**Factors influencing the choice of delivery places by pregnant women in selected health facilities in the Sagnarigu municipality**

**ABSTRACT**

**Introduction:** Motherhood is frequently a gratifying and pleasurable experience; nonetheless, it is associated with sorrow, poor health, and even mortality for several women. Cultural traditions persistently influence pregnancy and childbirth in Ghana, shaping the preferences of expectant women about birthing venues. Insufficient health knowledge and skills of professionals in managing obstetric patients may impede delivery in healthcare settings.

**Aim:** The primary aim of the study was to investigate the factors that affect pregnant women's decisions about delivery locations in specific healthcare facilities.

**Methods:** Purposive and convenience sampling approaches were employed to get a sample of 100 pregnant women. The primary research instrument was the questionnaire. The acquired data was processed with the SPSS software, evaluated, and presented through descriptive statistics to derive frequencies and percentages.

**Results:** The study indicated that the distance to health centres, the availability of traditional birth attendants, and the inadequate quality of highways linking communities to health facilities are geographical factors that influenced women's selection of delivery places. Pregnant women are typically content with the services provided by healthcare establishments. Although respondents indicated a preference for health centres as their delivery place, prevailing societal and cultural attitudes around pregnancy and childbirth, together with economic and geographic factors, continue to compel individuals to give birth at home and in spiritual centres.

**Conclusion:** The selection of birth location among pregnant women in Ghana is influenced by a confluence of economical, cultural, logistical, and healthcare-related issues. Community-based educational initiatives must highlight the advantages of expert delivery and rectify misconceptions regarding facility-based care. Augmenting and outfitting healthcare institutions, especially in remote regions, will improve accessibility and the quality of services.

**Key Words: *Pregnancy, Health facility, Delivery, Location, Childbirth***

**INTRODUCTION**

Motherhood is frequently a gratifying and pleasurable experience; nonetheless, it is associated with hardship, poor health, and even mortality for several women (WHO, 2009). Pregnancy should be uncomplicated if there are no complications and a regular cycle culminates in labour, requiring no external assistance. In practice, however, due to the unusual character of birth outcomes, proficient delivery help is advised. Within uncomplicated access to a healthcare centre, to facilitate appropriate management of challenges in instances of necessity (WHO, 2009).

Worldwide, the determinants influencing a woman's choice of delivery location as a singular factor have become exceedingly intricate, more so than ever before, in the context of globalisation (Sabine et al. 2009). Socioeconomic position, demographic characteristics, and biological variables are often critical indicators of medical care demand and utilisation among women (Sabine et al. 2009). The configuration of social structures, via a series of social interactions, norms, and institutions, is affecting women's chosen childbirth sites globally (Sabine et al. 2008; Obago, 2010). Globally, women have consistently endeavoured to establish environments that are both comfortable and less distressing for themselves (WHO, 2012). Globally, over eighty percent of pregnant women seek to deliver at health centres, perceiving them as safe, yet ultimately give birth at home (Josephine et al. 2009).

 Several studies in Africa have proven the correlation between a family's socioeconomic status (SES) and a woman's choice of birthplace. There is, still, contention on the optimal method to determine a woman's socioeconomic level. Maureen and Peter (2008) demonstrated that women from disadvantaged socioeconomic backgrounds are less inclined to give birth in healthcare facilities compared to women from more affluent socioeconomic strata. Most research, conversely, compares women and families from diverse socioeconomic backgrounds, revealing that women's birthplace decisions are adversely affected by low socioeconomic status (Hassan et al., 2010). The considerable distance between health clinics in Nigeria leads most women to prefer home births. Magadi, 2011.

 The pursuit of medical care, especially among women, has driven many globally to seek various sorts of medical aid, particularly during pregnancy (McDonagh, 2006; Kowalewski, 2010). Cultural perspectives, together with accessibility and cost considerations, influence its form (Patricia & Olorunnisola, 2017). A survey conducted by Magadi (2005) revealed that the majority of women opted for home delivery due to their preference for cost-effective and timely services during childbirth. In Africa, traditional birth attendants (TBAs) command significant respect and trust from the women in their communities (WHO, 2010). The service is utilised extensively by individuals across all socioeconomic strata, including the educated and affluent (Ogunlesi 2005). The practice is prevalent, especially in regions with state-of-the-art medical facilities (Mulusew, 2003; Ochako, 2011).

