease. In 2006, the estimated MMR was 1044–1400 per 100 000 live births. A woman in Somalia has a one in 10 chance of dying due to pregnancy or childbirth related causes during the course of her life. (40)

The infant mortality rate in Somalia is 119 per 1000 live births. The perinatal death rate is estimated at 81 per 1000 live births, with neonatal deaths believed to account for more than half of these. The high per natal mortality rate is mainly due to suboptimal pregnancy and birth care and, resulting in low birth weight, premature births and birth injuries. (41)

Reproductive health service coverage in Somalia is low. Antenatal care coverage is 26% and the number of basic emergency obstetric care facilities per 500 000 population is 0.8, compared with an international standard of 5. (41)

Somaliland has one of the highest maternal mortality ratios in the world at 1,044 deaths per 100,000 live births (MICS, 2006). According to MICS, 2006, only thirty-two percent of women received antenatal care (ANC) from skilled health personnel; whereas ANC coverage is only 26%, TT coverage stands at 26.3% and pregnant women receiving Vitamin at 4-25%. Although this is low coverage, given the Somali context, it is an opportunity to reach out with preventative services to women. (42)

Poverty, low levels of female literacy and lack of female empowerment are factors that correlate strongly to poor reproductive health outcomes in different countries. (42)

Maternal Mortality rates in Somaliland are amongst the highest in the world; one out of every seven Somaliland 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). (43)

In Somaliland, matters have been worsened by chronic war and conflict over almost two decades, lack of a functional central government, and poor access to quality reproductive health services. Despite increases in knowledge of in reproductive health, progress in maternal health towards MDG 5 is not on track. (44)

2.4. The essential elements of a focused approach to antenatal care

Identification and surveillance of the pregnant woman and her expected child Recognition and management of pregnancy-related complications, pre-eclampsia Recognition and treatment of underlying or concurrent illness

Screening for conditions and diseases such as anaemia, STIs (particularly syphilis), HIV infection, mental health problems, and/or symptoms of stress or domestic violence

Preventive measures, including tetanus toxoid immunisation.

Measurement of weight/body mass index (BMI) and assessment of nutritional status Monitoring blood pressure and signs and symptoms of pre-eclampsia/eclampsia Prevention of malaria in pregnancy

Intermittent preventive treatment (IPT) for malaria Insecticide treated bed nets (ITNs). (45)

Recognition and treatment of sexually transmitted infections (STIs)
Counselling and testing for HIV and education and clinical services for the PMTCT Confirmation of fetal position by 36 weeks of pregnancy
Urinalysis for proteinuria in third trimester if signs of pre-eclampsia
Advice and support to the woman and her family for developing healthy home behaviours and a birth and emergency preparedness plan. (46)

2.5. How many visits?

A recent multi-country randomized control trial led by the WHO and a systematic review showed that essential interventions can be provided over four visits at specified intervals, at least for healthy women with no underlying medical problems.
The result of this review has prompted WHO to define a new model of ANC based on four goal- oriented visits. This model has been further defined by what is done in each visit, and is often called FANC. The optimum number of ANC visits for limited resource settings depends not only on effectiveness, but also on costs and other barriers to ANC access and supply (47).
WHO recommended a minimum of four antenatal care visiting? First visit: early in first trimester after two missed periods.
Second: at 28 weeks
Third visits: between 34 to 36 weeks Fourth visit: after 36 weeks. (48)

2.6. Indicators for antenatal care

- Proportion of pregnant women who have at least one antenatal clinic visit
- Proportion of pregnant women who have at least four ANC visits
- Tetanus protection at birth
- The percentage of pregnant women who receive IPTP for malaria according to the national protocol of IPTP
- Antiretroviral course for PMTCT of HIV
- Prevalence of syphilis in pregnant women

2.7. The proportion of pregnant women with a written birth and emergency plan by 37 weeks of pregnancy. (49)

2.8. Quality of care

ANC is one of the core interventions for improving maternal outcomes. ANC services enable early identification of pregnancy related risks and complications; and ensure access of services including health education, vaccines, diagnostic tests and treatments. It also helps to establish good relationship between pregnant women and service providers. Moreover, a pregnant woman visiting health facilities for ANC would get advice and support, and will be more informed about health needs and self-care, and leaded to an increased utilization of emergency care services. (50)
For those reaching ANC services, the quality of care is poor and a missed opportunity. According to MICS (Multiple Indicator Cluster Survey) only 14.2% of women that gave birth during the last two years had a blood test taken during the pregnancy. Twenty one percent had blood pressure measured and 9% had urine analysis performed. These numbers are low considering that 26% of women at some point make the effort to come for ANC. (51)
According to UNICEF data from MCHs, looking services provided the ANC visit only 15% of pregnant women get adequate TT-vaccination and 4-25% women get Vitamin supplementation. Only half of ANC attendees recall being informed of pregnancy Complications (51)
Breaks in supplies, absence of qualified staff, short working hours and weak supervision are some of the factors believed to be responsible for low quality of services. Although syphilis screening of pregnant women to prevent congenital syphilis is considered a cost-effective intervention in eastern Africa, only in exceptional cases was this offered at HC-level, whereas most hospitals would offer the service. (51)
Quality of ANC has been designated one of the four Pillars of Safe Motherhood, along with clean and safe delivery, essential obstetric care and family planning which could 2 contribute to reduction of maternal mortality. (52)
It is necessary to promote a better access of all women to ANC in developing countries antenatal care is still very low and the quality of those services is very insufficient in Somaliland. (52)

2.9. Initiation of the first antenatal care visit

The WHO recommends that pregnant women should go for their first ANC visit in the first trimester. This section discusses findings from previous researches on how pregnant women initiate ANC in globally, sub-Saharan Africa, Ethiopia and Somalia. (53)

2.9.1. Initiation of the first antenatal care visit globally

Studies in Asia indicate that most women do not initiate ANC in the first trimester as recommended by the WHO. A descriptive study in Bangladesh, which was based on national surveys, showed that the median gestation time of the first visit in 2007 was 5.0 months. (53)

The majority of Nepali women do not attend ANC early, according to the results of the National Demographic Health Survey of women aged 15–49 years. Of these women, 45% had their first ANC visit after three months into their pregnancy, and 28% did not receive any ANC at all. In a cross-sectional study, Yoshida, Harun-Or-Rashid and Sakamoto (2010) in Kham District, Japan, the same trend of receiving ANC late was discovered. The majority (58.7%) of the respondents in the study initiated ANC in the second trimester. Those who initiated ANC in the first trimester were only 39.9% and 1.4% even initiated ANC in the last trimester. (54)

In another study on the utilisation of ANC in the four counties in Ningxia in China, Ren revealed that the majority of the women in the study started ANC in the second and third trimester of their pregnancy. According to the findings, 35.2% began ANC in the first trimester, 44.2% in the second trimester, and 20.6% in the last trimester. (55)

Comparative studies between rural and urban women on the utilization of ANC services have revealed that rural women initiate ANC late. Tran, Nguyen, Nguyen, Eriksson, (2011) compared the pattern and adequacy of ANC in rural and urban discovered a wide between urban and rural women in terms of initiation of ANC. Pregnant rural women tended to attend ANC later than their urban counterparts, with an urban/rural ratio of 1: 4 in the first trimester. (55)

Contrary to these results indicated that more than half of the women initiated ANC early. Found that 60% of the 15 pregnant women initiated ANC in the first trimester of pregnancy. These were women who were married, had higher income and a higher level of education, and had planned their pregnancies. (55)

2.9.2. Initiation of the first antenatal care visit in sub—Saharan Africa (SSA)

Despite by the WHO many pregnant women in sub-Saharan Africa tend to start ANC late, especially adolescent women, resulting in them not benefiting from preventative and curative measures. Findings from a cross-sectional study in 2008 that was carried out government health institutions in Addis Ababa, where the services for ANC are free and physically accessible, support the finding that women initiate ANC late. Only 40.2% of the respondents began ANC within the recommended time (in the first trimester) and the majority (59.8%) booked late. (55)

The range of initiation of ANC was from 1–9 months gestation with a mean timing of 4 months. These results are in line with a community-based cross sectional study, which was carried out in Southern Ethiopia. Only 8.9% of the respondents initiated ANC in their first trimester of pregnancy, the majority (68.2%) started ANC in the second trimester and some (22.9%) even in the third trimester. (55)

2.9.3. Initiation of the first antenatal care visit in Ethiopia.

Early initiation of ANC visits is an essential component of services to improving maternal and new born health. The Ethiopian Demographic and Health Survey conducted in 2011 indicated that only 11% of pregnant women start ANC in the first trimester. However, detailed study to identify factors associated with late initiation of care has not been conducted in Addis Ababa where access to health services is almost universal. The aim of this study was to assess the level of late first antenatal care visit and the associated factors. (4) Over 40% of pregnant women do not initiate ANC visit in the first trimester largely due to lack of correct knowledge of the recommended ANC schedule. (56)

2.9.4. Initiation of the first antenatal care visit in Somalia

The Somali Red Crescent Society's coverage for maternal- and child-related services is higher than the national average. 1 in 12 women dies due to pregnancy-related reasons in Somalia. According to UNICEF's and MICS, the number of women attending three or more ANC visits in Somaliland and Puntland stands at 26% and 11.5% respectively. In Somali Red Crescent Society's catchment area, 70% of pregnant women in Somaliland and 65% in Puntland and Central and South Somalia are going for 3 or more antenatal care visits. (57)

2.9. Knowledge of women towards Antenatal care

Health knowledge is considered to be one of the key factors that enable women to be aware of their right and health status in order to seek appropriate health services. Study conducted in different part of the world has discovered that level of knowledge of mothers toward ANC is important for utilizing ANC service. The level of knowledge of pregnant mother also varies in deferent part of the world. (58)

An institutional based cross sectional study conducted in north central Nigeria to investigate knowledge and utilization of ANC service has revealed that 87.7% of women in child bearing age were aware of the benefits of ANC out of which 25.9% had fair knowledge about the activities carried out during the ANC services, 69.9% had good knowledge while only 4.2% had poor knowledge. (58)

2.10. Attitude of women towards Antenatal care

"Attitude" is a state of readiness or tendency to respond in a certain manner when confronted with certain stimuli, is mostly dormant and is expressed in speech or behavior only when the object or situation is encountered. It is

person's affective feelings of like and dislike. (59)
So in this study, attitude refers to expectant mother's affective feelings of like and dislike to antenatal services. Thus, the pregnant women's personal experience to antenatal services can be positive or negative. (60)

2.11. Practice of women towards Antenatal care

Utilization of antenatal services and early booking are important factors in the reduction of maternal mortality and morbidity and these are influenced negatively by social, cultural and religious factors. (61)
A research carried out to ascertain the determinants of ANC booking time in a South-Western Nigeria revealed that, 57.3% of pregnant mothers felt that women should book by the first trimester but half of them actively booked late biggest impediments toward effective and sustainable implementation of focused ANC. Due to limited space, some crucial components of FANC, such as individualized counselling and laboratory tests. (62).

