

Factors associated with changes in adequate antenatal care visits among pregnant women aged 15-49 years in Tanzania from 2004 to 2016.

ELIZABETH KASAGAMA (✉ kasagamae93@mail.com)

Kilimanjaro Christian Medical University College <https://orcid.org/0000-0002-9900-4153>

Jim Todd

London School of Hygiene and Tropical Medicine

Jenny Renju

London School of Hygiene and Tropical Medicine

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Abstract

Background: Antenatal care (ANC) is crucial for the health of the mother and the unborn child as it delivers highly-effective health interventions that can prevent maternal and newborn deaths and morbidity. In 2002, the World Health Organization (WHO) recommended a minimum of four ANC visits for a pregnant woman with a positive pregnancy during the entire gestational period. Tanzania has sub-optimal adequate (four or more) ANC visits and the trend has been fluctuating over time. An understanding on the factors that have been contributing to the fluctuating trend over years is crucial in increasing the proportions of pregnant women attaining adequate ANC visits in Tanzania.

Methods: The study used secondary data from Tanzania Demographic Health Survey (TDHS) from 2004 to 2016. The study included 17976 women aged 15-49 years. Data were analyzed using stata version 13. Categorical and continuous variables were summarized using descriptive statistics and using the weighted proportions. A Poisson regression analysis was done to determine factors associated with adequate antenatal. A multivariable Poisson decomposition analysis was done to determine factors associated with changes in adequate ANC visits among pregnant women in Tanzania from 2004 to 2016.

Results: The overall proportion of women who had adequate ANC visits in 2004/05, 2010 and 2015/16 was 62%, 43% and 51% respectively. The identified determinants of adequate ANC visits were: early ANC initiation, zones, having more than one child, being aged 20 years and above, wanting pregnancy later, belonging to a richer and richest wealth quintile, having secondary and higher education, reporting distance to health facility not a big problem and watching TV at least once per week. Comparing 2004/05 and 2010 surveys, changes in the population structure contributed 4.2% of changes in adequate antenatal care visits while changes in coefficients contributed 95.8% of the changes. Also, comparing 2015/16 to 2010 surveys, changes in population structure and coefficients contributed 66.2% and 33.8% respectively.

Conclusion: Early ANC initiation has greatly contributed to increased proportion of pregnant women who attain four or more ANC visits overtime. More effort should focus on pregnant women to initiate ANC in the first trimester in order to increase proportion of women with adequate ANC visit.

Background

Adequate and quality antenatal care (ANC) is effective at promoting better health outcomes for both the mother and child during pregnancy(1,2). Strong evidence exists to support the link between ANC during pregnancy, skilled birth attendant during delivery and quality postnatal and reduced maternal and infant morbidity and mortality(3-8). Globally, almost 60% of stillbirths are due to poor fetal growth, untreated and unattended maternal infection and conditions, which could have been prevented or treated by expert attention available during ANC visits(7). A wide range of services can be offered during ANC including screening, detection, prevention to treatment of any pregnancy related complication, infection or morbidity(9).

WHO 2002 Focus Antenatal care (FANC) model recommends a minimum of four ANC visits for a woman with uncomplicated pregnancy with the first visit during the first trimester, although currently there is an 8 contacts model in place (9,10). In 2002 Tanzania adopted FANC which is still in use to date, but the first ANC is to be initiated within 16th gestational weeks Globally, ANC coverage (percentage of women aged 15–49 with a live birth in a given time period that received antenatal care provided by skilled health personnel at least once during their pregnancy one ANC visit) is 86%, however only 62% of women meet the recommended four ANC visits. In Africa ANC coverage is 69% with only 54% of women attending the minimum of four ANC visits, in Tanzania ANC coverage is higher (98%) but only 51% of pregnant women attain the minimum of four ANC visits(12). Despite a high ANC coverage, adequate (four or more) ANC visits is still suboptimal and could in part explain the unacceptably high neonatal mortality and still birth rates in Tanzania, 25 deaths/1000 live births and 39 deaths/1000 pregnancies respectively(13).

In order to further promote uptake of ANC and to address the burden of maternal mortality, additional interventions were introduced. These included the provision of free maternal and child health services. In 2012, Tanzania's National Safe Motherhood Campaign "Wazazi nipendeni campaign" was implemented to encourage pregnant women to initiate the first ANC within 12 gestational weeks and adherence to ANC services

Poor quality of ANC service offered, lack of essential ANC services, differentials in roll out of FANC, shortage of skilled staff and supplies have been reported to hinder uptake of ANC services at different settings in Tanzania

This study aims to show how much individual factors have contributed to the decline from 2004/04 to 2010 and the increase from 2020 to 2015/16 TDHS and how they have been contribution to the varying low proportions of adequate ANC visits overtime. Filling this gap of knowledge may help identify the key contributing factors and provide valuable information on how the programmatic changes during 2004 to 2016 have impacted adequate ANC attendance. Moreover, understanding the factors associated with changes in adequate ANC visits may help to provide valuable information to policy makers, project implementing partners and in designing target interventions that may improve adequate ANC visits.

Methods

Study design and study settings

The study was conducted in Tanzania, which includes mainland and island. This was a Crosssectional study. The study used data from the Tanzania Demographic Health Survey (TDHS), Further details of the survey are available elsewhere(13), but in brief this is a national representative survey done after a period of five years and the main objective is to obtain the current and reliable information on demographic and health indicators with regard to family planning, fertility levels and preferences, maternal mortality, infant and child mortality, nutritional status of mothers and children, ANC, delivery care, and childhood immunizations and diseases. Data were obtained from www.dhsprogram.com, DHS measure website

whereby the permission to access the data was first obtained before being authorized to download data from DHS measure website. Data from 2004/04, 2010 and 2015/16 surveys were used.

Study population

The population was all women of reproductive age (15-49 years) who had given birth to at least one child within the five years prior to the survey and had information on ANC visits. For a woman with multiple birth during the five-year period, we considered the most recent birth for this analysis. A total of 33,734 women age 15-49 years in Tanzania participated in the three TDHS surveys. After excluding those with missing information on our outcome of interest we remained with a total of 17,976. Of the 17,976 women enrolled in the study; 4541(77.9%), 4201(76.9%) and 5193(70.1%) for 2004/05, 2010 and 2015/16 surveys respectively (figure 1).