 The World Health Organization's Constitution of 1948 recognises the impact of social and political factors on women's health-seeking behaviour, as well as the necessity for collaboration with health, housing, and social welfare sectors to attain health improvements for women, especially concerning childbirth. In Kenya, the availability of traditional birth attendants, whom women recognised as culturally knowledgeable and consistently accessible during emergencies, was a significant determinant of their delivery location choices (Marjolein, 2003). Male dominance within the household significantly influenced women's selection of birthplaces in Uganda (Ochako, 2011). In Tanzania, the practice of placenta burial has deterred pregnant women from delivering at health facilities (Mulusew, 2003).

 In Ghana, pregnant women opt for home deliveries due to their experiences of recurrent mistreatment by healthcare personnel during childbirth at medical facilities. Moreover, study in Ghana determined that a woman's economic status is not the sole factor influencing her choice of birthplace; poverty, educational background, the career and income level of her spouse, and adverse cultural practices also play significant roles. Research indicates that poverty is associated with women's preferences for birthplace in rural regions of Ghana. Women with limited income are more likely to deliver at home compared to those use a health centre. Abbey (2008) asserts that women's preferences for birth sites are shaped by a variety of elements, including cultural and demographic considerations. As per the Ghana Statistical Service of 2010 (referenced in Hazemba & Siziya, 2011), more than 95 percent of pregnant women in the northern region attend antenatal clinics; however, only 27 percent of deliveries are conducted by skilled providers, while 56 percent are assisted by traditional birth attendants, and approximately 17 percent receive no assistance. The northern regions of Research by GHS (2010) indicates that a significant percentage of mothers in Ghana deliver at home. Such deliveries generally lead to delivery and postpartum difficulties, and mothers are regularly referred to health facilities for treatment. Nonetheless, most women who utilised TBA services subsequently returned to hospitals with various complications, some of which were fatal, complicating obstetric care and incurring significant costs, occasionally necessitating surgical intervention. This unfortunate situation reinforces the public perception that surgery is the sole treatment option available at hospitals. The primary aim of the study was to investigate the factors that affect pregnant women's decisions about delivery locations in specific healthcare facilities.

**METHODOLOGY**

Study design: The study employed a descriptive cross-sectional study design to look at the factors that influence women's choice of delivery places in the Sagnarigu Municipality. This kind of research is mostly done to assess the frequency of a particular outcome in a specific population, most frequently for health planning. Cross-sectional studies, in this sense, provide a snapshot of the outcome and its associated variables at a single moment in time.

Population: Women of reproductive age in the Municipality were included in the study population. They included expectant mothers and multiparous who gave birth with the help of skilled or unskilled birth attendants.

Sampling Technique and Size:

50 women were sampled from selected health facilities in the Sagnerigu Municipality. The sample size was determined using a formula developed by Varkevisser et al: n = p (1-p)/e2.

Where n = sample size P = estimated population of childbearing women

P = estimated error at 2.5 percent

z = confidence interval at 95 percent = standard value of 1.9

n = 3.2(100-3.2)/ (2.5)2 = 50

A 10% non-response rate was added, resulting in a total of 55 participants.

Purposive sampling was used to select respondents from the study area for the administration of the questionnaire.

Data Analysis: The data was collected by editing, coding, categorizing, and entering it into statistical packages for social sciences (SPSS) computer software for analysis. With the frequencies and percentages, tables and pie charts were used. These were used by the researchers due to their convenience, consistency, validity, and reliability.

**RESULTS**

The study collects biographical information from respondents, including age, marital status, religion, educational attainment, ethnicity, and employment status. 14% of respondents are single, 72% are married, 8% are cohabitating, and only 6% are divorced. This conclusion is corroborated by Kabakyenga (2012) and Adeyemi (2007). Research indicated that married women cohabiting with their spouses were more inclined than unmarried pregnant women to opt for delivery at a health centre. This conclusion, however, contradicted Berman's (2000) findings that a woman's marital status had no influence on her place of childbirth. The most significant factor influencing women's selections of delivery sites is their own preferences, as indicated by his data. 62% of respondents are Islam and 34% are Christians whiles only 14% of respondents are affiliated with other religious groups. Thirteen percent of respondents had attained primary education, twenty percent had completed secondary education, and fifty-five percent had achieved higher education, but twelve percent had obtained no education. The majority of responders possessed a tertiary education (55 percent). This conclusion aligns with a survey undertaken by Kamga et al. (2012), which indicated that as women's education levels increase, their preference for health facilities over home birthing also rises.