III. METHODOLOGY

3.0 Introduction

This chapter presents the methodologies that was used for data collection and analysis of the research. The chapter examined further the topics including Study area, the study design, the Study period, the study population, the Inclusion and Exclusion Criteria, the Sample Size, the Sampling Method, the Data Analysis, the Limitation of the study, the Definition of Operational terms and the Data Collection Methods used for collecting data and also this chapter clearly showed the ethical consideration and lastly Validity and reliability of the research.

3.1 Study area

The study was carried out in Hargeisa, Somaliland especially district 26 June, Hargeisa. It is the largest city in Somaliland and also capital city of Somaliland, located Somalia to the east, Djibouti to the northwest, and Ethiopia to the south and west.
Consequently the study was conducted in Dr Khalid MCH, 26 June District, Hargeisa-Somaliland. The study was widely focus on the assessment of the knowledge, attitude and practice towards antenatal care services among reproductive age group women at Dr Khalid MCH, in 26 June district, Hargeisa-Somaliland.

3.2 Study design

This research based on Descriptive cross-sectional research design that identifies the knowledge, attitude and practice towards antenatal care services among reproductive age group women at Dr Khalid MCH, in 26 June district, Hargeisa- Somaliland.
Descriptive cross sectional study design was chosen because this type of study describes the problem in relation to place, person and time. And also this method was inexpensive, time saving; researcher has control over selection of the study subject and measurements used. That was why this design was selected.

3.3 Study period

This study started from March-06-2019 up to August-16-2019.

3.5. Population

3.5.1 Source population

All reproductive women who was visiting the MCH that are selected in Hargeisa for the purpose of assessment of KAP antenatal care service among reproductive age group women and also the source population of the study was all reproductive age female in the MCH during the study period.

3.5.2 Study population

The study population included: The study populations were all reproductive women age group (15-49) years old female in Dr Khalid MCH. All Pregnant women who were came for antenatal care service to MCH both multipara and Prim gravida during data collection period.

3.5.3.0 Inclusion and exclusioncriteria.

3.5.3.1 Inclusion criteria

- All age group (15-49) years old female at the time of data collection.
- Reproductive age group women who were in the selected MCH.
- Reproductive age women who were willing to participate.

3.5.3.2 Exclusion criteria

- All women aged above 49 years and less than 15 years excluded from this study.
- Reproductive age group women who were not attending Dr. Khalid MCH during study period
- Reproductive age group women who were not willing to participate the study

3.6. Sampling method

A sampling technique of the study was simple random sampling and its easy method, therefore the participants was

selected by probability sampling method. SRS is a method used of ease and accurate representation of the larger population. SRS was selected by probability sampling method because every member of the larger population has an equal chance of being selected.

3.7. Sample size determination

To determine the sample size of this study, investigators was used to probability sampling method with random sampling sampling Slovenes formula which selected the participants who have acquired information according to the study objectives, because the 26 June is one of district of Marodijeh region was choosen from the other six districts in Marodijeh region. And every member which include target population have got equal chances of being included in the study that's why we was used probability sampling method. The target population was all age groups (15-49) years old female of Dr Khalid MCH. Therefore the mothers those coming every 1 months the MCH are estimated 155 mothers, so we took the sample in there.

The sample size of this study was determine by using Slovene's formula as shown below:

$$n = \frac{N}{1 + Ne^2}$$

n = Total Population

e = error

N= 155

e2= 0.05

n =?

n = $\frac{155}{1+155(0.05)2} = \frac{155}{1+155(0.0025)}$ = 111.712 Therefore sample size of this study= 112

3.8. Method Data collection

3.8.1 Questionnaire

The questionnaire was used as data collection tools in questionnaire which was the main research instrument. The questionnaire was used to assess the knowledge, attitude and practice towards antenatal care services among women with reproductive age at Dr Khalid MCH, in 26 June district, Hargeisa-Somaliland.

The questionnaire was written English language then translated it into Somali language since most of the population did not know English language.

The research explained the purpose of the study to the respondent to get accurate and reliable data. The choice of this questionnaire was easy to conduct and quick method at the side of data collection, it was also less time consuming.

3.9. Methods Data processing and analysis

The questionnaire was edited and responses were coded before data was entered into the computer by the using excel and Statistical Packages for Social Science (SPSS), version20.Cross tabulation was the main method used for data analysis. After analysis, data was summarized and presented in form of frequency tables and percentages.

3.10. Ethical consideration

The study obtained Ethical clearance and approval from Research and Ethical committee of Gollis University (GU). Before the start of the study institutional permission was given by the director of Dr Khalid MCH. On the other hand we took permission latter from the GU. For all participants, the aim of the study was explained and reassured that their responses were used only for research purposes and remained confidential. Similarly after clear discussion about the purpose of the study, the study participants made oral consent which was obtained from each study subjects. The study subjects right to refuse is also respected. To assure the confidentiality of study subject's response, writing their names or any identification in the questionnaire were not done.

Limitations of the study

- Deprivation of adequate time.
- Financial problem
- Transportation problem
- The study was carryout only in Dr Khalid MCH.

3.11. Validity and reliability

The panel of expert was checked and the questionnaire was a consistence so test-retest technique was used before administering the questionnaire on the respondents. In order to become valid and reliable measured by repeatedly checking, and also there were questionnaire translation to the respondents and pre-test were done.

3.12. Definition of Operational terms

Antenatal care

Antenatal care is the health care services given to a mother during Pregnancy that helps to ensure healthy out comes for women and new-born.

Antenatal care visit

Antenatal care visit is the routine health control of presumed healthy pregnant women without symptoms (screening), in order to diagnose diseases or complicating obstetric conditions without symptoms, and to provide information about lifestyle.

Focused antenatal care

Focused antenatal care (FNAC) Skilled Health Workers it is vital that a woman attends and receives antenatal care, to help ensure that her pregnancy results in the delivery of a healthy baby without impairing the mother's health.

Gestational age

Gestational age is the common term used during pregnancy to describe how far along the pregnancy is. It is measured in weeks, from the first day of the woman's last menstrual cycle to the current date. A normal pregnancy can range from 38 to 42 weeks.

Gravidity

Gravidity is defined as the number of times that a woman has been pregnant.

Hypertensive disease of pregnancy

Hypertensive disease of pregnancy is a group of diseases which includes: preeclampsia (is a disorder of pregnancy characterized by high blood pressure it occurs in the third trimester of pregnancy and gets worse over time.), eclampsia (is the onset of seizures (convulsions) in a woman with preeclampsia.), gestational hypertension, and chronic hypertension.

Post-partum haemorrhage

Post-partum haemorrhage is often defined as the loss of more than 500 ml or 1,000 ml of blood within the first 24

hours following childbirth.

Parity

Parity is defined as the number of times that of pregnancies has given birth to a fetus or ability of a fetus to survive outside the uterus (including live births and stillbirths).

Abortion

Abortion is the ending of a pregnancy by removal or expulsion of an embryo or fetus before it can survive outside the uterus.

IV. FINDING

4.0. INTRODUCTION

This chapter presents the analysis and detail of the findings from the study. The results are based on the responses of 112 of reproductive aged women from Dr Khalid MCH at district Hargeisa Somaliland to assess the knowledge, attitude and practice to ward antenatal care services among reproductive age women.

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. the result was illustrated in by Statistical package for social sciences (SPSS) and Microsoft Excel (pie chart, histogram, graphs and tables) was used to aggregate and analyse the data presented in this chapter.

Figure 4.1 Age

Source: primary data

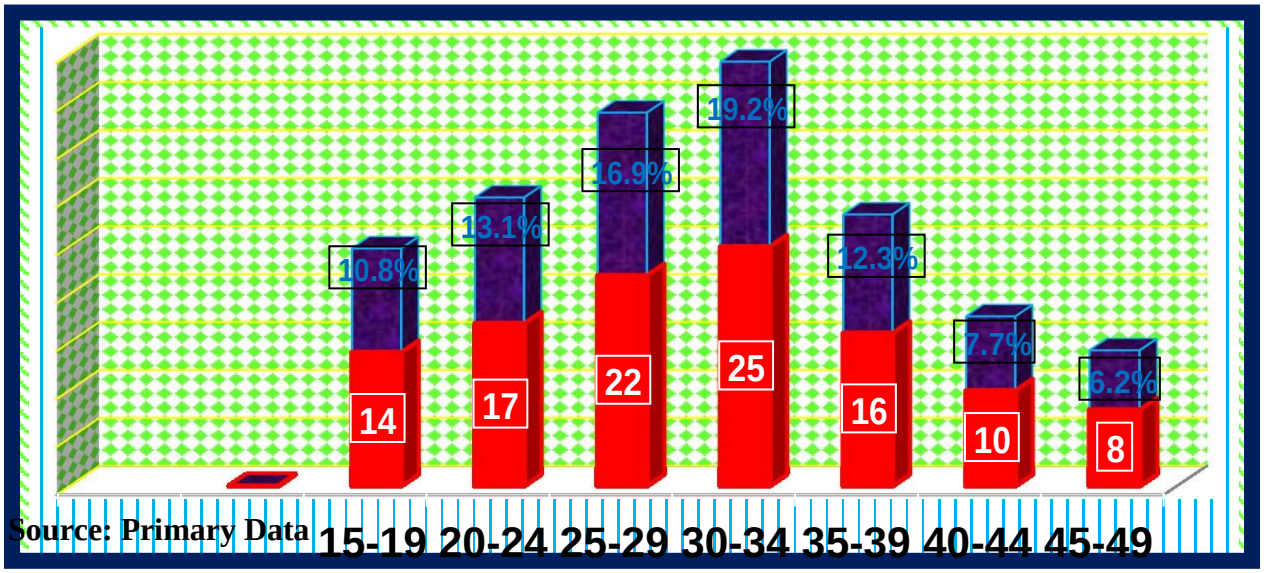
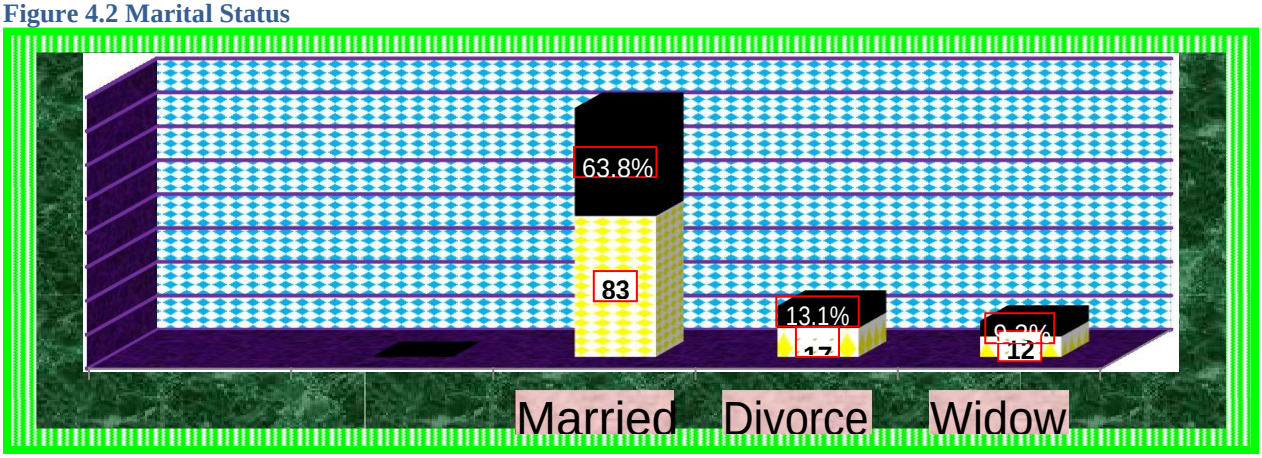


