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Choice of place of maternity care among women in a semi urban population

Sunday Joseph Ayamolowo[1]

[1]Department of Nursing Science, Faculty of Basic Medical Sciences, Obafemi Awolowo University, Ile-Ife, Nigeria

***Corresponding author:**
Sunday Joseph Ayamolowo, Department of Nursing Science, Faculty of Basic Medical Sciences, Obafemi Awolowo University, Ile-Ife, Nigeria.

olowoyamolowo@yahoo.com

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ABSTRACT

Objectives: Persistent home birth among pregnant women is a significant public health concern in Nigeria. Increasing the proportion of births attended by skilled health personnel has been emphasized as a viable measure of progress for positive maternal and newborn outcomes worldwide. This study assessed the choice of place for antenatal care (ANC) and childbirth among women in a semi-urban population in southwestern Nigeria.

Materials and Methods: The study employed a cross-sectional design. A sample of 168 pregnant women in the third trimester of pregnancy and who had had a minimum of one previous childbirth was selected through a multistage sampling method from all the administrative wards in two local government areas in a state in southwestern Nigeria. A structured and pretested questionnaire was used for data collection. Data were analyzed using Statistical Package for the Social Sciences software, version 25; descriptive statistics were presented in tables, and inferential statistics were analyzed at a level of significance of 0.05.

Results: The results revealed that many of the respondents had skilled ANC (140, 83.3%) and skilled attendants at birth (120, 71.4 %) in their last pregnancy. A significant relationship was found between women's choice of place of maternity care and trust in the traditional birth attendants (χ^2 = 7.714; P = 0.005), lack of transportation to the hospital (χ^2 = 42.0; P = 0.000), perception of birth at hospital as not necessary (χ^2 = 6.095; P = 0.014), flexible payment method for care in mission/spiritual home (χ^2 = 16.095; P = 0.000), and the actual cost of hospital birth (χ^2 = 24.381; P = 0.000). Husbands (114, 50%) were the major contributors to the women's decisions in place of maternity care.

Conclusion: The study concluded that most women utilized skilled care for pregnancy and childbirth, but not all the women who had ANC in the hospital utilized the hospital for childbirth as a result of personal and hospital-related factors. There is a need for health education intervention that can adequately inform and improve women's self-efficacy to use skilled care in pregnancy and childbirth.

Keywords: Antenatal, Birth attendant, Home birth, Hospital birth, Maternity care

INTRODUCTION

All women need skilled care during pregnancy, childbirth, and after birth to ensure optimal pregnancy outcomes. Childbirth, though it is a normal phenomenon among human beings, could also be the most stressful experience in women.[1,2] Pregnancy and childbirth are usually accompanied by some forms of discomfort irrespective of women's educational, ethnic, social, or financial background. However, women should have the possibility to have a good birth experience.[3] Optimal experience of childbirth induces an increased sense of satisfaction, increases self-esteem and confidence in parenting, promotes the mother's and her family's mental

health, strengthens the self-confidence for a future birth, reduces fear of childbirth, and leads to the choice of giving birth in the same place subsequently.[4,5] On the other hand, a previous negative experience during childbirth could also influence the decision about the choice of place of birth for the future.[6] A woman's choice of place of birth, though, may be influenced by several factors, and the choice has far-reaching consequences and outcomes for both the mother and the newborn.

Where a woman received maternity care should not ordinarily determine the fate of the mother and her baby. The western world, the United Kingdom for example, has regulations and training that prepare and support midwives to provide supervised care for women who opt for birth outside the hospital.[7,8] In such planned home births, a midwife provides care during labor and following birth. The midwives are trained to help the mother give birth at home safely and will also advise her if transferring to an obstetric unit would be best. The case is not the same for developing countries such as Nigeria. The World Health Organization advocated skilled attendants at every birth,[9] which is only possible in Nigeria within the confines of hospitals. The other available birthplaces for mothers in Nigeria who cannot access public or private hospitals and maternity homes with skilled birth attendants are faith-based mission homes and traditional birth attendant homes with unskilled attendants taking birth of the mothers and home birth settings without attendants and often with unskilled birth attendants.[10]