Study variables

The dependent variable was adequate ANC visits, which was categorized as four or more ANC visits and coded 1. Less than four ANC visits as inadequate and coded 0. The independent variables included were respondent's age at last birth (15-19 years, 20-24 years, 25-29 years, 30-34 years, 35+ years), education level (no formal education, primary education, secondary and higher education), employment status (unemployed, employed), marital status (married/cohabiting, single, divorced/widowed/separated), residence (urban, rural), wealth index (poorest, poorer, middle, richer, richest), zones; these are administrative regions grouped according to the geographical location (western zone, northern zone, central zone, southern highlands, southern zone, south west highlands zone, lake zone, eastern zone, Zanzibar), first ANC initiated (women with first ANC visit later than 12 gestational weeks, women with first ANC visit by 12 gestational weeks), decision maker of respondent's health care (respondent alone, respondent and partner, partner alone, someone else), parity (1 child, 2-3 children, 4-5 children, 6 or more children), frequency of listening to radio (not at all, Less than once a week, at least once a week), frequency of watching TV (not at all, less than once a week, at least once a week), desire of last pregnancy (wanted then, wanted later, wanted no more), history of terminated pregnancy (never had, ever had) and distance from health facility (big problem, not a big problem). The selection of variables was made using the Andersen's Behavioural Model of Health Services Use(34)Andersen's Behavioral Model of Health Services Use

Statistical analysis

Data were analyzed using STATA Corporation, College Station, TX, USA version 13. Analysis took into account the complex survey features. A multivariable Poisson decomposition analysis was conducted to determine factors associated with changes in adequate ANC visits. The decomposition analysis was conducted to understand whether observed changes in adequate ANC visits could be explained by changes in factors over time or in the population structure (population dynamics). Decomposition

analysis was conducted between two time points, 2004/05 to 2010 surveys and 2015/16 to 2010 surveys. Contributions were considered statistically significant at a P-value of less than 0.05.

Results

Characteristics of the study participants

A total of 17,976 women across all the three surveys were enrolled in the study. Most of the participants were from the rural areas, the mean age (\pm SD) of the study population was 27.06(\pm 7.00). More than a half of the respondents in each survey had at least primary education level. The majority of the participants were married or cohabiting: 85.4%, 84.2% and 81.6% for the 2004/05, 2010 and 2015/16 survey respectively. The proportions of women aged 35 to 45 years increased across the survey years, from 15.6%, in 2004/05 to 17.8% in 2015/16. The percentage of women who achieved secondary education and above also increased from 9.2% in 2004/05 to 19.9% in 2015/16 and the percentage of women without formal education decreased from 26.8% in 2004/05 to 19.5% in 2015/16. Substantial regional variation in survey participation was observed; throughout the three surveys the Lake Zone had the highest percentage of women participating in the survey (18.7%, 19.2% and 25.7% for 2004/05, 2010 and 2015/16 surveys respectively) while the Southern zone had lowest (6.5%, 6.4% and 4.9% for 2004/05, 2010 and 2015/16 surveys respectively) (Table 1).

Table 1 Characteristics of the study participants (N=17976)

	2004-05 TDHS	2010 TDHS	2015-16 TDHS
Variables	Frequency (%) (n=5632)	Frequency (%) (n=5325)	Frequency (%) (n=7019)
<i>Age at delivery (in years)</i>			
15-19	961(17.1)	775(14.5)	1253(17.8)
20-24	1532(27.2)	1376(25.8)	1733(24.7)
25-29	1326(23.5)	1249(23.5)	1593(22.7)
30-34	933(16.6)	940(17.7)	1194(17.0)
35+	880(15.6)	985(18.5)	1246(17.8)
Mean age (\pm SD)	27.1(\pm 7.07)	27.80(\pm 7.10)	27.41(\pm 7.23)
<i>Zones</i>			
Western zone	522(9.3)	502(9.4)	619(8.8)
Northern zone	546(9.7)	489(9.2)	562(8.0)
Central zone	676(12.0)	625(11.7)	690(9.8)
Southern Highlands	399(7.1)	366(6.9)	561(8.0)
Southern zone	368(6.5)	342(6.4)	347(4.9)
South West Highlands zone	499(8.9)	410(7.7)	778(11.1)
Lake Zone	1051(18.7)	1020(19.2)	1803(25.7)
Eastern zone	522(9.3)	534(10.0)	713(10.2)
Zanzibar	1049(18.5)	1037(19.5)	946(13.5)
<i>Place of residence</i>			
Rural	4541(80.6)	4201(78.9)	5193(74.0)
Urban	1091(19.4)	1124(21.1)	1826(26.0)
<i>Highest level of education</i>			
No formal education	1509(26.8)	1262(23.7)	1368(19.5)
Primary education	3603(64.0)	3393(63.7)	4255(60.6)
Secondary and above	520(9.2)	670(12.6)	1396(19.9)
<i>Current marital status</i>			
Single	285(5.0)	296(5.6)	451(6.4)

Married/Cohabiting	4809(85.4)	4486(84.2)	5724(81.6)
Widowed/Divorced/Separated	538(9.6)	543(10.2)	844(12.0)
<i>Employment status*</i>			
Unemployed	1029(18.3)	929(17.5)	1515(21.6)
Employed	4602(81.7)	4388(82.5)	5504(78.4)
<i>Wealth index</i>			
Poorest	1167(20.7)	1006(18.9)	1441(20.5)
Poorer	1131(20.1)	1150(21.6)	1356(19.3)
Middle	1082(19.2)	1078(20.2)	1376(19.6)
Richer	1247(22.1)	1161(21.8)	1544(22.0)
Richest	1005(17.9)	930(17.5)	1302(18.6)

***Employment status 2004/5 (n=5631)**

***Employment status 2010 (n=5317)**

Trends of adequate antenatal care visits

The trend in adequate ANC attendance fluctuated over time. Adequate ANC attendance decreased from 61% in 2004/05 to 43% in 2010 survey, and then increased again to 51% in the 2015/16 survey (Fig 2). Similar pattern was also found when stratified by zones. The eastern zone had the highest percentage of women with adequate ANC attendance for all the three surveys (fig 3). Percentage of women with four ANC visit who initiated the first ANC visit in the first trimester increased over time (Fig 4).

Factors associated with adequate antenatal care visits.

Various factors were associated with adequate ANC visits for each survey. First ANC in first trimester, multiparous, wanting pregnancy later, watching TV at least once a week, older age, zones, secondary education and above, reporting distance to health facility not a problem, richer and richest household wealth index had influence on adequate ANC visits.

In the multivariable Poisson regression analysis, for all the three surveys ANC initiation within the first trimester had a positive effect on adequate ANC visits. The proportion of women with adequate ANC attendance was 1.47(95% CI: 1.41-1.52) times greater among women who initiated ANC within first trimester compared to those who initiated later in 2004/05, and 1.96(95% CI: 1.82-2.11) times higher in 2010, and 1.89 (95% CI: 1.79-2.00) times higher in 2015/16. Whereby, wanting pregnancy later had a negative influence on adequate ANC visits. In 2004/05 adequate ANC attendance was 0.96 (95% CI: 0.90-1.02) times lower among women who wanted pregnancy later compared to a woman who wanted pregnancy then, 0.82 (95% CI: 0.74-0.92) times lower in 2010, and 0.92 (95% CI: 0.86-0.98) times lower in 2015/16.

Factors associated with changes in adequate antenatal care visits across the three surveys.

The multivariable decomposition regression models found that 95.8% of the decline in adequate ANC visits from 2004/05 (62%) to 2010 (43%) were due to changes in the coefficients (prevalence ratios of factors obtained from the surveys) and only 4.2% of the changes was due to the change in the population characteristics (population dynamics). There were no significant changes in the population structures during this period suggesting that the population remained relatively static between the 2004/05 and 2010 survey. The Southwest highland zone had contributed 14.2% to the observed decline in 2004/05 and 2010 surveys, this was statistically significant. Meaning that, the zone where a pregnant woman lived affected her ability to attain adequate ANC. Changes in the initiation of first ANC within the first trimester slowed down the decline by 8.7%, this was also statistically significant.