Figure. 4.1. Illustrate age of respondents 14(10.8%) of the respondents were 5-19, 17(13.1%) were 20-24, 22(16.9%) were 25-29, while 25 (19.2%) were 30-34, 16(12.3%) between 35- 39, 10 (7.7%) age between 40-44 and 8(6.2%) of respondents were 45-49years.

Figure 4.2 Marital Status



Source: primary data

Figure 4.2 demonstrate the marital status of the reproductive age group women. The majority of 83(63.8%) were married, 17(13.1%) were divorced and 12(9.2%) were widowed.

Figure 4.3 Education level

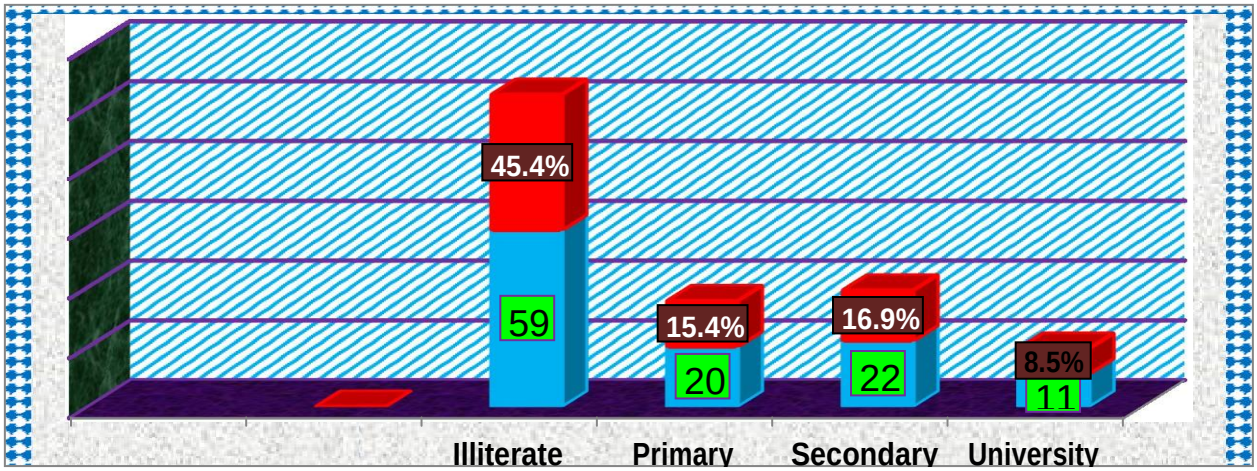
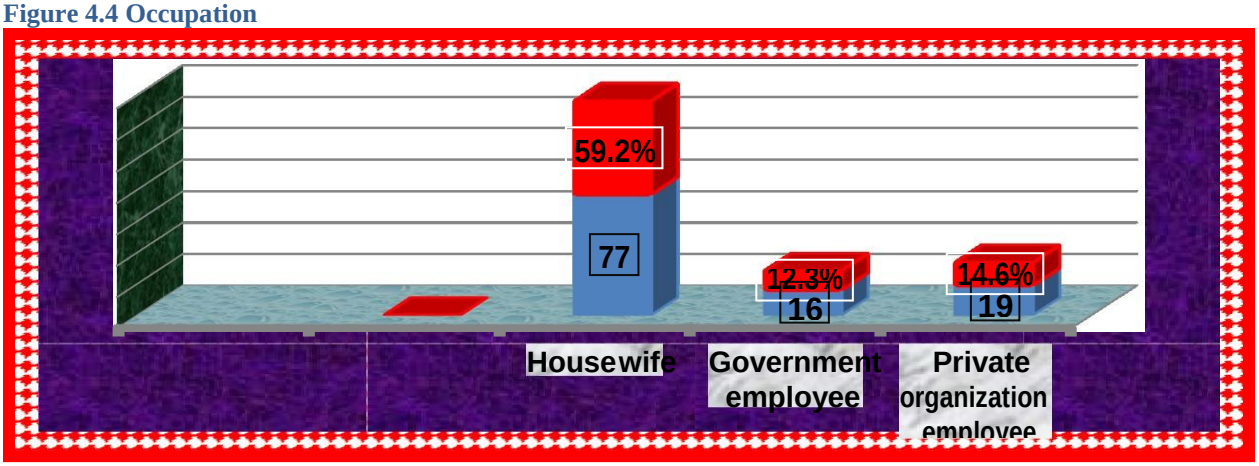


Figure 4.4 Occupation



Source: primary Data

Figure 4.4 shows the occupational level of the reproductive age group women. Most of the study participants 77(59.2%) were Housewife's, 16(12.3%) were government employees and 19 (14.6%) were private employees.

Figure 4.5 monthly Income

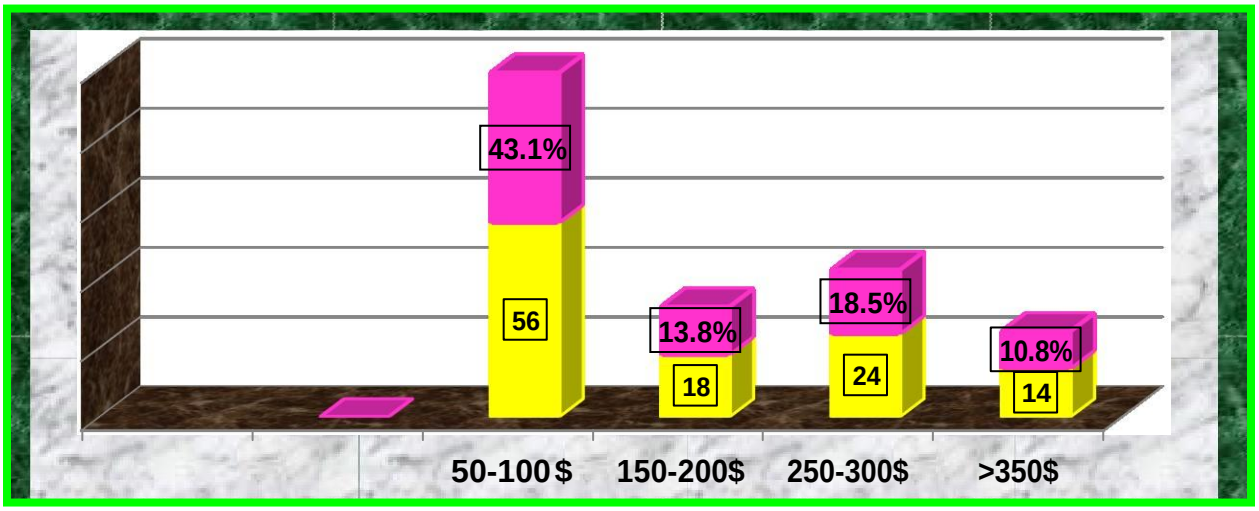
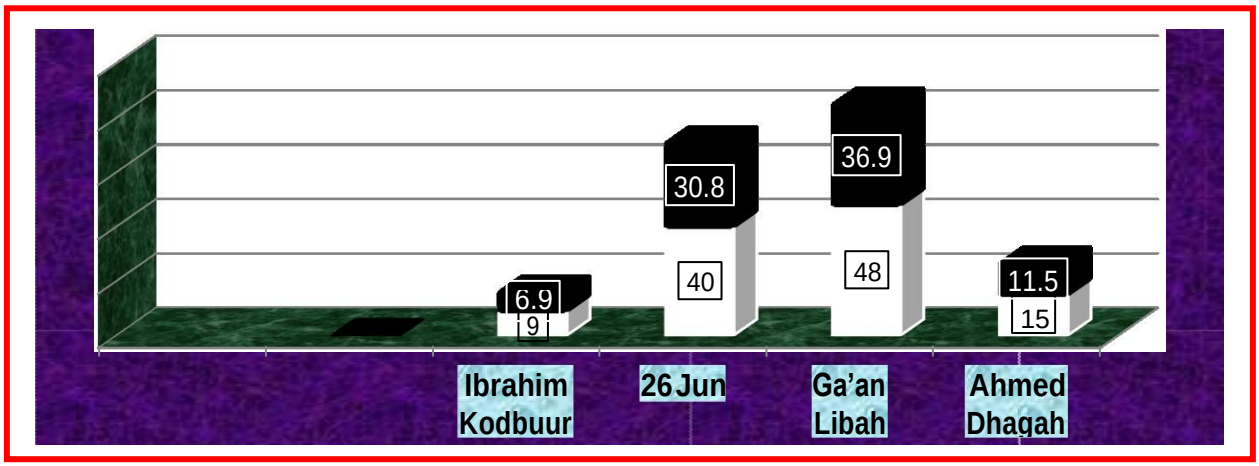