Regarding ethnicity, 48% of respondents identify as Dagombas, 26% as Gonjas, 8% as Komkombas, and 18% as belonging to other ethnic groupings. Forty-eight percent of respondents identify as Dagombas. This may be attributed to the research region being situated in the Sagnarigu Municipality, which is predominantly inhabited by the Dagomba people. Regarding occupation, 33% of respondents are traders, 38% are public servants, and 29% are engaged in other professions. A substantial majority (38%) of respondents are employed in the public sector. This may be attributed to the fact that, in contrast to individuals in the informal sector, the majority of respondents in the formal sector experience superior working conditions and get a reliable monthly pay. These employed women, possessing a consistent income, were more inclined to autonomously decide their preferred locations for childbirth and to independently access health facilities for care. Moreover, these employed women could procure the essentials that healthcare providers often require during labour and delivery. The results of this study corroborate those of Kabakyenga (2012) and Adeyemi (2007), who identified a woman's socioeconomic status as the primary determinant of her subsequent childbirth location. Regarding the ideal location for the next delivery, 2% of respondents indicated home, 90% indicated hospital, while 4% indicated clinics and CHIPS, respectively. A overwhelming majority (90%) of respondents believe that their chosen location for the next delivery will be the hospital. The results of this study corroborate those of Mbaruku et al. (2009), who indicated that the majority of women prefer to deliver in hospitals. The majority of individuals believe that women should be incentivised to deliver in healthcare facilities to mitigate any complications that could lead to mortality.

## **Factors and Social and Cultural Beliefs that Influence Pregnancy and Childbirth**

**Figure 1: Knowledge of Cultural Beliefs and Practices That Affect Pregnancy and Childbirth**

The researchers wanted to determine if respondents knew of any cultural beliefs or practices that influence pregnancy and delivery in their area, and as shown in Figure 1, 42 percent of respondents replied no, while 58 percent said yes. The majority of respondents (58%) are aware of cultural beliefs and practices that influence pregnancy and childbirth.

**Table 1: Pregnancy and Childbirth: Major Social and Cultural Beliefs and Factors**

|  |  |  |  |
| --- | --- | --- | --- |
| **Social and cultural beliefs and factors** | **Yes** | **No** | **Total** |
| Prolonged labour means unfaithfulness | 10 (34%) | 19 (66%) | 29 (100%) |
| Home delivery means the woman is brave | 14 (48%) | 15 (52%) | 29 (100%) |
| Successful previous home delivery means subsequent ones will be successful | 10 (34%) | 19 (66%) | 29 (100%) |
| Location of the health facility | 20 (69%) | 9 (31%) | 29 (100%) |
| Marital status of the woman | 13 (45%) | 16 (55%) | 29 (100%) |
| Fear of death | 19 (66%) | 34 (34%) | 29 (100%) |
| Fear of operation | 17 (59%) | 12 (41%) | 29 (100%) |

**Prolonged Labour Means Unfaithfulness**

The results indicated that 10 (34%) of respondents said yes to the issue of prolonged labor meaning unfaithfulness whiles the majority 19 (66%) of respondents said no, they do not consider prolonged labor to mean unfaithfulness to be culturally related. A clear majority of 19 women (66 percent) did not believe that prolonged labour was culturally associated with unfaithfulness.

**Home Delivery Means the Woman Is Brave**

Among those who were aware of the cultural beliefs influencing childbirth, 14 (48%) of respondents said yes, mothers who give birth at home are thought to be brave whiles the majority 15 (52%) of respondents said no, women who deliver at home are not considered brave. The majority 15 (52%) of respondents are of the view that women who deliver at home do not mean bravery. Many women choose home birth since they do not want to be recognized as such. When competitors dispute, one can even refer to the other as a coward and a weakling if she has ever given birth in a medical institution.

**Previous Home Deliveries Were Successful, So Subsequent Ones Will Be as Well.**

When asked if previous successful home deliveries indicate that future ones will be successful, 10 (34%) of participants believe that earlier successful home deliveries were a factor influencing women's choice of childbirth locations, while 19 (66%) do not believe that successful home deliveries were a factor influencing women's choice of childbirth locations. According to the majority of 19 (66 percent) women in the study, a positive home birth is not a factor that influences a woman's choice of birthing.

**Location of The Health Facility**

When asked if the location of the health facility was a major communal and cultural belief and factors underpinning pregnancy and childbirth, 20 (69%) said yes, whiles 9 (31%) of respondents think otherwise. Clearly, the majority 20 (69%) of women are of the view that, location of a health facility is a major factor underpinning women’s choice of place of delivery in the study area.