The proportion of women attending adequate ANC increased from 43% in 2010 to 51% in 2015/16. The slight increase was attributed by 33.8% of changes due to the coefficients and 66.2% due to the changes in the population characteristics. These changes were statistically significant with a p-value <0.001. The increase in proportion of women who had initiated ANC during the first trimester contributed 50.5% to the increase observed in 2010 to 2015/16 survey. This was statistically significant at a p-value <0.001. In the contributions due to differences in coefficients, South West highlands had contributed 21.4% in the overall increase.

Table 2 Factors associated with adequate antenatal care visits in Tanzania

Characteristics	2004-05 TDHS	2010 TDHS	2015-16 TDHS
	APR (95% CI)	APR (95% CI)	APR (95% CI)
<i>Age at delivery (in years)</i>			
15-19	1	1	1
20-24	0.92(0.85-0.99)	1.21(1.05-1.40)	1.06(0.96-1.18)
25-29	0.95(0.87-1.04)	1.21(1.03-1.42)	1.04(0.93-1.17)
30-34	0.95(0.85-1.06)	1.45(1.20-1.74)	1.15(1.01-1.30)
35+	0.96(0.85-1.09)	1.28(1.03-1.58)	1.19(1.02-1.38)
<i>Zones</i>			
Western zone	1	1	1
Northern zone	1.47(1.31-1.66)	1.45(1.19-1.77)	1.52(1.31-1.76)
Central zone	1.50(1.34-1.69)	1.37(1.13-1.66)	1.71(1.48-1.98)
Southern Highlands	1.37(1.21-1.56)	1.11(0.89-1.38)	1.25(1.07-1.46)
Southern zone	1.49(1.32-1.69)	1.16(0.93-1.45)	1.30(1.10-1.54)
South West Highlands	1.40(1.23-1.58)	0.74(0.58-0.96)	1.25(1.05-1.49)
Lake Zone	1.29(1.15-1.44)	1.27(1.06-1.53)	1.47(1.28-1.68)
Eastern zone	1.62(1.44-1.81)	1.53(1.26-1.85)	1.71(1.49-1.97)
Zanzibar	1.46(1.31-1.63)	1.27(1.05-1.53)	1.48(1.28-1.72)
<i>Place of residence</i>			
Rural	1.00(0.94-1.08)	0.98(0.87-1.11)	0.93(0.85-1.01)
Urban	1	1	1
<i>Highest level of education</i>			
No formal education	1	1	1
Primary education	1.04(0.98-1.10)	1.13(1.01-1.26)	1.05(0.96-1.14)
Secondary and above	1.09(0.99-1.20)	1.25(1.06-1.48)	1.12(1.01-1.25)
<i>Parity</i>			
1	1	1	1
2-3	0.98(0.92-1.05)	0.89(0.78-1.02)	0.88(0.81-0.96)
4-5	0.99(0.92-1.06)	0.76(0.64-0.91)	0.83(0.74-0.94)

6+	0.95(0.87-1.03)	0.74(0.60-0.92)	0.78(0.67-0.91)
<i>Decision maker on respondent's health</i>			
Respondent alone	1	1	1
Respondent and partner	0.94(0.88-1.00)	0.93(0.83-1.03)	1.05(0.97-1.13)
Partner alone	0.96(0.91-1.01)	0.87(0.78-0.98)	0.93(0.87-1.03)
Someone else	0.89(0.80-0.99)	0.89(0.58-1.37)	1.02(0.62-1.68)
<i>Desire of last pregnancy</i>			
Wanted then	1	1	1
Wanted later	0.96(0.90-1.02)	0.82(0.74-0.92)	0.92(0.86-0.98)
Wanted no more	0.95(0.86-1.06)	1.06(0.85-1.31)	0.93(0.78-1.11)
<i>Wealth index</i>			
Poorest	1	1	1
Poorer	1.08(1.00-1.17)	0.95(0.83-1.09)	1.03(0.93-1.14)
Middle	1.07(0.99-1.16)	1.03(0.90-1.17)	1.05(0.95-1.16)
Richer	1.12(1.03-1.21)	1.18(1.03-1.35)	1.22(1.11-1.35)
Richest	1.16(1.05-1.27)	1.10(0.93-1.31)	1.16(1.02-1.31)
<i>First ANC initiated</i>			
Later than 1 st trimester	1	1	1
Within 1 st trimester	1.47(1.41-1.52)	1.96(1.82-2.11)	1.89(1.79-2.00)
<i>Distance to Health facility</i>			
Not a big problem	1.06(1.01-1.12)	1.03(0.93-1.14)	1.05(0.99-1.11)
Big problem	1	1	1
<i>Frequency of watching TV</i>			
Not at all	1	1	1
Less than once a week	1.04(0.97-1.12)	1.03(0.91-1.17)	0.99(0.92-1.08)
At least once a week	1.01(0.93-1.08)	1.24(1.09-1.42)	1.05(0.96-1.16)

Table 3 Decomposition of changes in adequate antenatal care visits 2004 to 2010

Characteristics	Differences in Population structure (E)			Differences in coefficients(C)		
	Coefficient	%	p-value	Coefficient	%	p-value
<i>Age at delivery</i>						
<i>(in years)</i>						
15-19	1.0			1.0		
20-24	0.0015	-0.7	0.352	0.0345	-16.3	0.001
25-29	-0.0007	-0.3	0.709	0.0232	-11.1	0.013
30-34	-0.0026	1.2	0.707	0.0284	-13.4	<0.001
35+	-0.0038	1.8	0.707	0.0148	-7	0.065
<i>Zones</i>						
Western zone	1.0			1.0		
Northern zone	-0.0035	1.7	0.711	-0.0008	0.4	0.865
Central zone	-0.0012	0.6	0.711	-0.0045	2.1	0.431
Southern Highlands	-0.0001	0.1	0.73	-0.0074	3.5	0.083
Southern zone	0.0002	-0.1	0.729	-0.0071	3.3	0.037
SouthWest Highlands	-0.0008	0.4	0.71	-0.0301	14.2	<0.001
Lake Zone	0.0033	-1.6	0.713	-0.0014	0.7	0.941
Eastern zone	0.0029	-1.4	0.711	-0.0042	2	0.551
Zanzibar	-0.0005	0.2	0.713	-0.0014	0.7	0.291
<i>Highest level of education</i>						
No formal education	1.0			1.0		
Primary education	0.0014	-0.7	0.713	0.0197	-9.3	0.34
Secondary and above	-0.0014	0.7	0.709	0.002	-0.9	0.448
<i>Parity</i>						
1 child	1.0			1.0		
2-3 children	-0.0004	0.2	0.745	-0.0136	6.5	0.121
4-5 children	0.0039	-1.9	0.721	-0.0195	9.2	0.04
6+ children	0.001	-0.5	0.717	-0.0175	8.2	0.096

Wealth index

Poorest	1.0			1.0		
Poorer	0.0041	-1	0.745	-0.0121	5.7	0.111
Middle	-0.0001	0.05	0.792	-0.004	1.9	0.588
Richer	-0.0002	0.1	0.714	0.0035	-1.6	0.644
Richest	-0.0001	0.03	0.919	-0.0127	6	0.865

