**A DESCRIPTIVE ASSESSMENT OF MATERNAL AND SOCIO-CULTURAL FACTORS RELATED TO FOCUSED ANTENATAL CARE IN EKITI STATE, NIGERIA**

**Abstract**

**Aim:** The aim of this study is to assess the maternal and social -cultural factors related to focused antenatal care using descriptive analysis.

 **Study design**: This study employed cross sectional survey research design to elicit information on maternal and socio-cultural factors influencing the utilization of Focused Antenatal Care (FANC) in Ekiti State, Nigeria from 118 nurse midwives across three tertiary hospitals in Ekiti State.

**Place and Duration of Study:** Health centers at Ekiti State University Teaching Hospital, Ado-Ekiti, Federal Teaching Hospital, Ido-Ekiti and Afe Babalola University Multisystem Hospital, Ado-Ekiti, Ekiti state, Nigeria. The data were collected between January and April 2022.

 **Methodology:** The methodological framework employed descriptive design, with data validated through content analysis and reliability tests using Cronbach Alpha. Data was gathered using a structured questionnaire. The study targeted all 118 nurse midwives in these hospitals, comprising 49 from Ekiti State Teaching Hospital, 60 from Federal Teaching Hospital Ido-Ekiti, and 9 from ABUAD Multi-System Hospital. Total enumeration sampling techniques were utilized due to the limited number of participants. For analytical purposes, descriptive statistics—such as mean, median, mode, frequency, percentage, minimum, maximum, and standard deviation—were employed to provide insights into the data.

**Results:**

The findings highlight significant maternal factors such as age, education level, employment status, pregnancy intention, and history of stillbirth, as well as socio-cultural influences including distance to clinics, religion, spousal education, and cultural traditions. The study underscores the interplay of these variables, noting that higher education levels, planned pregnancies, and spousal support greatly enhance FANC uptake.

**Conclusion:** Maternal factors and social-economic factors are some of the determinants of focused antenatal care practices in Ekiti state, Nigeria. These findings call for multi-faceted approaches to promote FANC, such as community-based education, improved clinic accessibility, training for healthcare providers, and spousal inclusion strategies

**Keywords:** Focused Antenatal Care; Maternal Factors; Social-Cultural Factors, Pregnant woman

**1.0 INTRODUCTION**

Maternal mortality remains an intractable public‑health challenge: Nigeria recorded an estimated maternal‑mortality ratio (MMR) of about 825 per 100 000 live births in 2023, one of the highest in the world (Haruna et al., 2023). Stillbirths add a further layer of tragedy; recent qualitative work with Nigerian midwives underscores the continued burden of intrapartum stillbirths and links them to sub‑optimal antenatal and delivery care (Popoola, 2025). Achieving Sustainable Development Goal 3.1 therefore hinges on strategies that increase timely, high‑quality antenatal services for every pregnancy.

Kolawole-Odusina et al. (2024**)** analyzed compliance with WHO ANC recommendations in sub-Saharan Africa, noting low prevalence of eight or more ANC contacts in Nigeria . Antenatal care (ANC) has evolved from the four‑visit “Focused ANC” (FANC) model to the 2016 WHO recommendation of at least eight contacts. Yet uptake across sub‑Saharan Africa—and Nigeria in particular—remains poor: a 2024 multi‑country analysis found that only 9.9 % of women achieved eight contacts, with Nigeria’s compliance at 25 % Mare et al., 2024). Sub‑national analyses confirm persistent shortfalls; younger women, the less educated and those whose husbands dominate health‑care decisions are least likely to reach even four visits (Fagbamigbe et al., 2021). Consequently, many facilities (especially primary centres) in Nigeria still operationalise the earlier FANC schedule.

Despite widespread policy endorsement, awareness of the FANC concept itself is limited. A 2023 survey in Enugu State showed that fewer than half of pregnant women could correctly describe FANC, with late booking and long waiting times cited as deterrents (Nwabueze, 2023). This suggests that behavioural as well as health‑system factors drive under‑utilisation.