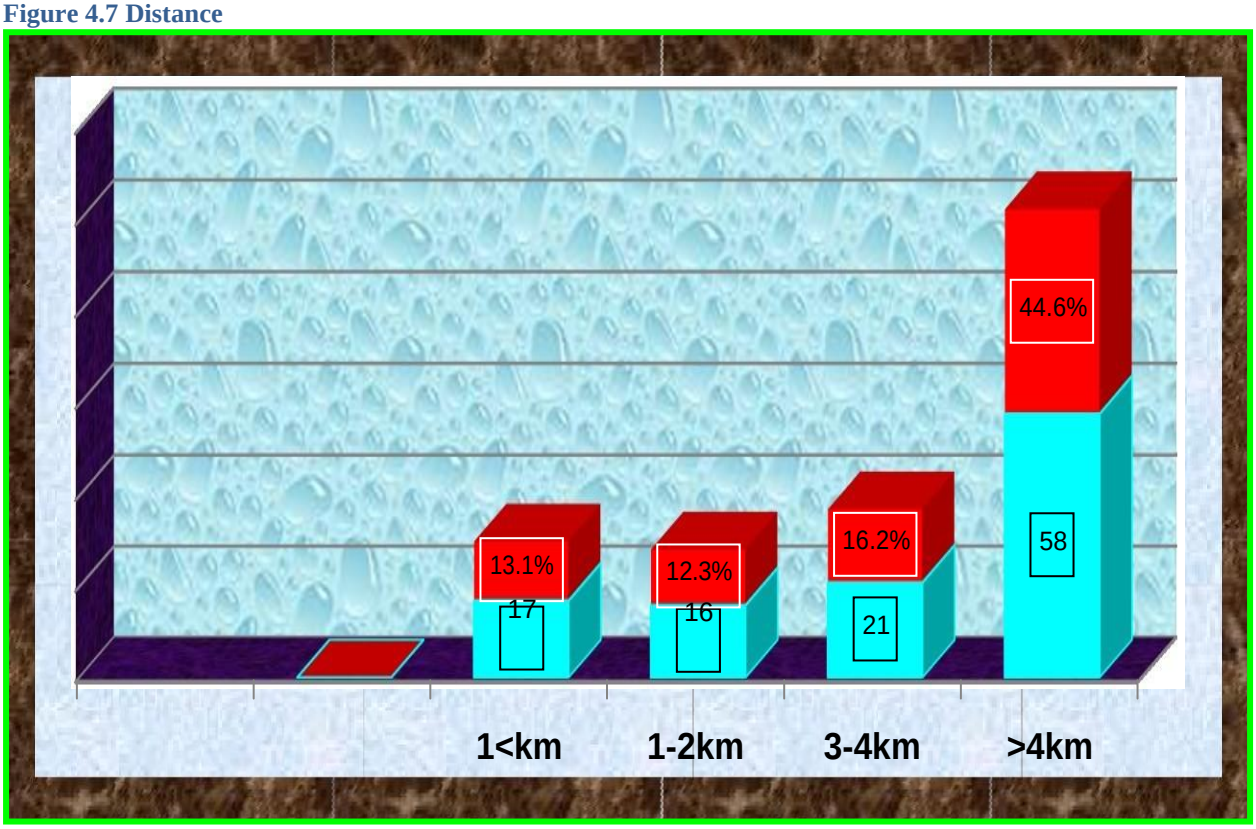
Figure 4.6 Residential area



Source: primary data

Figure 4.6 shows residential areas of reproductive group women. Majority of 48(36.9%) of the study population from Ga'an Libah and 26 June District both were most populated. While 15(11.5%) were from Ahmed Dhagah district and 9(6.9%) were from Ibrahim Koodbur district.

Figure 4.7 Distance



Source: primary Data. Figure 4.7 illustrate the Distance from your residence to Health facility, Majority of 58(44.6%) were from distance greater than 4KM and 21(16.2%) were from distance between 3-4KM, 17(13.1%) were from distance less than 1KM and 16(12.3%) were from distance between 1-2KM.

Figure 4.8 Gravidity

Source: primary Data

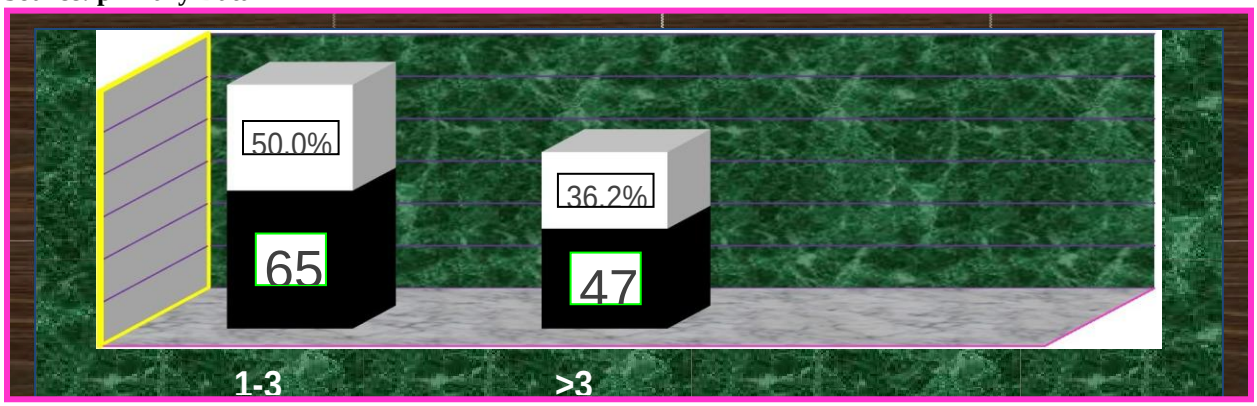
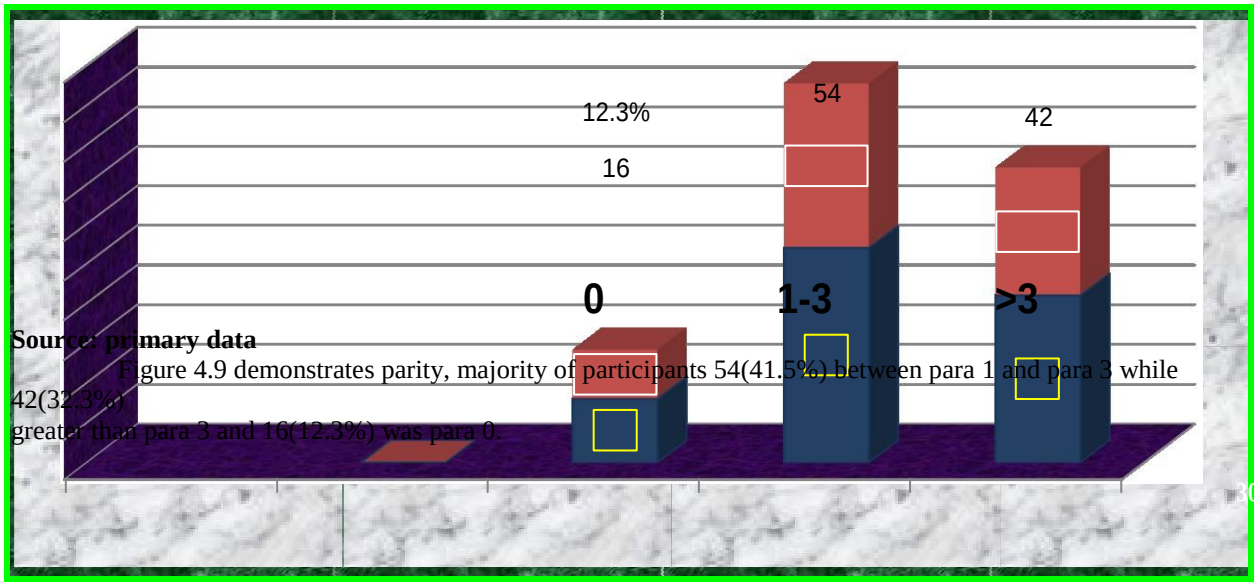


Figure 4.8 shows the respondent's Gravidity. Majority of the respondents 65(50.0%) were gravidity 1 and gravidity 3 while 47(36.2%) were greater than gravidity 3.

Figure 4.9 Parity

41.5%

32.3%



Source: primary data

Figure 4.9 demonstrates parity, majority of participants 54(41.5%) between para 1 and para 3 while 42(32.3%) greater than para 3 and 16(12.3%) was para 0.

Table 4.1 knowledge about ANC Services

Do you know about ANC service			If the answer is yes from where do you know about ANC service?			
	Frequency	Percentage	Radio	TV	MCH	Others
Yes	86	66.2%	19(14.6%)	17(13.1%)	37(28.5%)	13(10.0%)
No	26	20.0%				

Source: primary data

Table 4.1 as we showing the respondents two questions that's related together the first question shown as: do have you knowledge about ANC services, So Majority of mothers 86(66.2%) had Good knowledge about ANC services where 26(20.0%) they had poor knowledge about ANC services. Second questions, Majority of mothers 37(28.5%) they heard it from MCH, were 19(14.6) from Radio, 17(13.1%) heard it from TV and 13(10.0%) from others.