The proportion of births attended by skilled health personnel, which has been consistently emphasized as a viable measure of progress for maternal and newborn morbidity and mortality worldwide, has not improved in the past decade.[11] In Nigeria, a large number of women still give birth at home and other settings outside health facilities without skilled health attendants despite the free maternal and newborn health services put in place in public healthcare facilities in some states.[12-14] Over one-third of pregnant women in Nigeria do not attend antenatal care (ANC) services during pregnancy.[15] Many women attend ANC in health facilities but end up delivering outside such health facilities, and some only go back to the hospital when problems arise.[16] Anecdotal observation in clinical practice in the study setting showed that most women utilize both skilled and unskilled birth attendants at different phases of the maternity period. Many who receive ANC in public health facilities from skilled health professionals end up not giving birth to their babies in such facilities but go through childbirth with unskilled birth attendants. This trend is consistent with reports from similar settings in sub-Saharan Africa. Some women prefer home birth,[17,18] and some only make a few visits to the clinic during pregnancy to secure registration to be accepted at the hospital in case birth complications occur during home birth.[19,20] These categories of women usually treat health facilities as a last resort for maternal care and are only referred to the hospital in case of birth complications. Unfortunately, the assistance of skilled attendants for birth is usually sought very late, consequently resulting in negative maternal and newborn outcomes.[21,22]

The care received during the prenatal, intrapartum, and postnatal periods and the environment in which the women find themselves to a very great extent can determine the state of the health of women and the outcomes of birth for both the mother and child.[23] Health professionals such as doctors and midwives play important roles in providing continuous support for mothers during pregnancy and childbirth to ensure positive outcomes. On the other hand, childbirth practices of unskilled birth attendants are documented to be detrimental to the health of mothers, resulting in many complications and, ultimately, maternal or neonatal death.[24] Whether a mother will get all the benefits associated with quality ANC and skilled birth attendance is dependent on where she seeks care for pregnancy and childbirth. These observations prompted the need to assess what informed mothers' choices of the place of maternity care in the study area. This study sought to answer two specific questions: (1) What are the reasons for the choices of place of ANC and childbirth among mothers? and (2) what are the facilities available for maternity care, where do mothers receive ANC and where do they give birth in the study setting?

MATERIALS AND METHODS

The study adopted a cross-sectional design involving a quantitative data collection approach to assess the choice of place of maternity care among women in a semi-urban population in southwest Nigeria. The location for this study was two local council areas in Ekiti State, Nigeria.

The Ethics Review Board of the Ekiti State University Teaching Hospital, Ado Ekiti, Nigeria, approved the study (EKSUTH/A67/2016/05/006). Informed consent was obtained from all respondents after explaining the purpose of the study. Respondents' identities were not included so that their confidentiality could be assured.

The study population included 168 pregnant women in the third trimester of pregnancy and those who had a minimum of one previous childbirth. Cochran's formula for proportions was used for sample size calculation and adjusted for the finite population size and a non-response rate. This approach ensures adequate statistical power and representativeness within the defined population.

A sample size of 162 was obtained. However, a non-response rate of 10% was added to the sample to make 180 mothers. A total of 168 questionnaires were retrieved for analysis, giving a response rate of 93%. A multistage sampling technique

was used to select participants from all the administrative wards in two local government areas (LGAs) in Ekiti State, Nigeria. In the first stage, 19 administrative wards in the LGAs were divided into two clusters. The clusters were based on the closeness of the wards. Stage two involves a random sampling method (balloting) of five wards in each cluster. The sample size was divided equally among the 10 wards in the study setting. In the third stage, the purposive sampling method was used to select respondents through a house-to-house survey. The use of a non-probability sampling method, particularly purposive sampling, in the final stage of the multistage process aligns with the study's specific population criteria, resource limitations, logistical realities, and the need to achieve the desired sample size effectively. All eligible women who gave their consent were selected. Each ward was visited twice to ensure that all eligible women were captured until the desired sample size was recruited.

Data were collected using a structured and pretested questionnaire. It comprises Questions that elicit information on pregnant women's demographic and obstetric characteristics and decision-making process for maternity care among mothers. The questionnaire was pilot-tested among 14 mothers outside the study sample to evaluate its clarity and validity.