Maternal characteristics play a critical role in determining ANC utilisation. Teenage mothers tend to have the fewest contacts, while older maternal age is associated with increased utilisation (Fagbamigbe et al., 2021). Education and employment also significantly influence outcomes, as women and their husbands who have completed secondary education or are formally employed show higher odds of adhering to recommended visits (Mare, 2024). Reproductive history adds another layer of complexity, with prior stillbirths either motivating or deterring ANC based on past health-system experiences (Popoola, 2025). Pregnancy intention further affects compliance, as mistimed or unwanted pregnancies are 25–29% less likely to receive adequate ANC compared to planned pregnancies across 32 African countries (Ouedraogo & Bougma, 2024). Finally, financial autonomy emerges as a decisive factor, with Nigerian women who have full control over household finances significantly more likely to attend ANC, independent of their wealth status (Ilori, 2022).

Socio-cultural and environmental determinants play critical roles in shaping antenatal care-seeking behaviors. Religion and indigenous beliefs often influence the preference for traditional birth attendants or spiritual homes (Opara, 2024), while household decision-making autonomy predicts not only the timing but also the total number of antenatal visits (Imo, 2022). Furthermore, physical access remains crucial, as every additional kilometer from a health facility reduces the odds of attending antenatal care by approximately 4% (Bolarinwa, 2021). Spousal support is similarly impactful; in Ekiti State, about 40% of women reported that their male partners decided whether they should attend antenatal care, highlighting the patriarchal influence on maternal health behaviors (Ade-Ojo et al., 2025). Lastly, local traditions and ethnicity continue to shape antenatal care utilization; even in a state with high literacy rates like Ekiti, income disparities, non-Yoruba ethnicity, and entrenched cultural norms significantly modulate care-seeking behaviors (Oluwadare et al., 2024).

Ekiti State boasts the highest female literacy rate in Nigeria, yet faces high unemployment and pockets of poverty (Oluwadare, 2024) Previous studies highlight good baseline knowledge of ANC but reveal gaps in birth‑preparedness counselling and male‑partner engagement.(Adeojo, 2021). No published work has simultaneously examined how the age, education, reproductive history, pregnancy intention, employment status, distance, religion, spouse education and indigenous cultural practices of pregnant women collectively influence Focused Antenatal Care (FANC) utilisation, as perceived by front‑line health workers in Ekiti.

By exploring these maternal and socio‑cultural determinants through the lens of health‑care providers, this study aims to generate context‑specific evidence to inform targeted interventions—such as community‑based birth‑preparedness programmes, male‑involvement strategies and culturally responsive health education—that can accelerate progress towards universal, high‑quality antenatal care in Ekiti State and comparable settings in Nigeria.

**2. MATERIAL AND METHODS**

Focused Antenatal Care (FANC) is a strategic approach recommended by the World Health Organization (WHO) to improve maternal and neonatal outcomes through individualized, evidence-based care during pregnancy. Despite its proven benefits, the utilization of FANC remains suboptimal in many regions of Nigeria, including Ekiti State. Numerous maternal and socio-cultural factors influence the uptake of FANC services. This literature review synthesizes recent empirical studies (published within the last five years) that examine these determinants, with a focus on Nigeria and comparable contexts.

**2.1 Maternal Factors Influencing FANC Utilization**

Maternal age is widely acknowledged as a significant predictor of antenatal care utilization. Several studies report that younger mothers, particularly adolescents, are less likely to attend the recommended number of ANC visits compared to older women. This disparity is often linked to a lack of knowledge, financial dependence, and societal stigma surrounding teenage pregnancies. Conversely, older women are more likely to have experience, resources, and autonomy that facilitate engagement with ANC services.

Education plays a critical role in shaping health-seeking behavior. According to Obeng et al. (2021), maternal education, alongside wealth and media exposure, significantly influences ANC attendance in Nigeria. Women with higher levels of education are more likely to utilize FANC services because education enhances awareness of ANC benefits, empowers decision-making, and improves communication with healthcare providers. Supporting this, Ngowi et al. (2023) found that women with secondary education in Simiyu Region, Tanzania, had a 43% higher prevalence of FANC utilization than their counterparts with no formal education.