Decision on respondent's health

Respondent alone	1.0			1.0		
Respondent & partner	0.0136	-6.4	0.759	-0.0006	0.3	0.898
Partner alone	0.0042	-2	0.738	-0.0126	5.9	0.21
Someone else	-0.0028	1.3	0.743	0.0002	-0.1	0.96

Table 3 cont... Decomposition of changes in adequate antenatal care visits 2004 to 2010

Characteristics	Differences in Population structure(E)			Differences in coefficients(C)		
	Coefficient	%	p-value	Coefficient	%	p-value
<i>Desire of last pregnancy</i>						
Wanted then	1.0			1.0		
Wanted later	0.0022	-1.1	0.712	-0.0122	5.7	0.028
Wanted no more	0.0004	-0.2	0.775	0.026	-1.2	0.41
<i>First ANC initiated</i>						
Later than 1 st trimester	100			1.0		
Within 1 st trimester	-0.0016	0.7	0.352	-0.0188	-8.7	<0.001
<i>Distance to Health facility</i>						
Big problem	1.0			1.0		
Not a big problem	-0.0034	1.6	0.692	-0.0086	4.1	0.58
<i>Frequency of watching TV</i>						
Not at all	1.0			1.0		
Less than once a week	0.0004	-0.02	0.759	-0.0001	-0.01	0.984
At least once a week	0.0040	1.9	0.706	0.012	-5.7	0.013
<i>Constant</i>				-0.1929	60.8	0.004
<i>Total</i>		4.2	0.352		95.8	<0.001

Table 4 Decomposition of changes in adequate antenatal care visits 2010 to 2016

Characteristics	Differences in population structure (E)			Differences in coefficients (C)		
	Coefficient	%	p-value	Coefficient	%	p-value
<i>Age at delivery (in years)</i>						
15-19	1.0			1.0		
20-24	-0.0014	-1.7	0.138	-0.010	-12.2	0.209
25-29	-0.0002	-0.2	0.252	-0.009	-11.4	0.255
30-34	0.0002	0.2	0.009	-0.011	-13.1	0.116
35+	0.001	1.2	0.006	-0.001	-1.6	0.875
<i>Zones</i>						
Western zone	1.0			1.0		
Northern zone	-0.0005	-6.2	<0.001	0.0013	1.6	0.785
Central zone	-0.0006	-0.8	<0.001	0.0080	9.9	0.113
Southern Highlands	-0.0028	-3.5	0.006	0.0030	3.7	0.385
Southern zone	-0.0017	-2.2	0.004	0.0024	2.9	0.374
South West Highlands	-0.0016	-0.2	0.013	0.0173	21.4	0.001
Lake Zone	0.0026	3.2	<0.001	0.0126	15.6	0.239
Eastern zone	0.0108	13.4	<0.001	0.0053	6.6	0.303
Zanzibar	-0.0003	-0.4	<0.001	0.0011	1.4	0.333
<i>Highest level of education</i>						
No formal education	1.0			1.0		
Primary education	-0.0011	-1.3	0.324	-0.014	-17.6	0.356
Secondary and above	0.0063	7.1	0.073	-0.002	-2.4	0.367
<i>Parity</i>						
1 child	1.0			1.0		
2-3 children	0.0003	0.4	0.009	-0.078	-9.6	0.378
4-5 children	0.0025	3.1	0.001	-0.008	-0.2	0.488
6+ children	0.0023	2.8	<0.001	-0.004	-4.8	0.866

<i>Wealth index</i>						
Poorest	1.0			1.0		
Poorer	-0.0003	-0.4	0.645	0.0051	6.3	0.419
Middle	-0.0008	-0.9	0.3	0.0017	2.1	0.761
Richer	-0.0022	-2.7	<0.001	0.0044	5.5	0.428
Richest	0.0028	3.4	0.018	0.0087	10.7	0.122
<i>Decision on respondent's health</i>						
Respondent alone	1.0			1.0		
Respondent & partner	0.0042	5.2	0.255	0.0177	21.9	0.079
Partner alone	0.0057	7.1	0.125	0.0066	8.2	0.508
Someone else	-0.0008	-0.1	0.951	0.0005	0.6	0.728

Table 4 cont... Decomposition of changes in adequate antenatal care visits 2010 to 2016

Characteristics	Differences in Population structure (E)			Differences in coefficients (C)		
	Coefficient	%	p-value	Coefficient	%	p-value
<i>Desire of last pregnancy</i>						
Wanted then	1.0			1.0		
Wanted later	-0.003	-3.7	0.024	0.007	8.7	0.102
Wanted no more	-0.001	-0.1	0.483	-0.0017	-2.1	0.412
<i>First ANC initiated</i>						
Later than 1 st trimester	1.0			1.0		
Within 1 st trimester	0.0408	50.5	<0.001	-0.0016	-2.0	0.459
<i>Frequency of watching TV</i>						
Not at all	1.0			1.0		
Less than once a week	0.0007	-0.9	0.821	-0.0016	-1.9	0.542
At least once a week	0.0024	2.9	0.122	-0.0071	-8.8	0.062
<i>Constant</i>				-0.0045	-5.5	0.947
<i>Total</i>		66.2	<0.001		33.8	0.004

Discussion

This study has shown that adequate ANC visits have fluctuated in 10-year period between 2004/05 and 2015/16; starting at 62% in 2004/05, dropping to 43% in 2010 and then rising again to 51% in 2015/16.

This could be partially explained by changes in the timing of ANC initiation. This findings were similar to TDHS but contrast to Bangladesh and Ethiopia the proportion of women achieving an adequate ANC visits (13,30,35). Between 2004 and 2016 both the proportion of women achieving adequate ANC visits and those who initiated within the first trimester increased. Suggesting that women who initiate first ANC visit within the first trimester are more likely to attain four recommended ANC visits. The initial timing of the first ANC visit may, in some way, explain the decline in the proportion of women achieving adequate ANC visits that was observed between 2004 and 2010. The Tanzania National guideline for ANC recommends that a pregnant women should initiate ANC within 16th week of pregnancy unlike in other countries whereby it is within 12th gestational week(11). This of course, delays the first visit and could then subsequently lead to a lower adequate attendance

The study findings for 2004/05 TDHS suggest that women who initiate first ANC within first trimester were more likely to accomplish adequate ANC visits. These findings are consistent with another study done in Tanzania, Peru, Cambodia, Cameroon, Senegal, Uganda and Nepal (24,25). This similarity can be explained by various interventions that have been conducted in the mentioned countries on ANC utilization as well as early initiation of ANC visits among pregnant women. This positive association between early ANC initiation and adequate ANC visits has also been reported in many other literatures as well. These findings were also observed in 2010 and 2015/16 surveys as well.