The quantitative data collected was coded and inputted into a Statistical Package for the Social Sciences software, version 25, for analysis. Descriptive statistics were generated and used to summarize findings on sociodemographic and obstetric characteristics of respondents and facilities utilized for maternity care by mothers. Bivariate analysis was computed on reasons for the choices of place of ANC and childbirth among mothers and the relationship of selected sociodemographic and obstetric characteristics on choice of place of childbirth.

RESULTS

Table 1 presents the sociodemographic distribution of the respondents. Out of the 180 sampled women, a total of 168 questionnaires were retrieved for analysis, giving a response rate of 93.0 %. The mean age was 38.1 years (standard deviation ± 11.3 years), and 76 (45.2%) of the respondents were 40 years and above in age. 142 (84.5%) of the respondents were married, while 26 (16.5%) were single mothers. Over three-quarters (77.4%) of the mothers have a monogamous family, and 150 (89.3%) respondents were Yorubas by ethnicity. Many of the women, 152 (90.5%), were Christians, 86 (51.5%) had only secondary school education, 92 (54.8%) of their partners had tertiary level education, and 76 (45.2%) of the respondents were traders. The family income shows that the majority of the respondents, 128 (71.2), earned about #15,000 (Nigeria naira) on a monthly basis.

Table 2 presents a summary of respondents' obstetric characteristics. Of all the respondents, 60 (35.0%) started their

Table 1: Demographic characteristics of the respondents

Variable	Frequency (*n*=168) number of individuals	Percentage (%)
Age group (Mean: 38.1; SD: 11.32)		
18–29 yrs	37	22.0
30–39 yrs	55	32.7
40+yrs	76	45.2
Marital status		
Married	142	84.5
Others	26	15.5
Type of Family		
Monogamy	130	77.4
Polygamy	38	22.4
Religion		
Christianity	152	90.5
Islam	14	8.3
Traditional	2	1.2
Ethnicity		
Yoruba	150	89.3
Igbo	10	6.0
Hausa	2	1.2
Others	6	3.6
Occupation		
Civil servant	52	31.0
Self-employed	102	60.7
Student	8	4.8
Unemployed	6	3.6
The highest qualification attained		
No schooling	2	1.2
Primary school completed	26	15.5
Secondary school completed	86	51.2
Diploma Certificate	32	19.0
Bachelor's degree	8	4.8
Nigeria Certificate in Education (NCE)	14	8.3
Husband educational status		
No schooling at all	6	3.6
Primary school completed	18	10.7
Secondary school completed	52	31.0
Tertiary	92	54.8
Family income per month (in Naira)		
<5000	12	7.1
5,000–9,999	10	6.0
10,000–14,999	18	10.7
15,000 and above	128	71.2

SD: Standard deviation, Naira: Currency of Nigeria

menstruation at the age of 13–15 years, and 74 (44.0%) started their menstruation at the age of 16–18 years. Between 18 and 22 years of age, 56 (33.3%) of the respondents had given birth to their first child, while 14 (8.3%) were above 33 years of age before their first pregnancy. The number of pregnancies in relation to the respondents' number of children/birth experiences shows that 66 (39.3%) of the respondents had been pregnant not <2 times while 38 (22.6%) have had 5 or more pregnancies. Many of the respondents had skilled ANC (140, 83.3%) and skilled attendance at birth (120, 71.4 %) in their last pregnancy. Their birth experiences showed that the majority (150, 89.3%) had never had a stillbirth experience, while 18 (10.7%) respondents experienced a stillbirth in a previous pregnancy.