**Marital Status of The Woman**

Respondents were asked if the marital status of the woman was a major social and cultural belief and factor underpinning pregnancy and childbirth, it can be seen that, 13 (45%) of respondents said yes, whiles the majority 16 (55%) are of the view that, a woman’s choice of place of birth is not influenced by marital status.

**Fear of Death**

On the issue of fear of death, it can be seen that the majority 19 (66%) of women said yes, it was a factor underpinning pregnancy and childbirth whereas 10 (34%) of respondents said no, fear of death is not a factor underpinning pregnancy and childbirth. The majority 19 (66%) of pregnant women are of the view that fear of death influenced their place of childbirth.

**Fear of Operation**

According to the conclusions of the survey, 17 (59%) of respondents feel that fear of surgery is a big factor affecting pregnancy and delivery, while 12 (41%) believe that fear of surgery is not a factor determining birthplace. According to the majority of 17 (59 percent) respondents, fear of surgery is one of the factors in pushing women to deliver at home while seeking ANC treatments at health centers.

## **Economic, Geographic, and Other Bottlenecks That Influence the Choice of Place of Birth of Women.**

The researcher sought to know if economic, geographic, and other bottlenecks factors influenced the choice of place of birth of women and the responses are given below;

**Figure 2: Knowledge of Factors That Influence Pregnant Women’s Choice of place of Delivery**

When asked if they knew of any factors that influenced pregnant women's delivery choices, 43 percent said no, they didn't know of any factors that influenced pregnant women's delivery choices, whereas the majority (57 percent) said yes, they knew of factors that influenced pregnant women's delivery choices, as shown in Figure 2. The majority of women (57 percent) are aware of the factors that influenced pregnant women's decision on where to give birth.

**Table 2: Economic Factors That Influence Pregnant Women’s Choice of Delivery**

|  |  |  |  |
| --- | --- | --- | --- |
| **Statement**  | **Yes** | **No** | **Total** |
| Financial status of the family | 48 (96%) | 2 (4%) | 50 (100%) |
| Poor quality of services provided in health facilities | 7 (14%) | 43 (86%) | 50 (100%) |
| Cost of transportation | 33 (66%) | 17 (34%) | 50 (100%) |
| Type of occupation | 16 (32%) | 34 (68%) | 50 (100%) |

**Financial Status of The Family**

Table 2 shows that 48 (96%) of respondents said yes monetary status of the family influenced where women chose to deliver whereas only 4% of respondents said no, the monetary status of the family does not influence where women chose to deliver. The financial status of the family influences where pregnant women deliver as indicated by the majority 48 (96%) of respondents. The findings of this study back up those of the subsequent researchers (Amooti & Nuwaha, 2000; Adeyemi, 2007; Abyot & Asres, 2010), who discovered that a woman's economic level was a major predictor of where she should deliver. Despite Ghana's free maternal health policy, expectant women say they still have to pay a charge to midwives when giving birth at a health facility. The time spent hunting for money may cause individuals to put off seeking medical help, resulting in their not obtaining care on time. According to accounts, poor rural women found in Bangladesh who couldn't afford medical care had to rely on friends and relatives for assistance, and the majority were forced to give birth at home (Amooti & Nuwaha, 2000).

**Health-care facility services are of poor quality.**

When asked if poor-quality services supplied by health facilities affected their choice of child delivery, 7 (14% of respondents) replied yes, but the majority of 43 (86%) do not believe poor-quality services provided by health facilities influence women's choice of delivery location. Patients frequently complain about the poor quality of services in public health care facilities, according to Abbey (2008); According to Amooti and Nuwaha (2000), the bulk of complaints were about waiting times, an unsanitary hospital atmosphere, abuse and contempt, and health care personnel' disinterest.

**Cost of Transportation**

It can be seen that 33 (66%) of respondents said yes, the cost of transportation influenced their place of delivery whereas 17 (34%) of respondents think otherwise. The majority of pregnant women (66 percent) believe that transportation costs influence where they give birth, implying that while women may want to give birth in a health place, their inability to pay for transportation may force them to give birth at home.

**Type of Occupation**

On the issue of the type of occupation, 16 (32%) of respondents said yes, the type of occupation influenced their place of delivery whiles 34 (68%) of respondents said no, the type of occupation does not influence their choice of place of delivery. The occupation of the majority of pregnant women (34 percent) has no bearing on where they give birth.