Moreover, the study found that pregnant women belonging to richer or richest wealth status had higher prevalence of having adequate ANC visits. This findings are similar to a study done in Indonesia, Nepal, Senegal, Uganda and Ethiopia as well as Colombia (18,19,24,36,37). The findings complements the 2018 USAID Health Policy Plus report which also showed wealth status as a significant determinant of maternal healthcare utilization in Tanzania (17). This would reflect inequities across wealth quintiles which is a barrier in accessing ANC thus leads to not attaining adequate ANC attendance. This can also be explained by the indirect costs such as transportation, unexpected fees or costs for medication, tests or procedures which are not covered in waivers or exemptions policies for ANC services. Also, women from richer and richest household had most of women who had secondary and higher education 28.8% and 57.7% respectively. Education to a woman implies empowerment whereby she becomes more aware has autonomy in utilization health services which influences attaining adequate ANC visits during pregnancy. This highlights the need to address financial barriers and to accessing ANC service and advocating on educating girls and women which will help women from low income families to achieve adequate ANC visits.

The decomposition analysis in this study suggest that changes in both the population and the effects contributed to the changes seen in adequate ANC visits. Furthermore, Tanzania Service Provision Assessment Survey reported on differentials on the quality and availability of health care services offered across regions

For 2010 and 2015-16 survey, first ANC within the first trimester had contributed 50.5% of the increase in proportion of women with adequate ANC visits on differences due to population structure. Efforts to

ensure Tanzania reached the MDG 4 and 5 and “Wazazi nipendeni” campaign in 2012 could explain the increase in adequate attendance between 2010 and 2016 (14,16). For the South West Highlands the increase in proportion of pregnant women with adequate ANC visits compared to other zones could have been attributed by Wazazi na mwana campaign which was in Rukwa one of the regions included in the zone (40). Whilst it is not possible to directly attribute impact to these campaigns it is likely that these played a part in increases early attendance, which is a contributing factor to adequate attendance. Strengthened and focused efforts are needed where early ANC attendance and subsequent adequate attendance remains sub-optimal. So, a need to focus on other regions in Tanzania so as to promote early ANC initiation and subsequently lead to increase in number of women attaining adequate ANC.

5.2 Conclusion

The results of this study indicate that adequate ANC attendance has been declining from 2004 to 2010 but a gradual increase has been observed in 2016. ANC initiation within the first twelve months of pregnancy has greatly contributed to the recent observed increased proportion of pregnant women who attained four or more ANC visits in Tanzania.

5.3 Study limitation and strength

The study has successfully identified factors associated with changes in adequate ANC visits among pregnant women in Tanzania. With this it is possible to reallocate the limited resources in Tanzania to focus on the factors that have shown to have great contribution and influence on attaining adequate ANC visits among pregnant women in Tanzania. We have used national representative data which makes the study findings generalizable to the entire nation.

5.4 Recommendation

Basing on the findings obtained, we would recommend the government and policy makers to put more effort on promoting first ANC visit to be initiated within the first twelve months of pregnancy. Intensify ANC related interventions in zones that have shown to have lowest proportions of women with adequate ANC visits such as the western zone which includes regions Tabora and Kigoma. Further research to assess on the quality of ANC services offered as it may have contributed to the changes observed and sub-optimal ANC attendance while we have a 98% coverage of at least one ANC visit among pregnant women in Tanzania.

List Of Abbreviations

ANC Ante-natal care

APR Adjusted Prevalence Ratios

FANC Focused Antenatal Care

LBW Low Birth Weight

MDG Millennium Development Goals

MMR Maternal Mortality Ratio

SDG Sustainable Development Goals

TDHS Tanzania Demographic and Health Survey

WHO World Health Organization

Declarations

Ethics approval and consent to participate

Ethical approval to conduct the study was obtained from the Kilimanjaro Christian Medical University college research ethical committee. The ethical approval number granted was 2389.

Demographic and Health Survey Program authorized data access and the data were used solely for the purpose of the current study.

Consent for publication

Not applicable.

Availability of data and materials

Data and material will be available upon request from the corresponding author with authorization form demographic and health survey program, measure DHS.

Competing Interests

The authors declare that they have no competing interests.

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Authors' contributions

Concept development and study design: EK, JT, JR; Data acquisition: EK; Supervision of the study: JT, JR; Data analysis and statistical support: JT, JR; critically revised the manuscript: EK, JT, JR; All authors read and finally approved the manuscript draft for publication.

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References

1. WHO. The World Health Report 2005: Make every mother and child count The World Health Report 2005. World Heal Rep. 2005;
2. World Health Organization. Maternal mortality fact sheet. Dept Reprod Heal Res World Heal Organ. 2014;4.
3. Downe S, Finlayson K, Tunçalp, Metin Gülmezoglu A. What matters to women: A systematic scoping review to identify the processes and outcomes of antenatal care provision that are important to healthy pregnant women. BJOG An Int J Obstet Gynaecol. 2016;123(4):529–39.
4. Haftu A, Hagos H, Mehari MAB, Brhane G. Pregnant women adherence level to antenatal care visit and its effect on perinatal outcome among mothers in Tigray Public Health institutions , 2017: cohort study. BMC Res Notes [Internet]. 2018;1–6. Available from: <https://doi.org/10.1186/s13104-018-3987-0>
5. Ntui AN, Jolly PE, Carson A, Turpin CA, Zhang K, Berhanu T, et al. Antenatal care attendance, a surrogate for pregnancy outcome? The case of Kumasi, Ghan. Matern Child Heal J.

- 2016;18(5):1085–94.
6. Gupta R, Talukdar B. Frequency and Timing of Antenatal Care Visits and Its Impact on Neonatal Mortality in EAG States of India. *J Neonatal Biol* [Internet]. 2017;06(03). Available from: <https://www.omicsonline.org/open-access/frequency-and-timing-of-antenatal-care-visits-and-its-impact-on-neonatal-mortality-in-eag-states-of-india-2167-0897-1000263-97029.html>
 7. Blencowe H, Cousens S, Jassir FB, Say L, Chou D, Mathers C, et al. National, regional, and worldwide estimates of stillbirth rates in 2015, with trends from 2000: A systematic analysis. *Lancet Glob Heal* [Internet]. 2016;4(2):e98–108. Available from: [http://dx.doi.org/10.1016/S2214-109X\(15\)00275-2](http://dx.doi.org/10.1016/S2214-109X(15)00275-2)
 8. Govender T, Reddy P, Ghuman S. Obstetric outcomes and antenatal access among adolescent pregnancies in KwaZulu-Natal , South Africa Obstetric outcomes and antenatal access among adolescent pregnancies in KwaZulu-Natal , South Africa. *South African Fam Pract* [Internet]. 2018;60(1):1–7. Available from: <http://doi.org/10.1080/20786190.2017.1333783>
 9. Organization world health. WHO Recommendation on Antenatal care for positive pregnancy experience. WHO Recomm Antenatal care Posit pregnancy Exp [Internet]. 2016;152. Available from: <http://apps.who.int/iris/bitstream/10665/250796/1/9789241549912-eng.pdf>
 10. World Health Organization (WHO). WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience: Summary. *Who*. 2018;10(January):176.
 11. Kearns Annie, Hurst Taylor, Caglia Jacquelyn LA. Focused antenatal care in Tanzania. *Women Heal Initiat* [Internet]. 2014;(July):1–13. Available from: <http://www.mhtf.org/wp-content/uploads/sites/32/2014/09/HSPH-Tanzania5.pdf>
 12. UNICEF. ANTENATAL CARE [Internet]. Available from: <https://data.unicef.org/topic/maternal-health/antenatal-care/>
 13. Ministry of Health, Community Development, Gender E and CM, Ministry of Health, National Bureau of Statistics, Office of Chief Government Statistician, ICF. Tanzania Demographic and Health Survey and Malaria Indicator Survey 2015-2016. 2016; Available from: <https://dhsprogram.com/pubs/pdf/FR321/FR321.pdf>
 14. Evaluation A, Safe N, Campaign M. An Evaluation of Tanzania ' s National Safe Motherhood Campaign An Evaluation of Tanzania ' s National Safe Motherhood Campaign. 2014;(September).
 15. Exavery A, Kanté AM, Hingora A, Mbaruku G, Pemba S, Phillips JF. How mistimed and unwanted pregnancies affect timing of antenatal care initiation in three districts in Tanzania. *BMC Pregnancy Childbirth*. 2013;13:1–11.
 16. Bliss KE, Streifel C. Targeting Big Results in Maternal , Neonatal , and Child Health. 2015;(May).
 17. Teplitzkaya AL, Dutta A, Saint-firmin P, Wang Z. Maternal Health Services in Tanzania : Determinants of Use and Related Financial Barriers from 2015-16 Survey Data. 2018;(May).
 18. Titaley CR, Dibley MJ, Roberts CL. Factors associated with underutilization of antenatal care services in Indonesia: Results of Indonesia Demographic and Health Survey 2002/2003 and 2007. *BMC Public Health*. 2010;10.