Table 3 presents the summary of reasons for the mother's choice of place of maternity care. In the bivariate analysis, a significant relationship was found between women the choice of place of maternity care and good trust in the traditional birth attendants ($\chi^2 = 7.714$; $P = 0.005$), no means of transportation to the hospital ($\chi^2 = 42.0$; $P = 0.000$), perception of birth at the hospital as not necessary ($\chi^2 = 6.095$; $P = 0.014$), flexible payment method for maternity care in mission/birth attendant home ($\chi^2 = 16.095$; $P = 0.000$), and the actual cost of hospital birth ($\chi^2 = 24.381$; $P = 0.000$). The descriptive analysis also showed that most women utilize both skilled and unskilled attendants at different phases of the maternity period. A higher proportion of respondents was influenced by the distance of women's homes to the maternity center in their chosen place for childbirth (92, 54.8%) compared to their chosen place of ANC (70, 41.7%). This trend was repeated in all the variables measured except lack of means of transportation to the hospital and women's religion that is against hospital maternity care (42 [25%], 48 [28.6%] and 10 [6.0%], 16 [9.5%]), respectively. The choice of the place for childbirth of many of the respondents was influenced by the perception that the hospital has better birth equipment (126, 75.0%) and the affordability of the cost of hospital birth (122, 72.6%).

Table 4 presents a summary of facilities (plan and actual) utilized for maternity care services (antenatal and childbirth) among the respondents. The majority (106, 63.1%) of the respondents planned to receive ANC in the hospital, especially in public hospitals. While 106 (63.1%) planned to receive care in a public hospital and 22 (13.1%) in a private one, 112 (66.7%) ended up receiving care in a public hospital and 28 (16.7%) in a private one. Some respondents who did not plan to use the hospital for the ANC ended up receiving the care in the hospital. Birth planning shows that 104 (61.9%) planned for public hospitals and 22 (13.1%) for private hospitals, but only 92 (54.8%) actually used public hospitals and 28 (16.7%) used private hospitals. It is noted that some women who planned to use public hospitals for their childbirth did not use the facility. Although none planned to have the birth of their pregnancy at home, two (1.2%) of the respondents had a home birth, while the number for private hospitals and mission homes increased at the actual childbirth as against their plan.

Table 2: Summary of respondents' obstetric characteristics

Characteristics	Frequency (n=168)	Percentage
Age at onset of menstruation		
13–15	60	35.7
16–18	74	44.0
19–21	16	9.5
22–25	8	4.8
Unspecified age	10	6.0
Age at first pregnancy mean=25.2; SD=4.81		
18–22	56	33.3
23–27	66	39.3
28–32	32	19.0
33 and above	14	8.3
Age at last pregnancy mean=32.3; SD=6.58		
18–22	12	7.1
23–27	26	15.5
28–32	40	23.8
33–37	44	26.2
38 and above	46	27.4
Total number of pregnancies		
1–2	66	39.3
3–4	64	38.1
5+	38	22.6
Total number of children		
1–2	74	44.0
3–4	72	42.9
5+	22	13.1
Place of antenatal care in the last pregnancy		
Hospital	140	83.3
Non-Hospital	28	16.7
Place of birth of last pregnancy		
Hospital	120	71.4
Non-Hospital	48	28.6
Total previous stillbirth	18	10.7

SD: Standard deviation

Table 5 presents the binary logistic regression showing the effect of selected sociodemographic and obstetric characteristics on the choice of place of birth. It revealed that as age increases, there are increased odds of choosing a hospital for birth. For instance, women in the age