Figure 4.10 Respondents about Danger sign of pregnancy

Source: primary dada

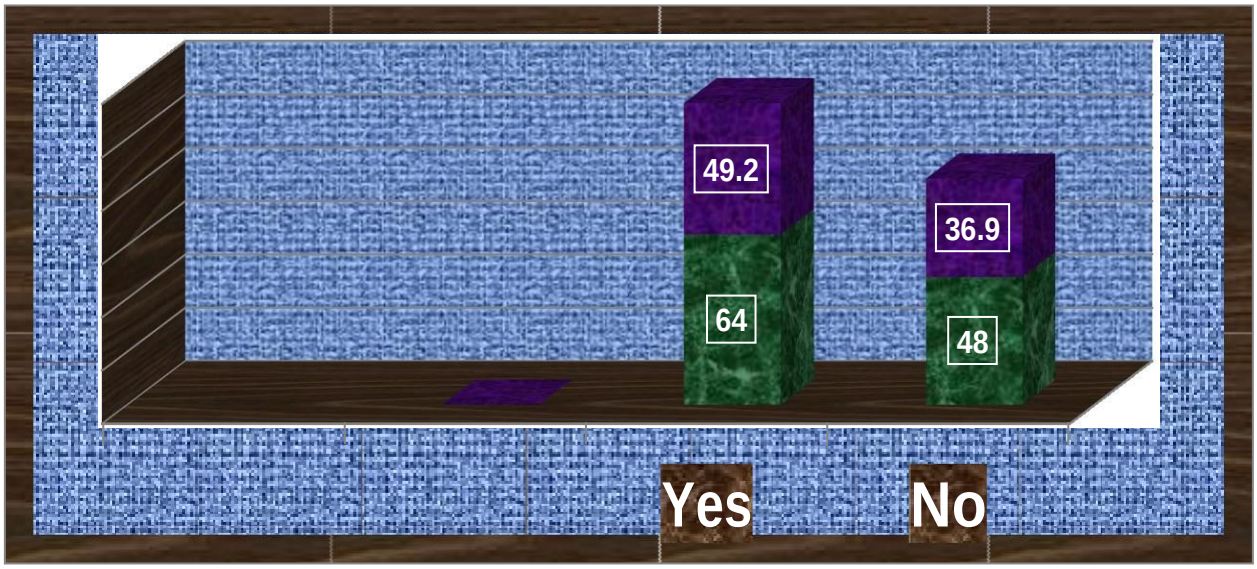
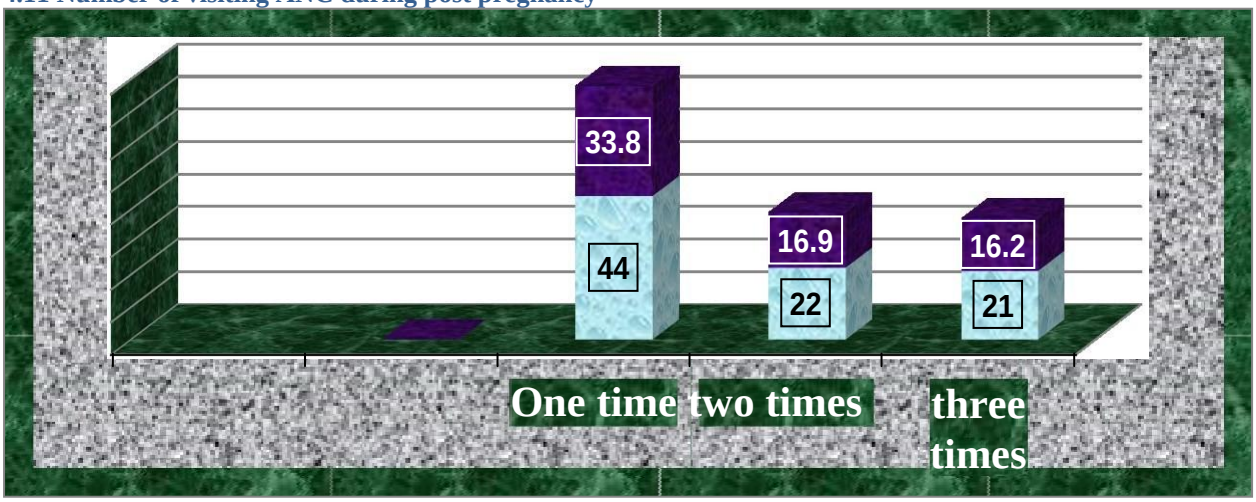


Figure 4.10 indicates danger signs of pregnancy. Majority of the respondents 64(49.2%)) of women who heard about the danger sign of pregnancy while 48(36.9) did not hear danger sign of pregnancy.

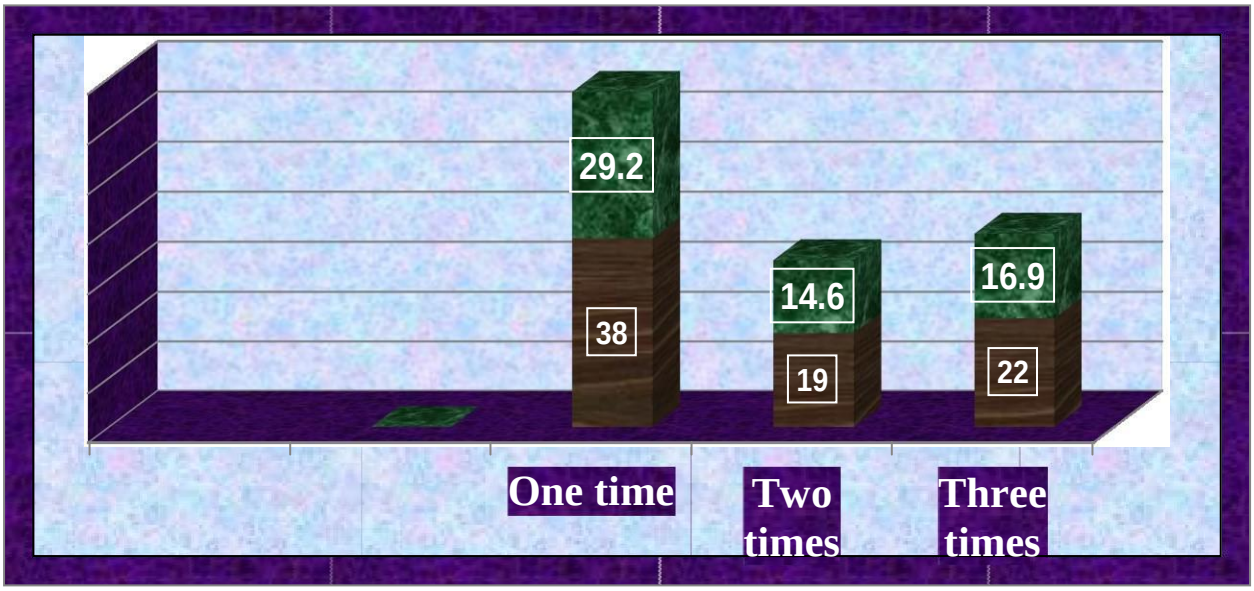
4.11 Number of visiting ANC during post pregnancy



Source: primary data

Figure 4.11 Number of visiting ANC during post pregnancy, Majority of 44(33.8%) of respondents visited ANC one time, 22(16.9%) visited ANC two times and 21(16.2%) visited ANC three times.

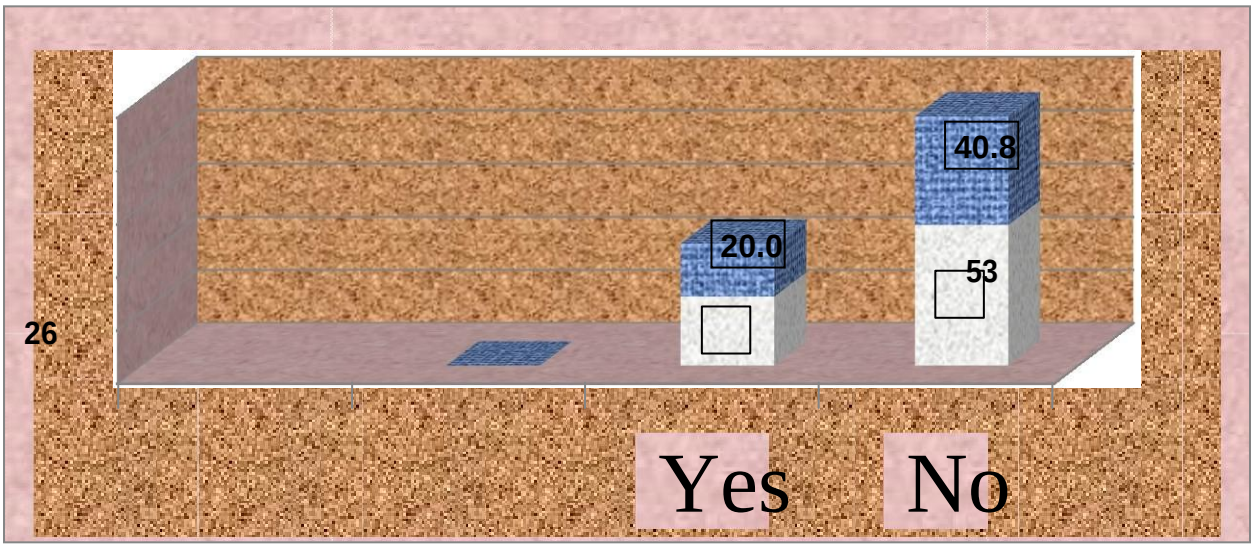
Figure 4.12 Number of visiting ANC during this pregnancy.



Source: primary data

Figure 4.12 shows Number of visiting ANC during this pregnancy, Majority of 38(29.2%) of respondents did ANC one time, 19(14.6%) did ANC two times and 22(16.9%) did ANC three times.

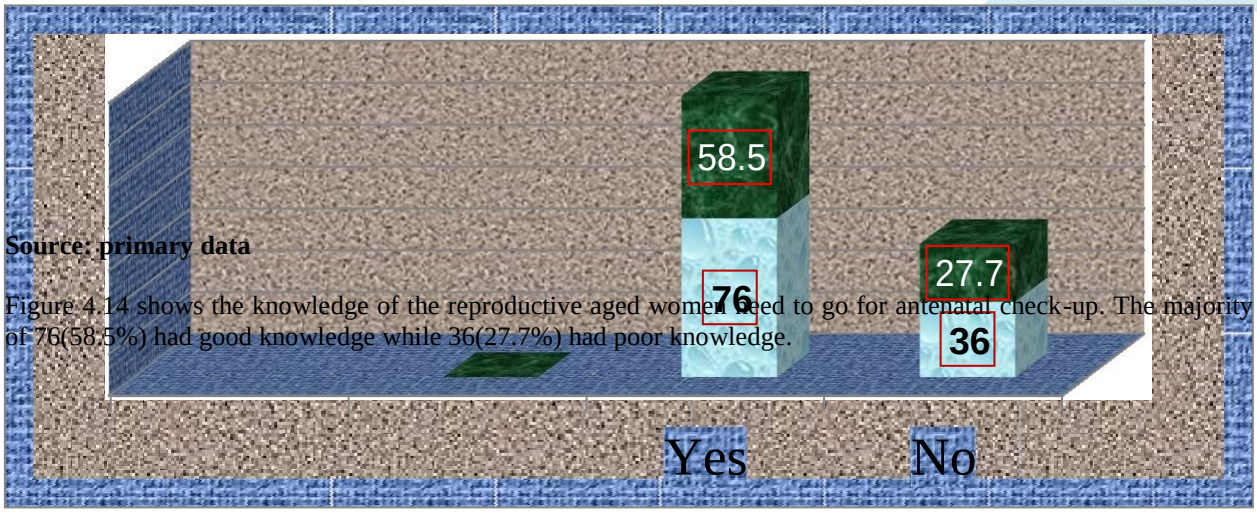
Figure 4.13 Show Any ANC Problem during This Pregnancy



Source: primary data

Figure 4.13 shows requirement to go for ANC even if there were any problem during this Pregnancy, Majority of 53(40.8%) had no problem while 26(20.0%) had got problem.