19. Joshi C, Torvaldsen S, Hodgson R, Hayen A. Factors associated with the use and quality of antenatal care in Nepal: a population-based study using the demographic and health survey data. 2014;1–11.
20. Kruk ME, Leslie HH, Verguet S, Mbaruku GM, Adanu RMK, Langer A. Quality of basic maternal care functions in health facilities of five African countries: an analysis of national health system surveys. *Lancet Glob Heal*. 2016;4(11):e845–55.
21. Assessment SP. Service Provision Assessment Survey 2014-2015. 2015;
22. Ediau M, Wanyenze RK, Machingaidze S, Otim G, Olwedo A, Iriso R, et al. Trends in antenatal care attendance and health facility delivery following community and health facility systems strengthening interventions in Northern Uganda. *BMC Pregnancy Childbirth*. 2013;13(June 2014).
23. Tesfaye G, Loxton D, Chojenta C, Semahegn A, Smith R. Delayed initiation of antenatal care and associated factors in Ethiopia: A systematic review and meta-analysis. *Reprod Health*. 2017;14(1).
24. Saad–Haddad G, DeJong J, Terreri N, Restrepo–Méndez MC, Perin J, Vaz L, et al. Patterns and determinants of antenatal care utilization: analysis of national survey data in seven countdown countries. *J Glob Health [Internet]*. 2016;6(1). Available from: <http://www.jogh.org/documents/issue201601/jogh-06-010404.pdf>
25. Gupta S, Yamada G, Mpembeni R, Frumence G, Callaghan-Koru JA, Stevenson R, et al. Factors associated with four or more antenatal care visits and its decline among pregnant women in Tanzania between 1999 and 2010. *PLoS One*. 2014;9(7).
26. Benova L, Tunçalp Ö, Moran AC, Campbell OMR. Not just a number: examining coverage and content of antenatal care in low-income and middle-income countries. *BMJ Glob Heal [Internet]*. 2018;3(2):e000779. Available from: <http://gh.bmj.com/lookup/doi/10.1136/bmjgh-2018-000779>
27. Njiku F, Wella HL, Sariah A, Protas J. Prevalence and factors associated with late antenatal care visit among pregnant women in Lushoto, Tanzania. *Tanzan J Health Res*. 2017;19(3):1–6.
28. Larson E, Mbaruku GM, Cohen J, Kruk ME. Did a quality improvement intervention improve quality of maternal health care? Implementation evaluation from a cluster-randomized controlled study. *Int J Qual Heal Care*. 2020;32(1):54–63.
29. Ebonwu A.; Uys, M.; Wainberg, M. L.; Medina-Marino, A. J. M. Determinants of late antenatal care presentation in rural and pen-urban communities in South Africa: A cross-sectional study. *PLoS One*. 2018;13(3):1–16.
30. Rahman A, Nisha MK, Begum T, Ahmed S, Alam N, Anwar I. Trends, determinants and inequities of 4+ ANC utilisation in Bangladesh. *J Health Popul Nutr [Internet]*. 2017;36(1):2. Available from: <http://dx.doi.org/10.1186/s41043-016-0078-5>
31. Nyamtema AS, Jong AB, Urassa DP, Hagen JP, van Roosmalen J. The quality of antenatal care in rural Tanzania: what is behind the number of visits? *BMC Pregnancy Childbirth [Internet]*. 2012;12(1):1. Available from: ???
32. Arsenault C, Jordan K, Lee D, Dinsa G, Manzi F, Marchant T, et al. Equity in antenatal care quality: an analysis of 91 national household surveys. *Lancet Glob Heal [Internet]*. 2018;6(11):e1186–95. Available from: [http://dx.doi.org/10.1016/S2214-109X\(18\)30389-9](http://dx.doi.org/10.1016/S2214-109X(18)30389-9)

33. Singh L, Dubey R, Singh S, Goel R, Nair S, Singh PK. Measuring quality of antenatal care: a secondary analysis of national survey data from India. *BJOG An Int J Obstet Gynaecol.* 2019;126(S4):7–13.
34. Andersen RM. Revisiting the behavioral model and access to medical care: does it matter? *J Health Soc Behav.* 1995;36(1):1–10.
35. Mekonnen T, Dune T, Perz J, Ogbo FA. Trends and Determinants of Antenatal Care Service Use in Ethiopia between 2000 and 2016. 2019;
36. Bbaale E, Bbaale E. Factors influencing timing and frequency of antenatal care in Uganda. 2011;4:431–8.
37. Yeneneh A, Alemu K, Dadi AF, Alamirrew A. Spatial distribution of antenatal care utilization and associated factors in Ethiopia: evidence from Ethiopian demographic health surveys. 2018;1–12.
38. Provision S, Survey A. Service Provision Assessment Survey 2006 (TSPA). 2006;2006.
39. Magoma M, Requejo J, Merialdi M, Campbell OMR, Cousens S, Filippi V. How much time is available for antenatal care consultations? Assessment of the quality of care in rural Tanzania. *BMC Pregnancy Childbirth [Internet].* 2011;11(1):64. Available from: <http://www.biomedcentral.com/1471-2393/11/64>
40. Health C, Goals MD, Mortality RC, Health IM, Internaconal P, Region R, et al. WAZAZI NA MWANA PROJECT BRIEF. 2015;(January 2012).