**Table 3: Geographic Factors That Affect Pregnant Women**

|  |  |  |  |
| --- | --- | --- | --- |
| **Statement** | **Yes** | **No** | **Total** |
| Long distance to health facility | 31 (62%) | 19 (38%) | 50 (100%) |
| Availability of TBA | 28 (52%) | 22 (44%) | 50 (100%) |
| Nature of roads leading to health Facility | 34 (68%) | 16 (32%) | 50 (100%) |
| The scent in the health Facility | 18 (36%) | 32 (64%) | 50 (100%) |

**Long Distance to Health Facility**

According to table 3, 31 (62%) of respondents said that vast distances to health centers pushed women to deliver at home, whereas 19 (38%) said the opposite. Pregnant women's birth decisions were impacted by the considerable distances between health centers.

**Availability of TBA**

Again, 28 (52%) of respondents said that the availability of TBA affected pregnant women's choice of birth location, while 22 (44%) said that the availability of TBA had no bearing on pregnant women's choice of delivery location. According to the majority of 28 (52 percent) respondents, the availability of TBA affected pregnant women's choice of birth location.

**Nature of Roads Leading to Health Facility**

According to the findings, 34 (68 percent) of respondents believe that the character of roads leading to health facilities influences pregnant women's choice of delivery, whereas 16 (32 percent) believe differently. Clearly, the majority of 34 (68 percent) of respondents feel that poor road conditions linking villages to health institutions affected women's birth place choices. Rural women in West Java Province, Indonesia, have less access to health services due to poor road conditions, a lack of community awareness because the majority of rural dwellers are illiterate, and an overemphasis on the use of TBA services (Titaley, Hunter, Heywood, & Dibley, 2010); the situation was found to be similar among Kenyan rural women (KDHS, 2009).

**The Scent in The Health Facility**

On the issue of the scent of the health facility, 18 (36%) of respondents said yes, it influences the choice of place of delivery whiles the majority 32 (64%) of respondents said no, the scent of the health facility does not influence the choice of place of delivery by pregnant women. The majority 32 (64%) of respondents do not believe that the scent of the health facility influences the choice of place of delivery.

**Table 4: Factors That Affect Pregnant Women’s Choice of Place of Delivery**

|  |  |  |  |
| --- | --- | --- | --- |
| **Statement**  | **Yes** | **No** | **Total** |
| Poor attitude of health workers towards clients | 41 (82%) | 9 (18%) | 50 (100%) |
| Inadequate access to maternity services | 38 (76%) | 12 (24%) | 50 (100%) |
| Preference for TBAs | 15 (30%) | 35 (70%) | 50 (100%) |
| Experience of previous abuse during labor and child delivery | 21 (42%) | 29 (58%) | 50 (100%) |
| Position of the husband on birthplace preference | 31 (62%) | 19 (38%) | 50 (100%) |
| Level of education | 30 (60%) | 20 (40%) | 50 (100%) |

Respondents were questioned about the elements that influence pregnant women's birthplace preferences. According to Table 4, the majority of 41 (82 percent) of respondents agreed that health staff had a terrible attitude toward clients. Thirty-eight percent claimed they had insufficient access to maternity care, whereas 62 percent and 60 percent said they agreed with their husband's choice of birthplace and educational level, respectively. However, 35 (70%) of respondents stated that women's preference for TBAs had no bearing on where they gave birth. A majority of 29 (58%) respondents also feel that past mistreatment during labor and childbirth has no bearing on a woman's decision to give birth in a certain location.

## **Risks and Other Difficulties Associated with Health Care Delivery That Influence Delivery Location Selection**

**Figure 3: Satisfied with The Services Provided at The Health Facility**

Figure 3 shows that 85% of respondents are happy with the services given by health facilities, whereas 15% are dissatisfied with the services offered by health facilities. The majority of respondents (85%) are happy with the services given by the health institutions.

**Figure 4: Number of Times Respondent Attended ANC During the Last Pregnancy**

The researchers wanted to know how many times the respondents went to ANC during their past pregnancy, and Figure 4 shows that 25% responded 1-5 times, 72% stated 5-10 times, and just 3% claimed they did not go to ANC during their last pregnancy. The majority of respondents (72%) said they went to ANC 5-10 times during their last pregnancy. ANC provides a chance for women to learn about crucial pregnancy and delivery problems. They are more aware of risk detection and complication indications, allowing them to seek treatment as soon as necessary. They are educated about the hazards of giving birth at home. Marjolein (2003) discovered that Women who attended more ANC visits were more likely to give birth in a health facility under the supervision of a skilled birth attendant than women who attended less visits, and (Mesko, 2004) discovered that women who had more ANC visits were also more likely to deliver in health facilities than those who had never done so.