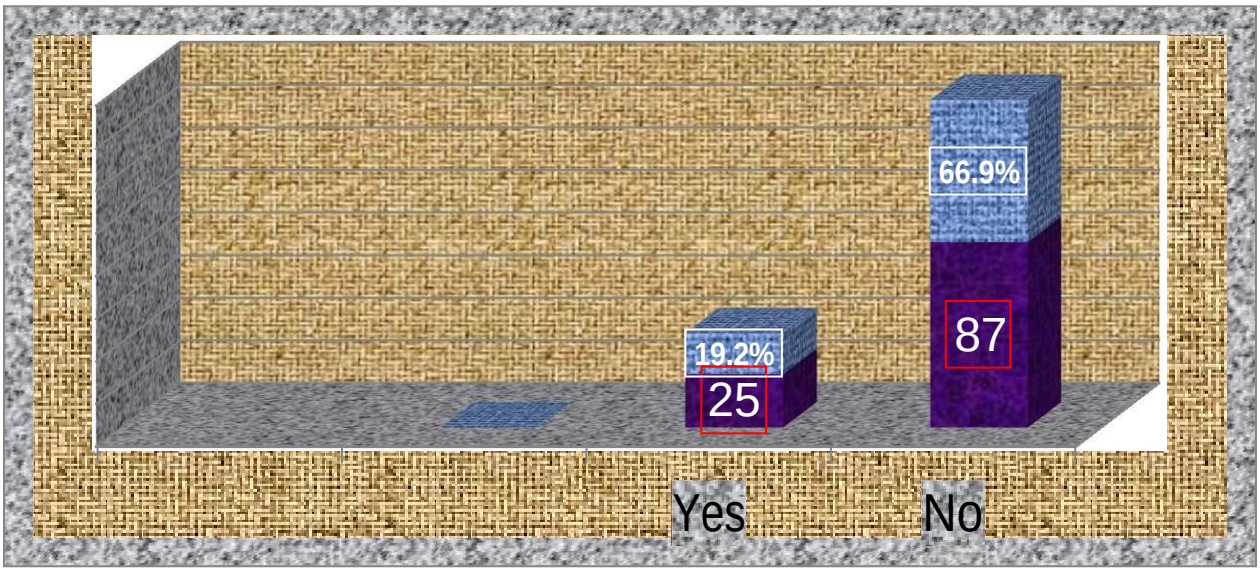
Figure 4.14 Show ANC need check-up when you are pregnant



Source: primary data

Figure 4.14 shows the knowledge of the reproductive aged women need to go for antenatal check-up. The majority of 76(58.5%) had good knowledge while 36(27.7%) had poor knowledge.

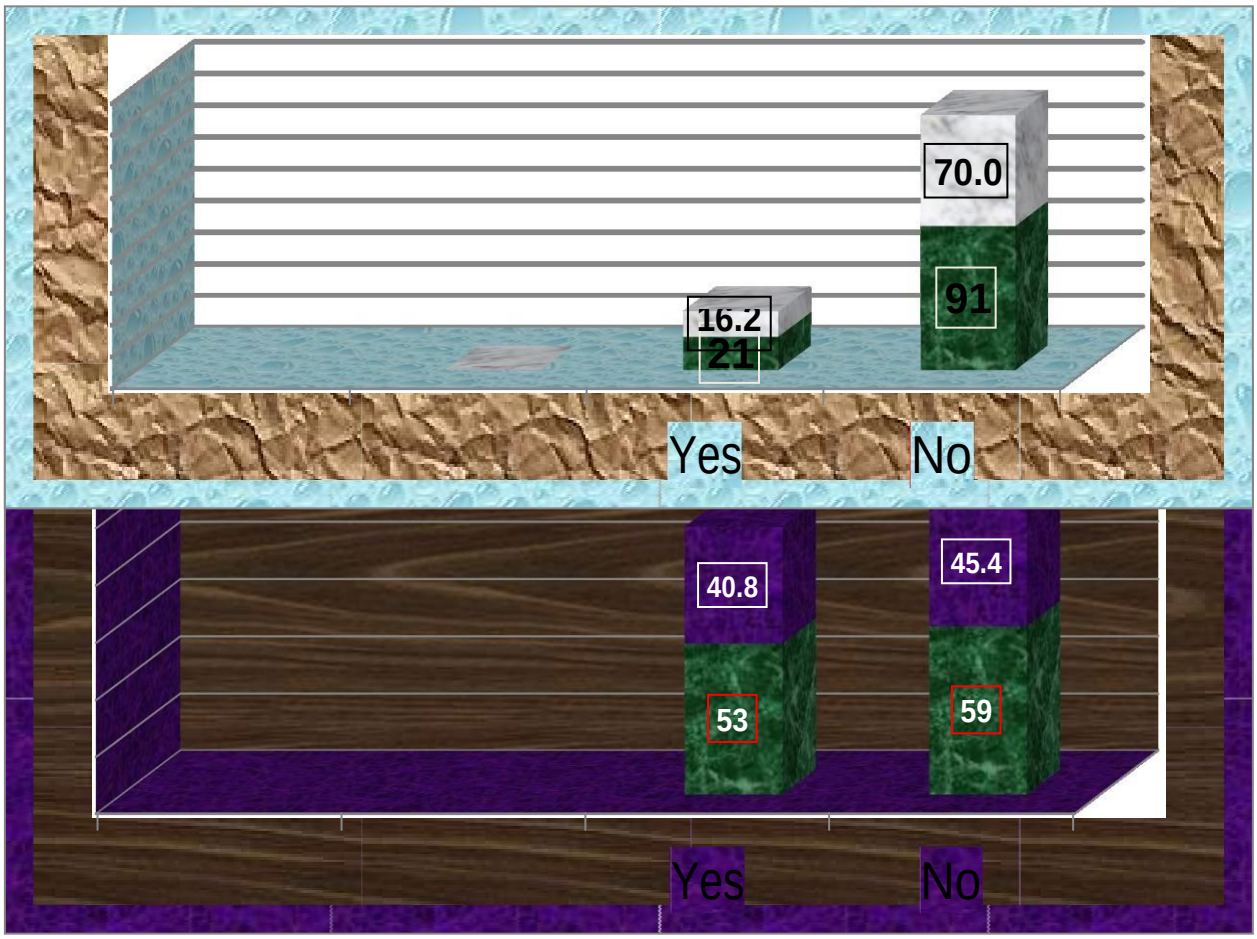
Figure 4.15 caesarean section



Source: primary data

Figure 4.15 shows mothers had previous caesarean section. The majority of 87(66.9%) had no previous caesarean section while 25(19.2%) had got caesarean section.

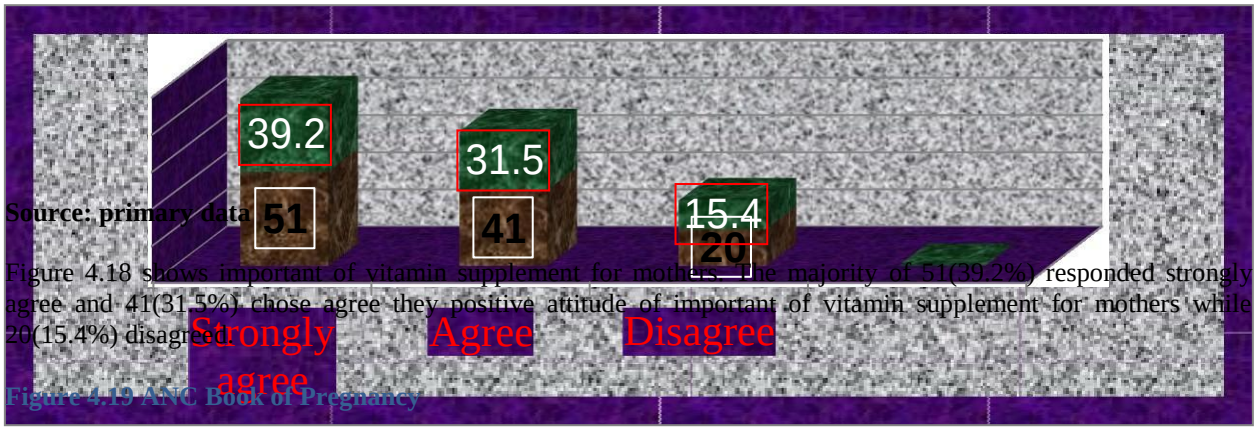
Figure4.16 Abortion



Source: primary data

Figure 4.17 shows mothers having any previous postpartum haemorrhage. The majority of 59(45.4%) had no previous postpartum haemorrhage while 53(40.8%) suffered previous postpartum haemorrhage.

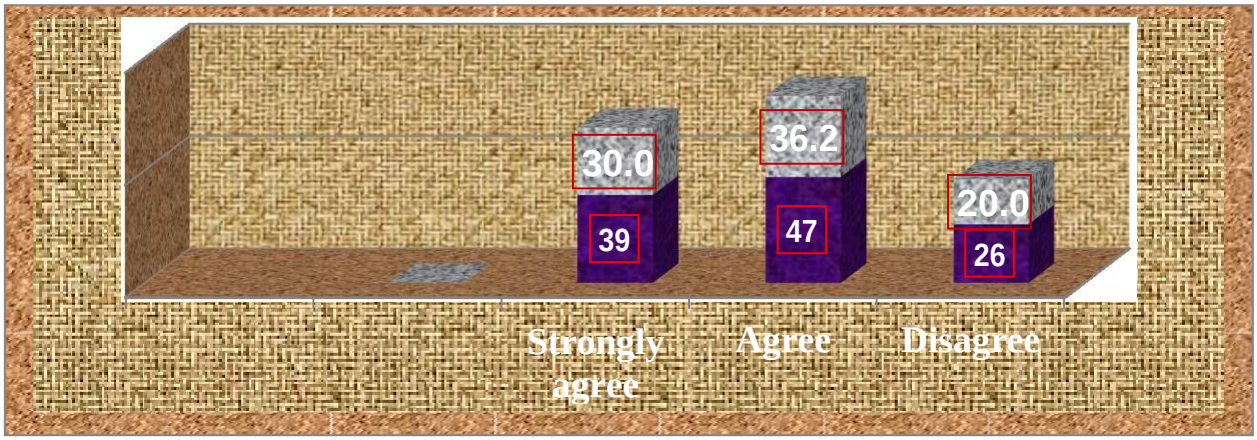
Figure 4.18 vitaminsupplements



Source: primary data

Figure 4.18 shows important of vitamin supplement for mothers. The majority of 51(39.2%) responded strongly agree and 41(31.5%) chose agree they positive attitude of important of vitamin supplement for mothers while 20(15.4%) disagreed.