Employment status and financial autonomy are also pivotal determinants of ANC utilization. Ilori et al. (2023), using data from the 2018 Nigeria Demographic and Health Survey, established that women's financial independence and education were significant predictors of ANC utilization. Women who are employed or have control over household finances are more capable of affording transportation and medical costs, thereby increasing ANC attendance. Another study using the same dataset found that women with full financial autonomy had significantly higher odds of utilizing ANC services (Ilori, 2022). Similarly, Adegbola and Arowolo (2022) highlighted how income levels and ethnic status influenced ANC attendance in Ekiti State.

Awareness of FANC also contributes to utilization rates. Uche and Nwafor (2023) revealed that increased awareness significantly improved ANC attendance among pregnant women in Enugu State. Furthermore, the intention behind pregnancy plays a critical role. Ouedraogo and Bougma (2024) reported that planned pregnancies in sub-Saharan Africa were associated with higher ANC attendance, owing to better preparedness and motivation. In contrast, unplanned pregnancies often lead to delays or avoidance of ANC due to denial, stigma, or lack of readiness. El-Khatib et al. (2020) emphasized the importance of integrating family planning and reproductive health education to address this issue.

A woman’s previous pregnancy experience can also influence her approach to ANC in subsequent pregnancies. For instance, Popoola (2025) found that women who had experienced stillbirths often demonstrated greater vigilance in seeking ANC to avoid recurrence. However, some women may also suffer trauma or fear that discourages healthcare engagement. Additionally, perceived quality of care and provider attitudes are vital. Aluko et al. (2022) noted that perceptions of healthcare quality and staff behavior significantly impacted ANC uptake in Osun State. Similarly, Adeyemi and Akingbade (2022) highlighted the role of decision-making autonomy in improving maternal health outcomes through increased ANC utilization.

**2.2** **Socio-Cultural Factors Affecting FANC Utilization**

Religious beliefs can either facilitate or hinder the use of ANC services. In some communities, religious doctrines support the use of modern healthcare, while in others, there is a strong preference for faith-based healing or traditional remedies. For instance, certain religious ideologies in Nigeria discourage medical interventions such as cesarean sections, thereby affecting maternal health outcomes (Ugwu, 2015). Adepoju and Oladipo (2024) emphasized the need for culturally sensitive healthcare strategies that respect religious and cultural values while promoting safe maternal practices.

Cultural norms, particularly in patriarchal societies, significantly impact ANC utilization. Women's autonomy in healthcare decisions is often restricted, requiring consent from male family members. Furthermore, preferences for traditional birth attendants, myths surrounding pregnancy, and the stigma of medical procedures may hinder ANC attendance. Opara (2024) highlighted that patriarchal structures in Kogi State restricted women’s access to maternal healthcare services, thereby reducing ANC uptake.

Ethnic diversity and cultural beliefs also shape health-seeking behaviors. Ogundairo and Jegede (2023) examined Fulani women in Oyo State and identified cost, health worker attitudes, and cultural traditions as barriers to ANC. Similarly, Oluwadare et al. (2024) found that ethnic background, religion, and income levels influenced ANC utilization in Ekiti State. Language differences in multicultural settings like Nigeria can further limit communication with healthcare providers, leading to dissatisfaction and poor service uptake. Thus, culturally and linguistically sensitive healthcare services are essential.

Family support plays a vital role in determining whether women access ANC services. Ngowi et al. (2023) observed that joint decision-making between spouses and higher educational attainment increased the likelihood of completing four or more ANC visits. Aghata (2023) also noted that in many Nigerian communities, women’s dependence on their male partners for financial and logistical support directly affects their ability to access care.

Accessibility to healthcare facilities remains a significant barrier, especially in rural areas. Women living far from healthcare centers often face transportation challenges, financial constraints, and time limitations. Adedokun (2023) reported that distance to health facilities significantly impacted ANC utilization in Nigeria. Similarly, Obeng et al. (2020) found that women in Ghana were less likely to attend ANC visits if they lived far from health facilities or harbored fears related to cultural superstitions, such as witchcraft.