Table 3: Reasons for mother's choice of place of maternity care

Reasons for choice of place of maternity care	Antenatal f (%)	Childbirth f (%)	χ^2	df	*P*-value
Distance of maternity center to women's home	70 (41.7)	92 (54.8)	1.524	1	0.217
Trust in the traditional birth attendants	50 (29.8)	66 (39.3)	7.714	1	0.005*
There is no means of transportation to the hospital	48 (28.6)	42 (25.0)	42.000	1	0.000*
Hospital birth is not necessary	54 (32.1)	68 (40.5)	6.095	1	0.014*
The cost of hospital birth is too high	42 (25.0)	52 (32.1)	24.381	1	0.000*
Flexible payment method for maternity care services in mission/traditional birth attendant home	48 (28.6)	58 (34.5)	16.095	1	0.000*
Behavior of health workers discourages me from using the public hospital	66 (39.3)	76 (41.7)	4.667	1	0.031*
The health facility is not always open for service	18 (10.7)	28 (16.7)	74.667	1	0.000*
Maternal services in health facilities are usually poor	28 (16.7)	28 (16.7)	74.667	1	0.000*
My husband did not allow me to use the hospital for maternity care	22 (13.1)	36 (21.4)	54.857	1	0.000*
Culture supports maternity care services in mission (religious)/traditional birth attendant home	38 (22.6)	52 (32.1)	24.381	1	0.000*
Needs for unexpected maternity care services between scheduled care	44 (26.2)	56 (33.3)	18.667	1	0.000*
Failure to book maternity care during pregnancy	10 (6.0)	16 (9.5)	110.095	1	0.000*
Previous bad experiences during antenatal, birth, or postnatal care in a public health institution	62 (36.9)	78 (46.4)	0.857	1	0.355
In-laws demanded home maternity care	8 (4.8)	10 (6.0)	130.381	1	0.000*
Better behavior of traditional birth attendants compared with midwives in public hospitals	28 (16.7)	38 (22.6)	50.381	1	0.000*
My religion is against hospital maternity care	16 (9.5)	10 (6.0)	130.381	1	0.000*
Clean and safe maternity care environment	70 (41.7)	74 (44.0)	2.381	1	0.123
Safe and acceptable maternity care services for pregnant women	88 (52.4)	92 (54.8)	1.524	1	0.217
Safe and acceptable maternity care services for newborn	86 (51.2)	96 (57.1)	3.429	1	0.064
Fear of surgery for childbirth in hospital	88 (52.4)	92 (54.8)	1.524	1	0.217
The approach of health workers in hospitals is the best	76 (45.2)	88 (52.4)	0.381	1	0.537
There is no reliable maternity care center in my neighborhood	36 (21.4)	36 (21.4)	54.857	1	0.000*
The cost of hospital birth is affordable to me	108 (64.3)	122 (72.6)	34.381	1	0.000*
The hospital has better birth equipment	122 (72.6)	126 (75.0)	40.506	1	0.000*

*Significant at $P<0.05$, f: Frequency (percentage), χ^2: Chi squared test, df: Degrees of freedom

group 30–39 had about four fold the odds of choosing a hospital for birth relative to those in the lowest age group, and women that are 40 years and above compared to those in the age group 18–29 had 30% higher odds of choosing a hospital for the birth. With respect to respondents' educational level, those who completed secondary education had about 3.2 higher odds of choosing a hospital for birth compared to those with no schooling at all. Similarly, those with other educational levels relative to respondents with no schooling at all had 1.8 higher odds of delivering at a hospital. The implication of husbands' education on the choice of place of birth showed some levels of inconsistency; for instance, while respondents whose husbands had completed primary school had 1.5 the odds of choosing a hospital for birth, those with husbands with tertiary education had 57% lower odds of choosing a hospital for birth. Focusing on the place of antenatal, the table revealed ironically that women who had their ANC at a hospital had about 90% lower odds of opting for hospital for birth relative to those who chose non-hospital for ANC. Evident also in the table is that compared to respondents with less than 4 antenatal visits, respondents with 4 or more antenatal visits had 1.5 higher log odds of choosing a hospital for birth. In relation to distance to the maternity center, compared to women who spend <10 min before reaching their maternity centers, women who spend between 10 and 29 min had 92% lower odds of choosing a hospital for birth, whereas those who spend between 30 and 60 min had 55% lower odds of opting for a hospital for birth.

Table 4: Facility utilized for maternity care services

My last baby…	Personal home f (%)	Traditional birth attendant home f (%)	Religious/ mission home f (%)	Private hospital f (%)	Public hospital f (%)
Total number of available places of maternity care services in the study setting	-	1	18	4	8
Place of antenatal care (Plan)	4 (2.4)	4 (2.4)	32 (19.0)	22 (13.1)	106 (63.1)
Place of antenatal care (Actual)	0 (0)	2 (1.2)	26 (15.5)	28 (16.7)	112 (66.7)
Place of childbirth (Plan)	0 (0)	8 (4.8)	34 (20.2)	22 (13.1)	104 (61.9)
Place of childbirth (Actual)	2 (1.2)	8 (4.8)	38 (22.6)	28 (16.7)	92 (54.8)

f: Frequency (percentage)

Table 5: Binary logistic regression showing the effect of selected sociodemographic and obstetric characteristics on choice of place of birth