Figure 4.19 ANC Book of Pregnancy



Source: primary data

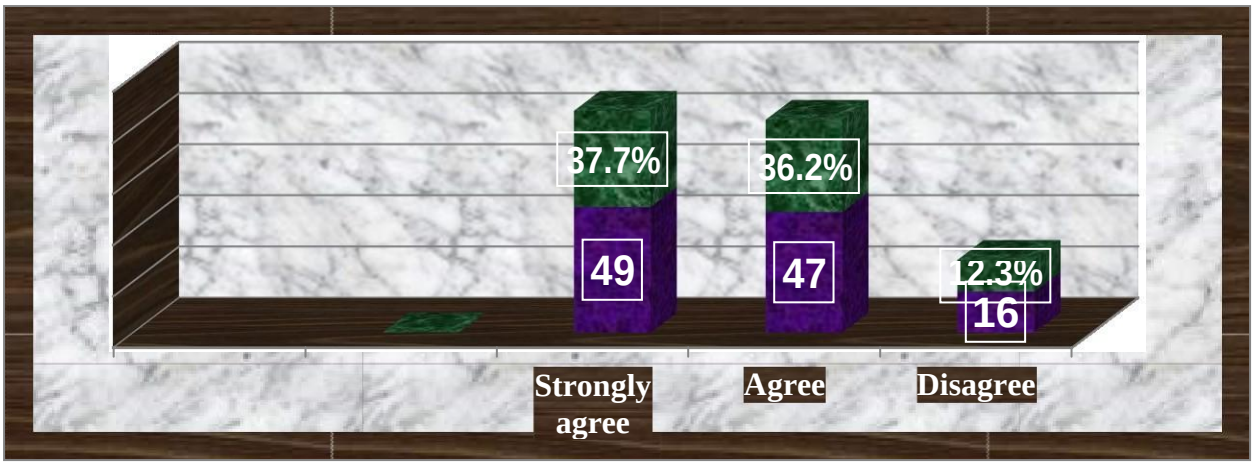
Figure 4.19 shows Early ANC booking is good for my pregnancy. The most of 47(36.2%) of reproductive aged women responded agree and 39(30.0%) responded strongly agree as they had positive attitude importance of early booking of antenatal care for the pregnant woman while 26(20.0.8%) disagreed.

Figure 4.20 ANC service where get

Source: primary data

Figure 4.20 describes the source of ANC facility, so the mostly 83(63.8%) of the respondents got it from public while 29(22.3%) from private facilities.

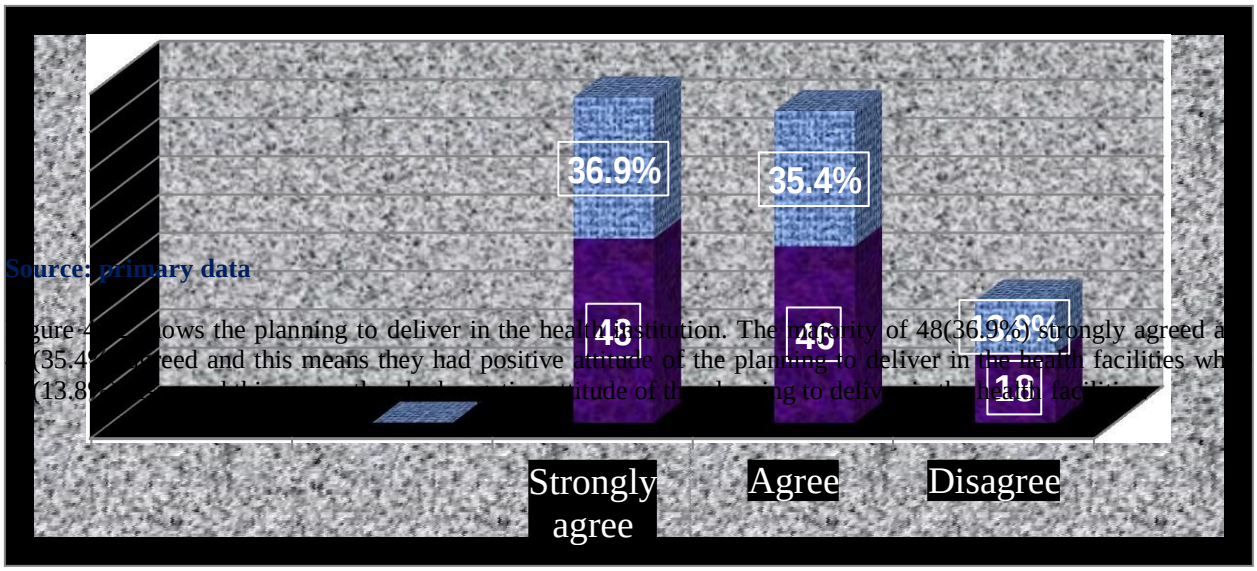
Figure 4.21 mother's and fetus' health



Source: primary data

Figure 4.21 shows the important of antenatal follow up to monitor mother's and fetes' health, The majority of 49(37.7%) selected strongly agree and 47(36.2%) selected agree. This means they had positive attitude level of about the important of antenatal follow up to monitor mother's and fetes' health while 16(12.3%) had selected disagree. This means that they had negative attitude of the important of antenatal follow up to monitor mother's and fetes' health.

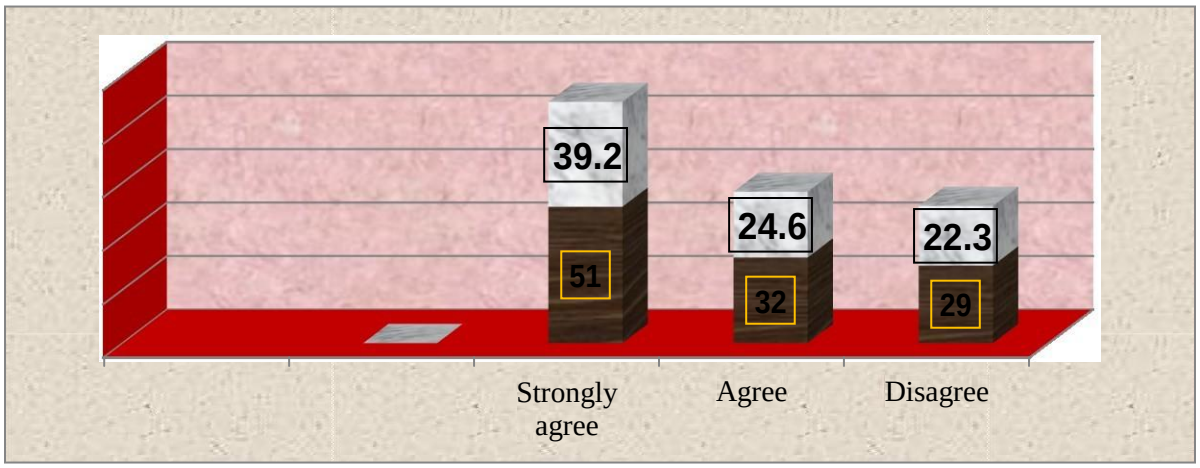
Figure 4.22 delivery



Source: primary data

gure 4 ows the planning to deliver in the hea stitution. The ority of 48(36.9%) strongly agreed a (35.4 eed and this means they had positive attitude of the planning to deliver in the health facilities wh (13.8 itude of th ng to deliv health fac

Figure 4.23 the early preparation for the delivery.



Source: primary data figure 4.23 shows the early preparation for the delivery. The majority of the respondents of 51(39.2%) strongly agreed and 32(24.6%) agreed, so they had positive attitude of the early preparation for the delivery while 29(22.3%) disagreed so they had negative attitude of the early preparation for the delivery.