In summary, both maternal and socio-cultural factors significantly affect the utilization of Focused Antenatal Care in Nigeria. Maternal age, education, employment, financial autonomy, pregnancy intention, past experiences, and awareness influence women's health-seeking behavior. At the same time, socio-cultural elements such as religion, patriarchy, spousal support, ethnicity, language, and geographic access play critical roles. Understanding these multidimensional factors is essential for designing targeted, culturally sensitive interventions that promote the uptake of FANC and improve maternal and neonatal health outcomes.

The study employed descriptive and explanatory research design through a cross-sectional survey to achieve its objectives. Data were gathered using a structured questionnaire, with the research setting focused on tertiary hospitals in Ekiti State: Ekiti State Teaching Hospital Ado-Ekiti, Federal Teaching Hospital Ido-Ekiti, and ABUAD Multi-Systems Hospital Ado-Ekiti. The study targeted all 118 nurse midwives in these hospitals, comprising 49 from Ekiti State Teaching Hospital, 60 from Federal Teaching Hospital Ido-Ekiti, and 9 from ABUAD Multi-System Hospital. Total enumeration sampling techniques were utilized due to the limited number of participants.

Focused antenatal practices were measured using binary questions with “Yes” or “No” responses, assessing adherence to the 2001 and 2016 WHO models. Similarly, health workers' knowledge about focused antenatal care was evaluated using binary questions, while attitudes were measured on a five-point Likert scale ranging from “Strongly Disagree” to “Strongly Agree.” This methodological structure ensured that key variables of knowledge and attitudes were systematically examined.

To establish the validity of the research instrument, the study employed content validity, adapting the questionnaire from previous studies and conducting a pilot test with 20 participants. Factor analysis was performed to further refine the instrument, using a threshold of 0.4 for factor loading. Questions contributing insufficient values were screened out. The Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy and Bartlett’s Test were also conducted to confirm data reliability, with KMO scores exceeding 0.5 and Bartlett’s significance levels below 0.05 indicating satisfactory correlations among variables.

Reliability tests were conducted through Cronbach’s alpha statistics to ensure internal consistency. The study adopted a benchmark of 0.7 for Cronbach’s alpha, discarding any variables falling below this threshold. Variables deemed unreliable were removed, and only those meeting reliability criteria underwent further analysis.

For analytical purposes, descriptive statistics—such as mean, median, mode, frequency, percentage, minimum, maximum, and standard deviation—were employed to provide insights into the data.

**3.0 Results and Discussion**

This section comprises the results of the analysis. The questions were first subjected to factor analysis and only the variables that have the factor loading of 0.4 and above were selected for reliability test using Cronbach Alpha. All the variables passed the reliability tests having coefficients of 0.7 and above. The questions were further subjected to descriptive analysis

**3.1 Descriptive Analysis of Focused Antenatal Care**

The descriptive analysis of focused antenatal care are shown in this section.

**Table.1. *Descriptive Statistics of Focused Antenatal Care***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Count** | **Subtable N %** | **Mean** | **Median** | **Mode** | **SD** | **Max** | **Mini** |
| Your clinic hours are friendly and convenient enough to accommodate the need of patients and their schedule of work. | No | 7 | 6.1% |  |  |  |  |  |  |
| Yes | 107 | 93.9% |  |  |  |  |  |  |
| Total | 114 |  | .94 | 1.00 | 1.00 | .24 | 1.00 | .00 |
| You ensure early identification and treatment of already established disease in the body of pregnant mothers | No | 3 | 2.6% |  |  |  |  |  |  |
| Yes | 111 | 97.4% |  |  |  |  |  |  |
| Total | 114 |  | .97 | 1.00 | 1.00 | .16 | 1.00 | .00 |
| Your hospital is culturally acceptable and appropriate as it respects specific myths and beliefs, taboos and practices surrounding pregnancy and childbirth | No | 23 | 20.7% |  |  |  |  |  |  |
| Yes | 88 | 79.3% |  |  |  |  |  |  |
| Total | 111 |  | .79 | 1.00 | 1.00 | .41 | 1.00 | .00 |
|  You include other activities such as sexually transmitted infection and HIV testing/ counselling, malaria detection and prevention, micronutrient provision, birth planning, emergency planning and family counselling in your antenatal care | No | 2 | 1.8% |  |  |  |  |  |  |
| Yes | 111 | 98.2% |  |  |  |  |  |  |
| Total | 113 |  | .98 | 1.00 | 1.00 | .13 | 1.00 | .00 |
| Your hospital has adequate plan for referral and transportation to the appropriate health facility | No | 1 | 0.9% |  |  |  |  |  |  |
| Yes | 112 | 99.1% |  |  |  |  |  |  |
| Total | 113 |  | .99 | 1.00 | 1.00 | .09 | 1.00 | .00 |