**Figure 5: Satisfied with The Services Provided**

When asked if they were pleased with the care provided during their most recent pregnancy, 86 percent replied yes, while 14 percent said no. The majority of respondents (86%) were happy with the health-care institutions' services.

**Do you think the following things might impact where a woman gives birth?**

The researcher sought to find out from respondents if the factors stated in Table 5 influenced where a woman would choose to give birth, and the results are shown below;

**Table 5: Factors Influencing a Woman's Choice of Delivery Location**

|  |  |  |  |
| --- | --- | --- | --- |
| **Statement**  | **Yes** | **No** | **Total** |
| Inadequate health-care providers' knowledge and skills | 38 (76%) | 12 (24%) | 50 (100%) |
| Absence or tardiness of health care providers at the health facility to work | 30 (60%) | 20 (40%) | 50 (100%) |
| Long waiting time at the health facility | 20 (40%) | 30 (60%) | 50 (100%) |
| Abuse and disrespect during labor and childbirth | 29 (48%) | 21 (42%) | 50 (100%) |
| Absence of medications in facility | 32 (64%) | 18 (36%) | 50 (100%) |
| Attitude of health workers towards their clients | 42 (84%) | 8 (16%) | 50 (100%) |

**Providers of health care have insufficient knowledge and skills.**

On the issue of inadequate knowledge and skills of healthcare providers as a factor that influences where a lady will choose to give birth, the majority of 38 (76 percent) respondents said yes, inadequate knowledge and skills of healthcare providers influence where a lady selects to give birth, while 12 (24%) of respondents believe otherwise.

**Health Care Providers' Nonappearance or Late Reporting to Work at The Health Facility**

Concerning the issue of health care providers arriving late for work at the health facility, 30 (60%) of respondents said yes, absenteeism was a factor that influenced the location where a lady might select to give birth whereas 20 (40%) of respondents thought otherwise.

**Long Waiting Time at The Health Facility**

The majority 30 (60%) of respondents were of the view that a long waiting time at the health facility does not affect a woman's position to choose to deliver whiles 20 (40%) of respondents said yes, a long waiting time at health facility influenced a woman to choose of a place of delivery. The majority 30 (60%) of respondents believe that a long waiting time does not, impact a woman's choice of delivery location.

**Abuse and Disrespect During Labor and Childbirth**

On abuse and disrespect during labor and childbirth, 29 (48%) of respondents said yes, it influences a woman's choice of place of delivery whiles 21 (42%) of respondents thought otherwise.

**Absence of Medications in Facility**

On the issue of the absence of medications in the facility, it can be seen that 32 (64%) of respondents said yes, the absence of medications in the facility influenced women's choice of a place of delivery whiles 18 (36%) of respondents thought otherwise.

**The attitude of Health Workers Towards Their Clients**

When asked if the attitude of health workers towards their clients was a factor that affects a woman to choose a place to deliver, 42 (84%) of respondents said yes, whiles only 8 (16%) of respondents said no.

**Figure 6: The Dangers of Pregnant Women Delivering at Home**

The researchers sought to find out from respondents the risks associated with pregnant women delivering at home and from Figure 6, it can be seen that, 29% of respondents said women may die, 31% said the woman may lose the baby and 30% said retention of placenta whiles 10% said pregnant women may be faced with other associated risk. A majority (31%) of respondents are of the view that the risk associated with pregnant women delivering at home is they may lose the baby. According to Amooti and Nuwaha (2000), whose study looked into pregnant women's knowledge of the risks associated with giving birth at home, 56 percent of the women said it was hazardous because the woman could die, and 20% claimed the placenta could remain in the womb for an extended period of time, and 24% said the mother and the baby might die during childbirth. According to a similar study (WHO, 2010), during pregnancy, millions of women and newborns die or suffer major health problems and delivery every year in developing countries, which can result in lifelong damage or death.

**Figure 7: Do you believe that poor health-care delivery influences women's choice of delivery location?**

Figure 7 shows that 95% of respondents feel that inadequate health-care delivery effects women's choice of delivery location, whereas just 5% believe differently. Poor health care delivery, according to the majority of respondents (95 percent), can impact women's choice of birth location. Patients frequently complain about the poor quality of services in public health care facilities, according to Abbey (2008); According to Amooti and Nuwaha (2000), the bulk of complaints were about waiting times, an unsanitary hospital atmosphere, abuse and contempt, and health care personnel' disinterest.