Figure 4.24 alcoholdrinking

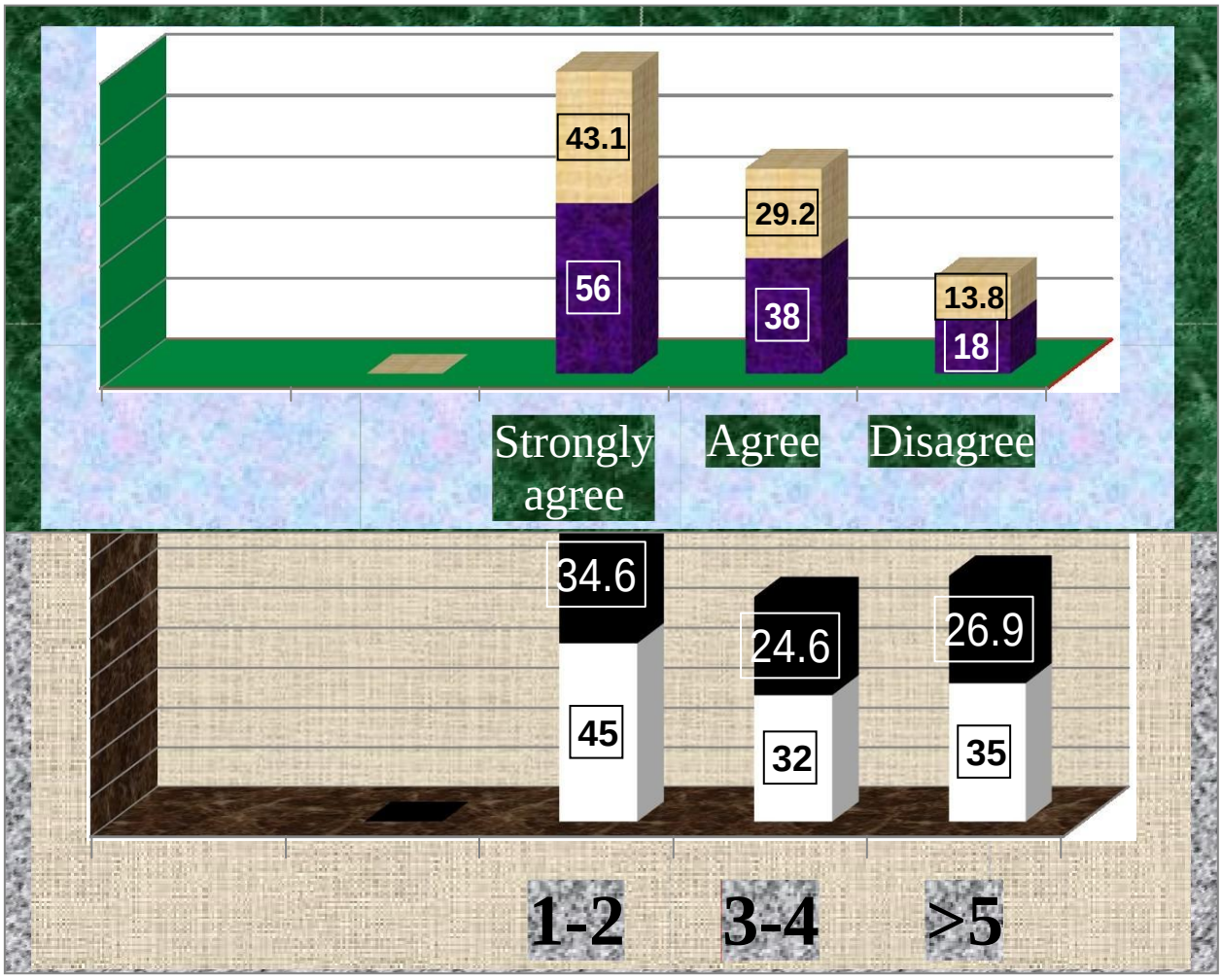


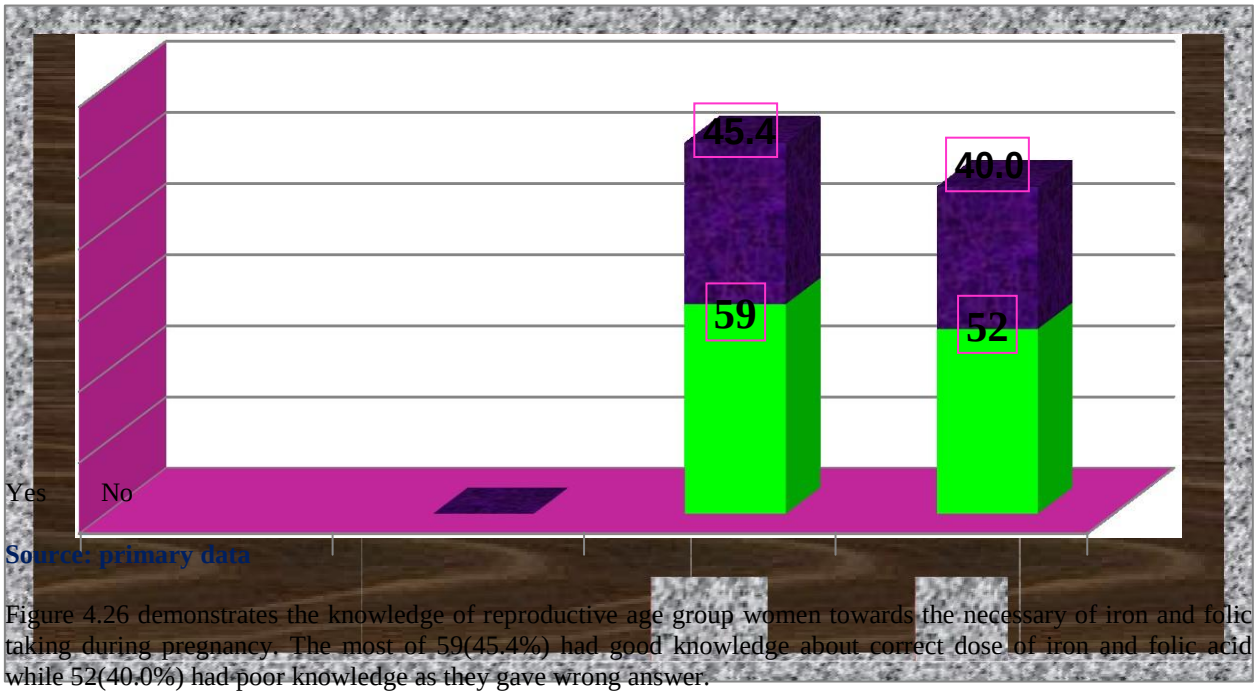
Table 4.2 place of birth children and If it is home birth, why?

Where was the birth place of your children?			If it is home, why?			
	Frequency	Percentage	No nearby health facility	No transportation	Lack of money	Others
Hospital	58	44.6%				
MCH	14	10.8%				
Home	40	30.8%	8(6.2%)	12(9.2%)	12(9.2%)	8(6.2%)

Source: primary data

Table 4.2 as presenting the respondents two questions that's related together the first question the place of most recent delivery. The majority of the respondents of 58(44.6%) their delivery places were hospitals, 14(10.8%) their delivery places were MCHs, 40(30.8%) their delivery places Home.
Second question, indicates home birth, the majority home birth because both of 12(9.2%) lack of transportation and 12(9.2%) lack of money while others 8(6.2%) was not nearby health facility and 8(6.2%) responded other options.

Figure 4.26 the necessary of iron and folic taking during pre



Source: primary data

Figure 4.26 demonstrates the knowledge of reproductive age group women towards the necessary of iron and folic taking during pregnancy. The most of 59(45.4%) had good knowledge about correct dose of iron and folic acid while 52(40.0%) had poor knowledge as they gave wrong answer.

V. Discussion, Conclusion and Recommendation

5.1 Discussions

5.1.1 Socio-demographic characteristics

The majority of our population study of 25(19.2%) of the reproductive aged women were the age between 30-34, 17(13.1%) were the age between 20-24, 22(16.9%) were the age between 25-29,
14(10.8%) were the age between 15-19, 16(12.3%) were age between 35-39, 10 (7.7%) were age between 40-44 and 8(6.2%) were age between 45-49.

The Most of the study population of 59(45.4%) were illiterate level, about 20(15.4%) were primary level, 22(16.9%) were secondary level and 11 (8.5%) were university level.

Most of the reproductive aged women of 77(59.2%) were Housewife's, 16(12.3%) were government employees and 19 (14.6%) were private employees.

Most of 56(43.1%) their family income was between 50-100 of dollars per month, 18(13.8%) their income was between 150-200$, 24(18.5%) their income was between 250-300$ and 14(10.8%) their income was above 300 of dollars per month.

Majority of 48(36.9%) of the study population were from Ga'an Libah and 26 June District both because they were most populated are near, 15(11.5%) were from Ahmed Dhagah district and 9(6.9%) were from Ibrahim Koodbur district.

Compared our study to other study was done by Athanase G Lilungulu, Dismas Matovelo and A Gesase in Dodoma Municipal, Tanzania shows that there are more differences between these two studies says: The largest number of the respondents 59.8% (299 out of 500) The mean age was
25.5 years (SD=3.1 years) and ranged between 19 to 31 years. A total of 477(95.4%) were at the level of primary education. Quite a low proportion of the women 20(4%) receive secondary education and only 2(0.4%) and 1(0.2%) had highest education level. About (68.2%) of them were housewives while (31%) of them worked as Petty business and only (0.8%) worked at the public (government employees). (1)

5.1.2 Assessing the knowledge of ANC among reproductive aged women

Majority of mothers 86(66.2%) are Good knowledge about ANC services where 26(20.0%) they are poor knowledge about ANC services.

Compared another research made by Fantanesh Desalegn (bscn) in Addis Ababa, June, 2015 states 59% had good knowledge ANC and 41% had poor knowledge ANC. (9)

5.1.3 Assessing Attitude towardsantenatal

The most of the respondents of 72.3% had positive attitude while 23.4% of the respondents had negative attitude. Compared another research made by Fantanesh Desalegn (bscn) in Addis Ababa, June, 2015 states 55.3% had positive attitude while 44.7% had negative attitude. (9)

5.1.4 Assessing Practice towards antenatal

Majority of 45(34.6%) have children between 1-2 children, 32(24.6%) was the number of children have between 3-4 children and 35(26.9%) was said the number of children have greater than 5 children.

Compared another research made by Journal. The majority of respondents of our study population of (53.1%) had never got pregnant as they were single or still not get pregnant; the most of (35.7%) had children between 5-7, the (51.6%) they don't visit,(51.8%) had agreed the need of pregnant women for antenatal care, (53.1%) had been counselled when to start antenatal care check-up, (53.9%) had been counselled about danger signs of pregnancy and (28.6%) their most delivery places were hospital. (63)

5.2. Conclusions

Antenatal care is extremely important for diagnosing and treating complications that could endanger the lives of women and children in our societies. The main objective of this study was to assess the knowledge, attitude and practice to ward antenatal care services among reproductive age Group women at Dr Khalid MCH, in 26 June district Hargeisa Somaliland.

112 reproductive aged women were interviewed on their socio-demographic characteristics such as age, marital status, educational level, resident family income per month and occupational level and the three main keys which were knowledge, attitude and practice of antenatal care.

Majority of mothers 86(66.2%) are Good knowledge about ANC services where 26(20.0%) they are poor knowledge about ANC services.

The majority of our population study of 25(19.2%) of the reproductive aged women were the age between 30-34, 17(13.1%) were the age between 20-24, 22(16.9%) were the age between 25-29,
14(10.8%) were the age between 15-19, 16(12.3%) were age between 35-39, 10 (7.7%) were age between 40-44 and 8(6.2%) were age between 45-49.

The Most of the study population of 59(45.4%) were illiterate level, about 20(15.4%) were primary level, 22(16.9%) were secondary level and 11 (8.5%) were university level.

Most of the reproductive aged women of 77(59.2%) were Housewife's, 16(12.3%) were government employees and 19 (14.6%) were private employees.

The most of the respondents of 72.3% had positive attitude while 23.4% of the respondents had negative attitude.
Majority of 45(34.6%) have children between 1-2 children, 32(24.6%) was the number of children have between 3-4 children and 35(26.9%) was said the number of children have greater than 5 children.

Recommendation

- In a long run, women empowerment through education and income generating activities as well as involvement of husbands during information education and communication are recommended.
- The health care workers should also inform pregnant women about the advantage of antenatal care and its benefits.
- Information, education and communication on ANC should be intensified in order to reach all segments of the population.
- Community health practitioners, public health educators and social workers should plan appropriate technique to modify the attitude of some pregnant women on the concept of antenatal services.
- Community health practitioners, public health educators and social workers should plan appropriate technique to modify the attitude of some pregnant women on the concept of antenatal services.
- Health Care Providers should organize regular health education programs for women to enlighten them on issues of Antenatal Care and other Maternal Health Services. This would ensure that pregnant women attend ANC on timely rather than turning up late during the 3rd trimester.
- To improve the antenatal care Develop linkages with other programmes, especially traditionally vertical intervention.
- To reduce barriers to accessing care and reach out to women not accessing care the Ministry of health must give awareness to the community.
- Training should be given to the traditional midwife in order to minimize mother mortality rate and also complication of the delivery.
- Lastly, religious leaders should partner with the government in preaching on the vitality of attending to

antenatal care so as to make it look like a taboo if one does not attend. The community should be collectively sensitized and those that comply could be motivated with at least a postnatal baby kit to make them want to attend to these services in their subsequent pregnancies.

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