 **Source: Author’s Computation (2025)**

From table 1, 107(93.9%) of the respondents made their clinic hours friendly and convenient enough to accommodate the need of patients and their schedule of work which implies they practice focused antenatal care. However, seven (7) (6.1%) do not practice focus antenatal care. On average, all the respondents practice focused antenatal care (Mean = 0.94± .24 approximately 1, Median = 1, Mode =1). Also, 111 (97.4%) respondents ensure early identification and treatment of already established disease in the body of pregnant mothers which is an indication of focus antenatal care, but three (3) (2.6%) do not. On average, all the respondents agreed that they ensure early identification and treatment of already established disease in the body of pregnant mothers (Mean = .97± .16, Median = 1, Mode = 1).

 Also, 88 (79.3%) of the respondents agreed that their hospital is culturally acceptable and appropriate as it respects specific myths and beliefs, taboos and practices surrounding pregnancy and childbirth which is an indication of focus antenatal cate, but 23 (20.7%) do not. On average, all the respondents made their clinic culturally acceptable (Mean = .79± .41, Median = 1.0, Mode = 1.0). Likewise, 11(98.2%) of the respondents include other activities such as sexually transmitted infection and HIV testing/ counselling, malaria detection and prevention, micronutrient provision, birth planning, emergency planning and family counselling in their antenatal care which implies the practice of focus antenatal care, but 2 (1.8%) do not. On average, all the research participants include other activities in their antenatal care (Mean = .98±. 13, Median = 1.0, Mode = 1.0) which indicates the practice of focused antenatal care. Finally, 112 (99.1%) of the respondents have adequate plans for referral and transportation to the appropriate health facility, but one (1) (0.9%) of them did not. On average, all the respondents agreed that their hospitals make adequate plans for referral which is also an indication of focused antenatal care (Mean = .99 ± .09, Median = 1.0, Mode = 1.0).

**3.2 Maternal Factors Influencing FANC Utilization**

The results of maternal factors influencing FANC utilization were discussed in this section. The age of the mother, educational level,History of stillbirth, planned pregnancy, Employment status and Spouse’s education were analysed in Table 2.

**Table 2:***Maternal Factors Influencing FANC Utilization*

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Factor | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree | Total Count | Mean | Median | Mode | SD | Max | Min |
| Age of mother | 3 (2.7%) | 27 (23.9%) | 11 (9.7%) | 51 (45.1%) | 21 (18.6%) | 113 | 3.53 | 4.00 | 4.00 | 1.13 | 5.00 | 1.00 |
| Educational level | 5 (4.3%) | 16 (13.7%) | 10 (8.5%) | 52 (44.4%) | 34 (29.1%) | 117 | 3.80 | 4.00 | 4.00 | 1.13 | 5.00 | 1.00 |
| History of stillbirth | 6 (5.1%) | 34 (29.1%) | 23 (19.7%) | 31 (26.5%) | 23 (19.7%) | 117 | 3.26 | 3.00 | 2.00 | 1.22 | 5.00 | 1.00 |
| Planned pregnancy | 6 (5.5%) | 10 (9.2%) | 7 (6.4%) | 51 (46.8%) | 35 (32.1%) | 109 | 3.91 | 4.00 | 4.00 | 1.12 | 5.00 | 1.00 |
| Employment status | 5 (4.3%) | 28 (24.3%) | 11 (9.5%) | 48 (41.7%) | 23 (20.0%) | 115 | 3.51 | 4.00 | 4.00 | 1.21 | 6.00 | 1.00 |
| Spouse’s education | 6 (5.2%) | 29 (25.0%) | 7 (6.0%) | 49 (42.2%) | 25 (21.6%) | 116 | 3.50 | 4.00 | 4.00 | 1.23 | 5.00 | 1.00 |