Figures

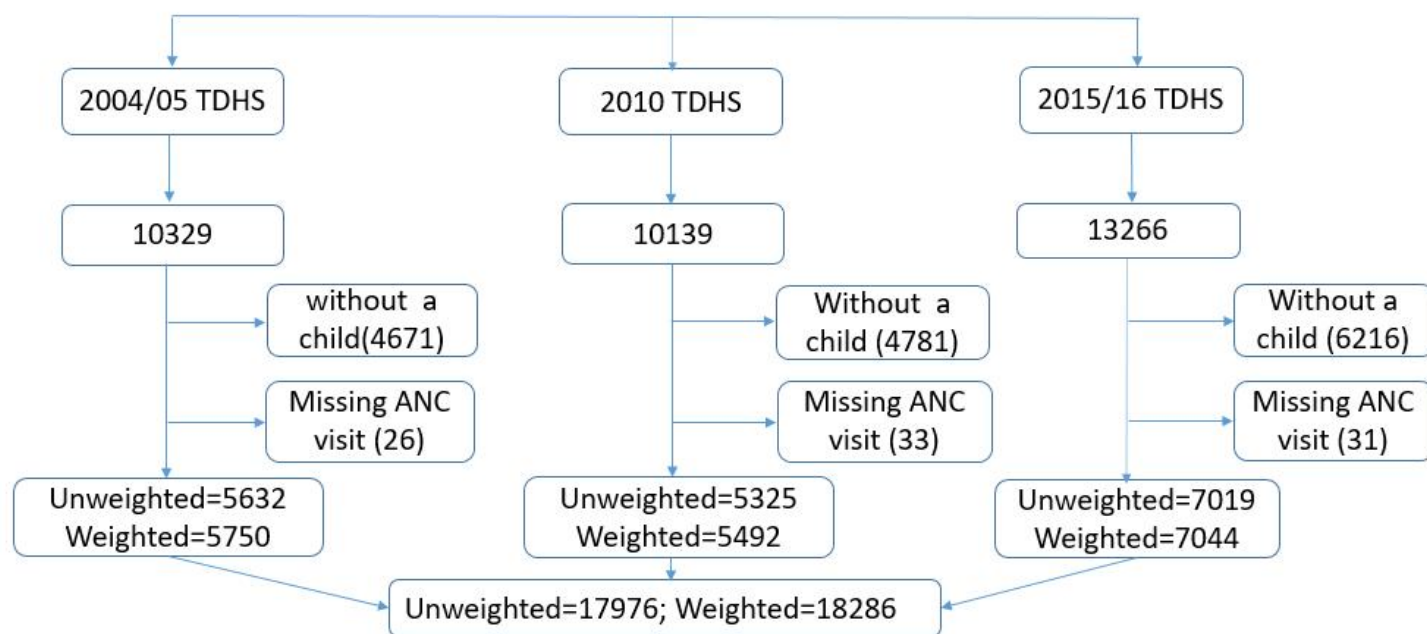


Figure 1

Flow chart showing participants enrolled in the study per respective survey years