Characteristics	OR	Sig.	S.E.	95% (C.I. for OR)	
				Lower	Upper
Age					
18–29	1.00	-	-	-	-
30–39	3.742	0.294	1.257	0.319	43.933
40+	1.303	0.802	1.054	0.165	10.278
Educational level					
No schooling at all	1.00	-	-	-	-
Primary school completed	-	-	-	-	-
Secondary school completed	4.210	0.204	1.131	0.459	38.648
Others	2.822	0.124	0.674	0.753	10.573
Husband's educational level					
No schooling at all	1.00	-	-	-	-
Primary school completed	2.485	0.768	3.093	0.006	1065.989
Secondary school completed	0.127	0.072	1.147	0.013	1.199
Tertiary	0.430	0.182	0.632	0.125	1.483
Place of antenatal care					
Non-hospital	1.00	-	-	-	-
Hospital	0.010	0.000	0.989	0.002	0.073
Number of antenatal visits					
<4 visits	1.00	-	-	-	-
4 visits or more	2.456	0.363	0.987	0.355	17.008
Distance to the maternity center					
<10 min	1.00	-	-	-	-
10–29 min	0.081	0.003	0.844	0.016	0.424
30–60 min	0.448	0.289	0.758	0.101	1.978

OR: Odds ratio, CI: Confidence interval, SE: Standard error

DISCUSSION

All the respondents are mothers (women) who have had at least one childbirth experience and are currently pregnant. The minimum age of the respondents is 18 years, and the maximum age is 47 years old, while the mean age is 38.1, with a standard deviation of 11.32. The majority of the mothers are married. However, some claimed to be single mothers. This may be so in terms of responsibility taken by the mothers rather than the complete absence of the father. Out of the total number of mothers observed during the study, most of them had attained a certain level of formal education, while very few had a university education. Their job distribution is largely dependent on their level of education attainment.

Nevertheless, only very few of them can be rated extremely poor. In a previous study,[25] level of education, divorcees (single mothers), and lower income are identified as part of the reasons why women in the study opted for home birth. Another study[26] also identifies the level of education as part of the factors that determined the choice of place of birth. The respondents are predominantly Yorubas, and the community is Christian-dominated. This is typical of most towns in the southwestern states of Nigeria, especially the study setting.

Their obstetric characteristics reveal that most of the respondents commenced menstruation before 18 years of age. However, some of the respondents could not specifically recall when they started their menstruation. A few respondents had their first pregnancy before age 27, while the majority had their last pregnancy at age 33 years and above. This may, to some extent, be due to their education pursuits leading to delayed marriage, while those who had their pregnancy between ages 18 and 22 years may be out of wedlock, which may sometimes lead to single mothers.

Their maternity care experiences revealed that all of them attended antenatal clinics, but the time they started varied. The distance from the women's home to the maternity center was not a barrier in this study, and a majority of the respondents were able to reach the maternity facility within a 30-minute distance and could attend antenatal clinics more than four times. This finding is contrary to the report of a study which revealed that over one-third of pregnant women in Nigeria did not attend ANC service during pregnancy.[15] All the respondents were able to reach the maternity facility for their antenatal clinic, irrespective of the distance from their homes to the facility, within an hour. Time spent during antenatal clinics on average shows that the majority of the respondents spent less than three hours on average during their antenatal clinic session. This study also shows that the women and their spouses (to some extent) are wholly responsible and are major contributors to the choice of the place of childbirth. Most women reported that others, such as in-laws, siblings, parents, caregivers, or neighbors, contributed to the decision process and had the backing of their husbands. There is an overlap of others with the couple's input in the final decision. Therefore, the mothers and their spouses are major contributors to the final choice of the place of childbirth. This is a variance from other studies that did not consider the influence of the relatives on the choice of place of birth by mothers.[27,28] Women's birth plans show that the majority planned for a hospital birth, though some who planned to use the hospital as the place of choice for their childbirth did not use the facility. While none planned to deliver at home, few respondents did at home, and the number for private hospitals and mission homes increased at the actual childbirth as against their plan, evidenced by above identified determinant factors.