**Source: Author’s computation (2025)**

 Table 2 shows that 21 (18.6%) of the respondents strongly agreed that age of the mother influences the choice of focused antenatal care, 51 (45.1%) also agreed, 11 (9.7%) were not sure, 27 (23.9%) disagreed and three (3) (2.7%) strongly disagreed. On average, all the respondents agreed that age of the mother determine the patronage of focus antenatal care (Mean = 3.53 ± 1.13, Median = 4, Mode = 4). Also, 34(29.1%) strongly agreed that educational level of the mothers determine their level of patronage of focused antenatal care, 52(44.4%) also agreed with this statement, 10 (8.5%) were not sure, 16 (13.7%) disagreed with the statement and five (5) (4.3%) strongly disagreed. On average, all the respondents agreed that educational level influences the choice of focused antenatal care as the learned mothers use FANC more than uneducated mothers (Mean = 3.80 ± 1.13, Median = 4, Mode =4). Similarly, 23 (19.7%) strongly agreed those who had history of stillbirth attend FANC more than those who didn’t have the history, 31 (36.5%) also agreed, 23 (19.7%) were not sure, 34(39.1%) disagreed and six (6) (5.1%) strongly disagreed. Averagely, all the respondents were not sure (3.26 ± 1.22, Median = 3). The mode which is 2 implies that most of the respondents disagreed with the statements.

Furthermore, 35 (32.1) strongly agreed that Mothers with planned pregnancy prefer FANC, 51 (46.8%) also agreed with the statement, seven (7) (6.4%) were not sure, 10(9.2%) disagreed, six (6) (5.5%) strongly disagreed. On average, all the respondents agreed that Mothers with planned pregnancy prefer FANC (Mean = 3.91± 1.12, Median = 4, Mode = 4).

In the same manner, 23 (20%) of the respondents strongly agreed that employment status influences the choice of focused antenatal care as pregnant women with good job attend FANC more than those with low employment status, 48 (41.7%) also agreed, 11 (9.5%) were not sure, 28 (24.3%) disagreed, five (5) (4.3%) strongly agreed. On average, all the study’s participants agreed that employment status affects the choice of focused antenatal care (Mean = 3.51± 1.21, Median = 4.0, Mode = 4.0).

**3.3 Socio-Cultural Factors Affecting FANC Utilization**

The social -cultural factors capable of determining the focused antenatal care in Ekiti-State Nigeria are analysed in Table.3

**Table 3:** *Socio-Cultural Factors Affecting FANC Utilization*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Count** | **Subtable N %** | **Mean** | **Median** | **Mode** | **SD** | **Max** | **Min** |
| Pregnant mothers who stay a far distance away from the FANC clinic do not prefer FANC | Strongly Disagree | 6 | 5.2% |  |  |  |  |  |  |
| Disagree | 31 | 27.0% |  |  |  |  |  |  |
| Not sure | 27 | 23.5% |  |  |  |  |  |  |
| Agree | 36 | 31.3% |  |  |  |  |  |  |
| Strongly agree | 15 | 13.0% |  |  |  |  |  |  |
| Total | 115 |  | 3.20 | 3.00 | 4.00 | 1.13 | 5.00 | 1.00 |
| Religion of the pregnant mothers determines their preference for FANC | Strongly Disagree | 13 | 11.2% |  |  |  |  |  |  |
| Disagree | 37 | 31.9% |  |  |  |  |  |  |
| Not sure | 19 | 16.4% |  |  |  |  |  |  |
| Agree | 35 | 30.2% |  |  |  |  |  |  |
| Strongly agree | 12 | 10.3% |  |  |  |  |  |  |
| Total | 116 |  | 2.97 | 3.00 | 2.00 | 1.22 | 5.00 | 1.00 |
| Spouse’s education. The higher the education of the spouse, the more likely the pregnant mother will register for FANC | Strongly Disagree | 6 | 5.2% |  |  |  |  |  |  |
| Disagree | 29 | 25.0% |  |  |  |  |  |  |
| Not sure | 7 | 6.0% |  |  |  |  |  |  |
| Agree | 49 | 42.2% |  |  |  |  |  |  |
| Strongly agree | 25 | 21.6% |  |  |  |  |  |  |
| Total | 116 |  | 3.50 | 4.00 | 4.00 | 1.23 | 5.00 | 1.00 |
| Pregnant mothers with peculiar culture/traditions come for FANC | Strongly Disagree | 13 | 11.2% |  |  |  |  |  |  |
| Disagree | 30 | 25.9% |  |  |  |  |  |  |
| Not sure | 24 | 20.7% |  |  |  |  |  |  |
| Agree | 37 | 31.9% |  |  |  |  |  |  |
| Strongly agree | 12 | 10.3% |  |  |  |  |  |  |
| Total | 116 |  | 3.04 | 3.00 | 4.00 | 1.20 | 5.00 | 1.00 |