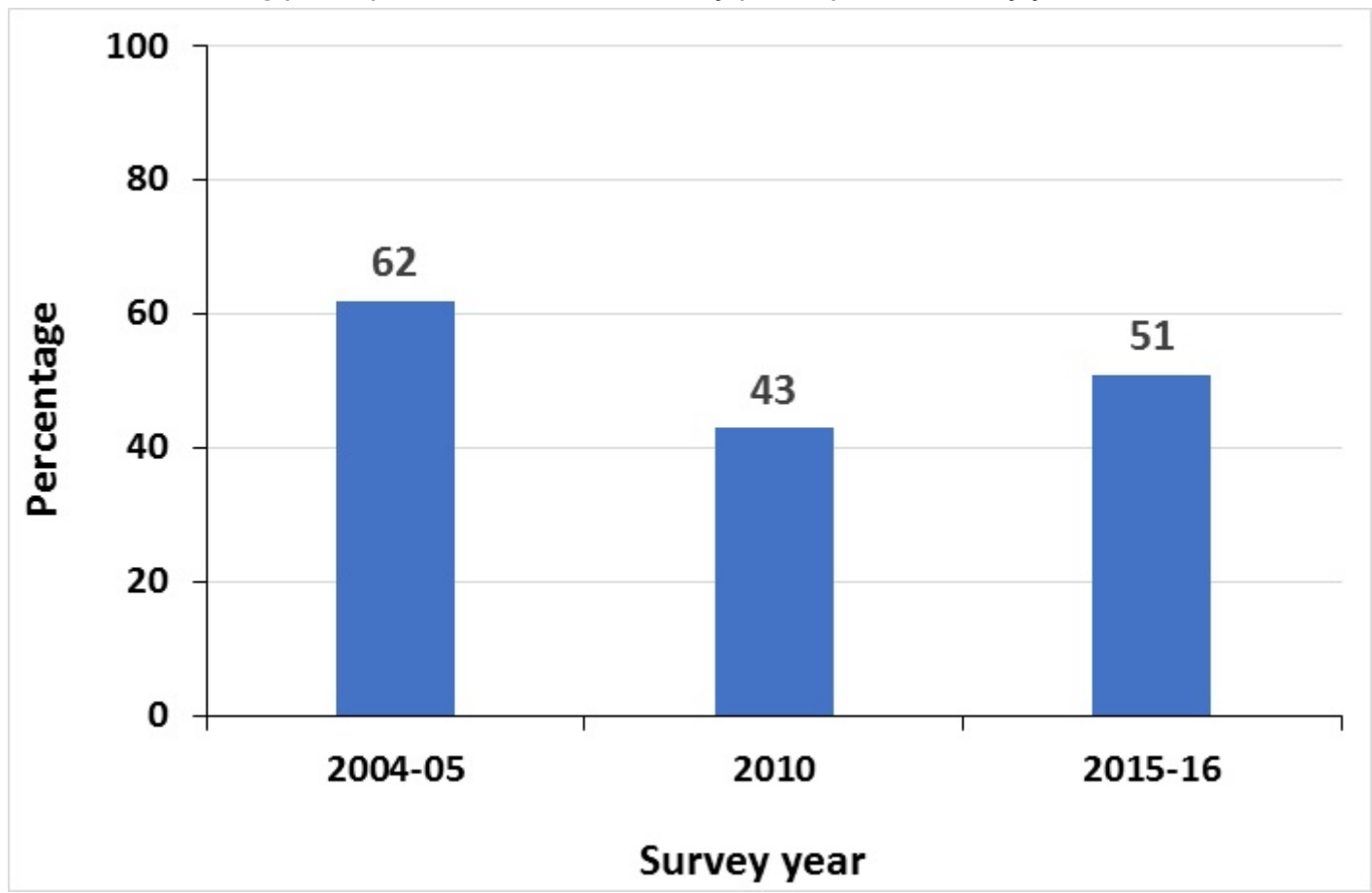


Figure 2

Percentage of pregnant women with adequate ANC visits from 2004 to 2016

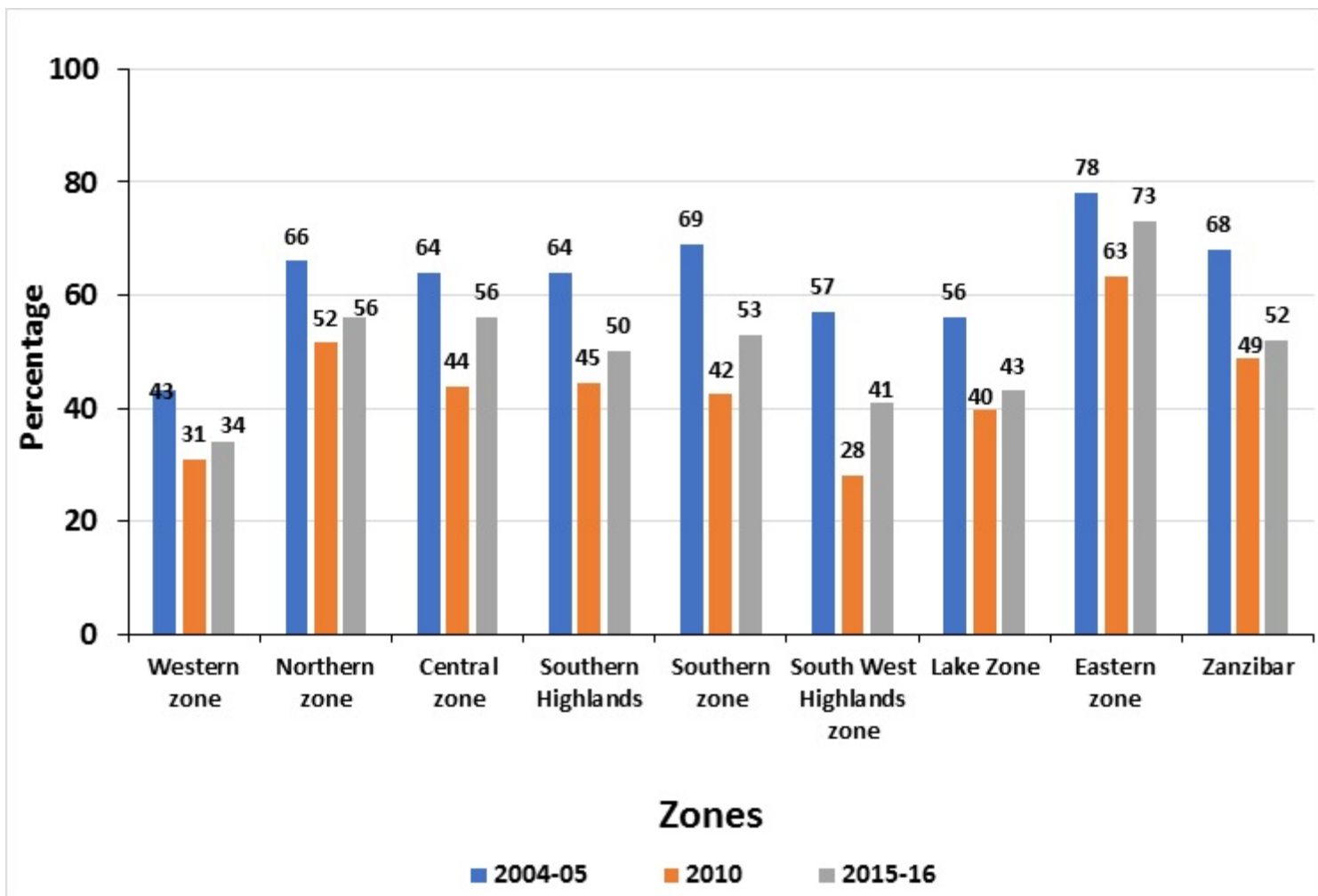


Figure 3

Percentage of pregnant women with adequate ANC visits by zones in Tanzania from 2004 to 2016

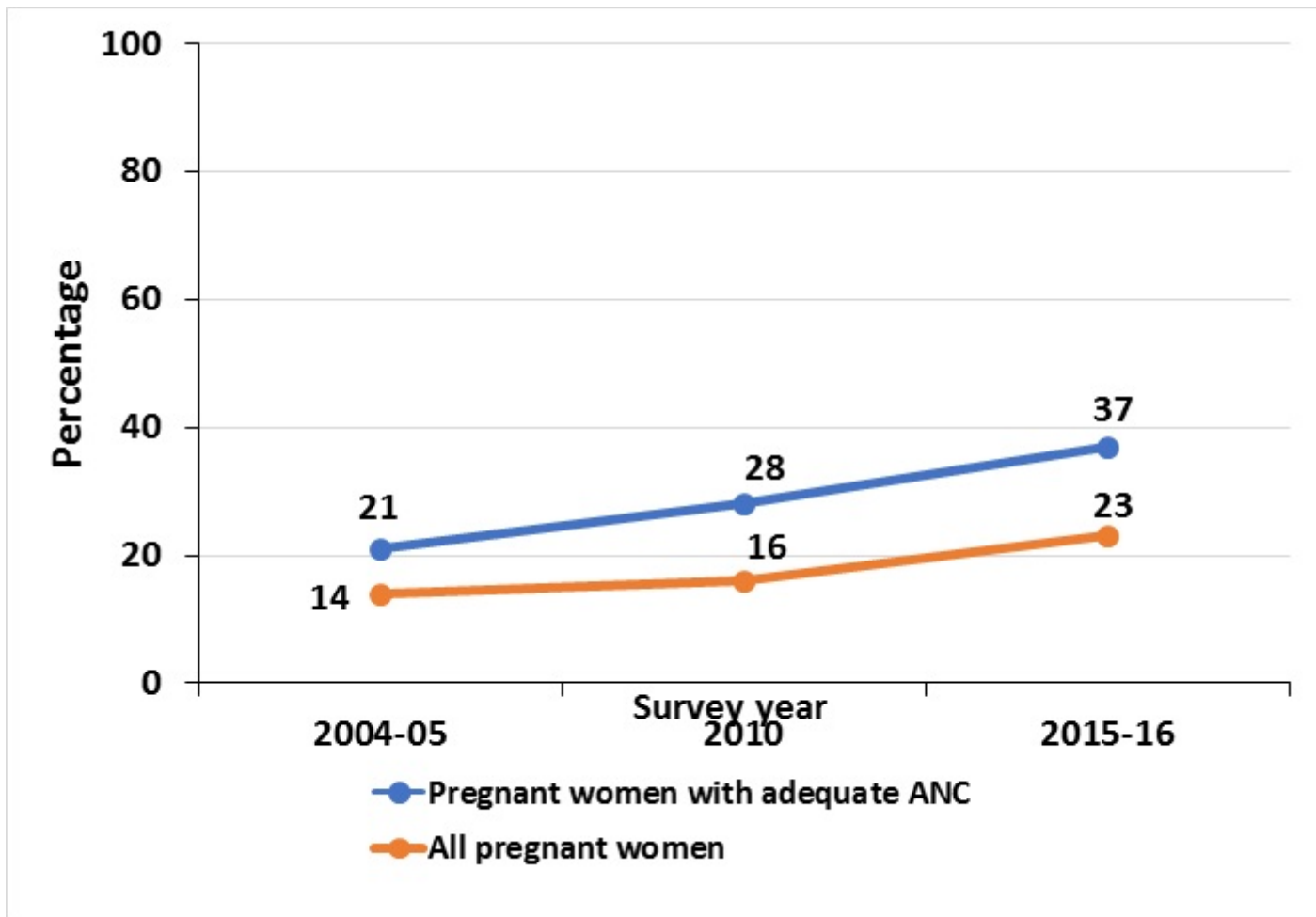


Figure 4

Percentage of pregnant women with first ANC visit in first trimester from 2004 to 2016