Most of the respondents did not trust traditional birth attendants; they rather believe that hospital birth is necessary and are not hindered from accessing the facility for their antenatal care. Furthermore, they did not agree that their culture or religion supports maternity care at home and were not allowed to use hospitals for their maternity care by their husbands or in-laws, and the cost is affordable to them. Hence, the majority still prefer to use hospitals for their ANC. Although many of the respondents believe that the approach of health workers in the hospital is not the best, they believe that the health workers are more reliable, the cost of the hospital is affordable, and the hospital is better equipped. Therefore, the majority of the respondents planned and received ANC in the hospital, especially in public hospitals. Even some respondents who did not even plan to use the hospital for the ANC ended up receiving the care in the hospital. All the respondents in this study attended antenatal clinics during their last pregnancy; this is contrary to a study that cited poor uptake of antenatal visits and failure to book as one of the reasons women opt for home birth.[29] The findings of this study also contrast with the submission of a study that cultural factors may negatively affect poorer women seeking maternal and reproductive health services because such women are less educated, prefer to give birth at home, and may not want to see a male doctor.[30,31]

The findings of this study revealed that many of the respondents were influenced by their choice of place of birth by many factors. Most mothers prefer hospitals as a place for childbirth because they are accessible, affordable, reliable, and have better birth equipment. Furthermore, in making their decision on the place of childbirth, the majority considered the distance, safety, and acceptable service procedures of the health institution both for the mother and the newborn and the fear of childbirth surgery in the hospital. Moreover, most of the respondents preferred the approach of the health workers in the hospital when compared with the traditional birth attendants and affirmed that the hospital has better birth equipment and safe and acceptable maternity care services for both pregnant women and newborns. Most of the deliveries were taken by skilled attendants (nurses/midwives and medical doctors) in the hospitals. The study revealed that as mothers' age, educational status, and number of antenatal clinic visits increase, the odds of skilled attendance for hospital birth increase. This finding corroborates the position of a similar study that common barriers to skilled maternity care include affordability of services, availability of services, distance to the services, lack of transportation, and lack of knowledge of maternal and newborn health services.[32-34] Distance from maternity healthcare centers to mothers' homes was not a significant factor that influenced the choice of place for maternity care. However, logistic regression reveals that women who had a shorter distance to cover before reaching their maternity home have higher odds of opting for the hospital for childbirth. Also, good trust in the

traditional birth attendants, no means of transportation to the hospital, perceiving that birth at the hospital was not necessary, and the high cost of hospital birth has a significant influence on the mother's choice of place of maternity care. These are consistent with some of the findings of a study that identifies reasons given by the women who chose not to use the hospital for their birth, such as the cost of hospital bills, the unfriendly attitude of healthcare workers, unexpected labor, no means of transportation, and strike action of health workers.[35] Another study also identified that distance to health facilities influences the use of hospitals for birth.[36]

The study is limited due to response bias in the form of social desirability on the use of skilled and unskilled care for pregnancy and childbirth. This could have influenced the response rate regarding the use of health facilities for maternity care. A qualitative study using interviewer-led focus group discussions will help to establish further the key reason associated with the choice of place of maternity care among women. A large-scale, community-based research study is needed to explore other personal and health system-related factors influencing the choice of place of maternity care among women in the semi-urban population in southwest Nigeria.

CONCLUSION

The study concluded that most women utilized skilled care for pregnancy and childbirth, but some still opt for unskilled care because of varying personal and hospital-related reasons. Safe childbirth is an important factor to be considered in the choice of the place of birth by the expected mothers. Skilled care in pregnancy and birth not only affects the mother but also the newborn in the most significant ways. A mother's capacity needs to be improved to make informed decisions in place of maternity care. It is recommended that health workers, especially maternity care service providers in public hospitals, improve their approach to encourage the use of hospitals by mothers. The information dissemination method of the maternity care service providers, especially during antenatal, should be improved. More emphasis should be laid on the importance of hospital birth during antenatal clinic meetings, and innovative methods of information dissemination through social media and government-sponsored promotional campaigns should be intensified. The government should ensure that hospital births are made more attractive by making adequate provisions for birth equipment and making the cost of birth more affordable, especially for the teeming indigents.

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