**Source: Author’s Computation (2025)**

Likewise, Table 3 reveals that 15 (13.0%) of the respondents strongly agreed that Pregnant mothers who stay a far distance away from the FANC clinic do not prefer FANC, 36 (31.3%) also agreed that distance is a factor, 27 (23.5%) were not sure, 31 (27%) disagreed and six (6) (5.2%) strongly disagreed. The mode which is 4 implies that the highest number of them agreed that distance affects the choice of focused antenatal care. Generally, all the respondents were not sure whether distance determines the choice of focus antenatal care or not (Mean = 3.2±1.13, Median = 3.0).

In like manner, 12 (10.3%) strongly agreed that religion of the pregnant mothers determines their preference for FANC, 35 (30.2%) also agreed, 19 (16.4%) were not sure, 37 (31.9%) disagreed and 13 (11.2%) strongly disagreed. Mode which is 2 implies that most of the participants disagreed that religion affects the choice of focus antenatal care. On average, all the participants were not sure if religion influences the choice of focused antenatal care or not (Mean = 2.97± 1.22, Median = 3). Also, 25 (21.6%) strongly agreed that Spouse’s education affects the decision for focus antenatal care as the higher the education of the spouse, the more likely the pregnant mother will register for FANC. 49 (42.2%) of them also agreed, seven (7) (6.0%) were not sure, 29 (25.0%) disagreed and six (6) (5.2%) strongly disagreed. On average, all the respondents agreed that the higher the education of the husband, the more likely the pregnant mothers will register for focused antenatal care (Mean = 3.5 ± 1.23, Median = 4.0, Mode = 4.0). Finally, 12(10.3%) strongly agreed that pregnant mothers with peculiar culture/traditions come for FANC, 37 (31.9%) of them also agreed, 24 (20.7%) were not sure, 30 (25.9%) disagreed and 13 (11.2%) strongly disagreed. Mode which is 4.0 implies that most of the respondents agreed that spouse education affects the patronage of focus antenatal care. However, on average, all the participants were not sure if the culture of the pregnant mothers affect their choice of focus antenatal care or not (Mean = 3.04± 1.2, Median = 3).

**4.0 Conclusion**

The findings indicate several factors influencing the patronage of focused antenatal care (FANC) among pregnant women. These factors include age, educational level, history of stillbirth, planned pregnancy, employment status, distance to the clinic, religion, spouse’s education, and cultural traditions. For instance, higher education levels of both pregnant women and their spouses positively correlate with increased utilization of FANC services. Similarly, planned pregnancies and good employment status were associated with higher patronage. However, factors such as religion, distance to clinics, and cultural traditions yielded mixed results, with respondents expressing varied perspectives on their impact. Overall, these findings highlight a complex interplay of socio-cultural and economic factors shaping the uptake of FANC services.

The study underscores the critical importance of socio-cultural and economic factors in determining the utilization of FANC services. While education, planned pregnancies, and employment status emerged as strong positive determinants, the influences of religion, distance, and cultural practices were less conclusive. These results indicate that addressing gaps in FANC utilization requires a multi-faceted approach that considers the diverse backgrounds and circumstances of pregnant women.

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