**Figure 8: How Does Poor Health Service Delivery Affect Pregnant Women?**

When asked ways by which poor health service delivery can affect pregnant women, 30% of respondents said it can lead to home delivery and poor ANC attendance respectively whereas 40% said it can lead to poor post-natal attendance. A majority (40%) of respondents are of the view that poor health service delivery can lead to poor post-natal attendance.

**Can the Following Influence Women's Attitudes Towards Health Care?**

The researchers sought to know if the quality of health care provided, effective Nurse-patient communication, availability, and provision of good medications as well as provision of privacy during labor and child delivery affect the attitude of women positively towards health care, and responses are given in the table below;

**Table 6: Can the following have a positive impact on women's attitudes toward health care?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Statement** | **Yes** | **No** | **Total** |
| Quality of health care provided | 50 (100%) | 0 (0%) | 50 (100%) |
| Effective Nurse-patient communication | 50 (100%) | 0 (0%) | 50 (100%) |
| Availability and provision of good medications | 47 (94%) | 3 (6%) | 50 (100%) |
| Provision of privacy during labor and child delivery | 44 (88%) | 6 (12%) | 50 (100%) |

**Quality of Health Care Provided**

The assumption that the quality of health care offered has an impact on women's attitudes regarding health care was validated by all 50 respondents. This might be because pregnant women will refuse to give birth at health facilities if they do not have complete access to maternal care. Patients commonly complain about the low quality of services offered by public health care institutions, with the bulk of complaints focusing on long wait times, an unpleasant hospital atmosphere, abuse and disdain, and health care workers' apathy (Amooti & Nuwaha, 2000; Abbey, 2008;).

**Effective Nurse-Patient Communication**

On the topic of successful nurse-patient communication, all 50 respondents agreed that good nurse-patient communication may influence women's attitudes regarding health care. Because women's attitudes to pregnancy and birth range from enthusiasm to terrified anticipation, the nursing care offered to them is crucial, according to the Ghana Health Service (GHS, 2007). As a result, researchers have argued that it is the role of midwives to educate and teach their patients about numerous pregnancy and delivery difficulties (Ali, 2006).

**Availability and Provision of Good Medications**

According to Table 6, 47 (94 percent) of respondents believe that the availability and provision of good medications affect women's attitudes toward health care, while 3 (6 percent) believe otherwise. The majority of respondents (47 percent) believe that the availability and provision of good medications influence women's attitudes toward health care.

**Provision of Privacy During Labor and Child Delivery**

The findings from Table 6 show that 44 (88%) of respondents said yes, whereas 6 (12%) of respondents said no, the provision of privacy during labor and child delivery does not impact the life style of women towards health care. The majority 44 (88%) of respondents are of the view that the provision of privacy during labor and child delivery affects the attitude of women towards health care.

**DISCUSSION**

This discourse integrates findings from research undertaken in Ghana and correlates them with current literature to emphasise significant factors influencing preferences for delivery locations.

Income and Financial Accessibility: Research demonstrates that financial limitations considerably influence women's choices regarding delivery locations (Ghana Statistical Service [GSS], Ghana Health Service [GHS], & ICF, 2018). Numerous women in rural and economically disadvantaged urban areas choose home deliveries or Traditional Birth Attendants (TBAs) because they cannot pay hospital fees, transportation charges, and related expenses. This corresponds with the findings of Awoonor-Williams et al. (2013), who indicated that out-of-pocket expenses inhibit facility-based deliveries in northern Ghana.

Women with education and formal work are more inclined to give birth in health facilities, attributed to enhanced health knowledge and access to insurance (National Health Insurance Scheme [NHIS]) (Dalinjong & Laar, 2012). In contrast, women with lesser educational attainment frequently depend on conventional practices shaped by familial and communal standards.

Cultural and Social Influences: In numerous Ghanaian societies, the decision-making process about childbearing is mostly influenced by spouses and senior family members as stated in Moyer et al., (2014) studies. Certain families favour home deliveries owing to cultural convictions, perceived safety, or scepticism towards healthcare providers. This finding supports the findings of Cotter et al. (2006) and Abyot & Asres (2010), who discovered that women prefer privacy during childbirth and feel more at ease when surrounded by family members rather than strangers. The ramifications of such a significant percentage of respondents thinking that cultural variables impact site of birth choice is mind-boggling, since this may drive women to pick delivery locations based on cultural beliefs. Abbey's (2008) findings that some cultural traditions continue to support pregnancy and delivery in Ghana, particularly in rural groups, are consistent with this conclusion.

The findings contrast those of Adeyemi (2012), who found that protracted labor suggested that a woman was unfaithful to her husband and that she needed to confess before she could deliver successfully at home. The findings of the study, however, contradict those of Mbaruku and Msambichaka (2009), who surveyed Thai women who were unaware that longer labor was linked to infidelity and birth location choice. The findings of this study contrast those of Hazemba and Siziya (2010), who showed that women saw home birth as a sign of bravery. Most women in some groups still assume that women who choose to give birth at home are courageous. This is due to the fact that labor and childbirth serve by way of a test for women in order to prepare them for the obligations of parenthood. In addition, polygamy is common in the research region, and female competition is on the rise. Women who choose to give birth at home display their ability to withstand discomfort. Women who choose to give birth in a health center are perceived as weaker. Specific ethnic communities link hospital births to heightened chances of caesarean sections or adverse spiritual repercussions (Sakeah et al., 2014). Traditional Birth Attendants (TBAs) continue to be favoured in certain areas because of their culturally attuned care methods. The findings of this study corroborate those of Kowalewski et al., (2002) and Birungi and Ouma (2006), who found that having TBAs in the community encouraged women to deliver at home with their assistance. They were confident in their capacity to execute on time and on budget.

Geospatial and Healthcare System Variables

Challenges Related to Distance and Transportation:

Inadequate road infrastructure and considerable distances to healthcare facilities deter facility-based deliveries, especially in rural regions (Amooti-Kaguna & Nuwaha, 2000). Emergency transport methods, such as ambulance services, frequently exhibit unreliability, hence discouraging hospital deliveries. The findings of this study corroborate those of Hulton (2007), who discovered that a woman's socioeconomic position influenced her choice of birthplace. The findings of this study are comparable to those of Amooti and Nuwaha (2000), who found that women with a high income would choose to give birth in a health facility because they could pay the fees of expert delivery care. Inadequate income women who could not afford to travel were more likely to give birth at home.

Quality of Care and Personnel Attitudes: The optimum place or setting for special deliveries has been termed as health centers (GHS, 2007). According to an Egyptian poll, the quality of care delivered to women is a critical factor of excellent mother and child health outcomes, and most women choose to give birth at home rather than at a health facility because they perceive poor health care there (WHO, 2004). Adverse experiences, such as inadequate treatment by healthcare professionals, affect women's decisions (Ganle et al., 2015). Inadequate resources, prolonged waiting periods, or unwelcoming staff in facilities compel women to seek alternative delivery methods. The findings of this study back up those of Kabakyenga (2012) and Adeyemi (2007), who discovered that a woman's financial level was the most important factor in determining where she may have her next kid. Employed women were also more likely to pay their healthcare bills if their partners did not agree to help them, according to the data. Women's income has been recognized as a major factor in their decision to give birth at a health center. Hulton (2007) discovered that women having a personal source of income were more likely than those with little or no money to deliver in a health institution and have a competent birth attendant help them during delivery. This study's findings corroborate those of Olatunji and Sule-Odu (1997). They noticed that a great distance to a health-care facility, particularly in rural regions, hindered mothers from delivering their babies at a health facility. It also corroborates the findings of (Khalid et al., 2006; Adeyemi, 2007; Envuladu et al., 2012), who discovered that women's choice of birthplace was influenced by their wealth and distance to health clinics. It's worth mentioning that where women choose to give birth is influenced by the location of the health facilities. When a health center is a long distance from a woman's home, she will choose to give birth at home since the journey from her home to the health facility is dangerous. To go to the health center, the bulk of these ladies walk or ride their motorbikes or bicycles. Women may give birth on their route to the health facility due to the lengthy distance. As a result, women weigh the potential for suffering and discomfort associated with going to facility and decide to stay at home and give birth instead of going from their homes to health-care facilities. In addition, labor could begin late at night, and they think it is unsafe to travel to the health center at that hour because it is so far away from their house. Unreliable transportation, particularly in rural areas, is a significant barrier to accessing skilled care.

Policy and Programmatic Initiatives:

The National Health Insurance Scheme (NHIS) has enhanced facility-based births by mitigating financial obstacles (Dalinjong & Laar, 2012). Moreover, community-based educational initiatives and the Free Maternal Health Care Policy have augmented institutional delivery rates (GSS et al., 2018). Nonetheless, ongoing issues like as delays in NHIS reimbursements and geographical discrepancies hinder complete efficacy.

**CONCLUSION**

The study's findings reveal that the accessibility of health facilities, fear of mortality, and reluctance towards surgery are substantial variables influencing women's decisions to birth at home, despite their engagement in antenatal care in health centres. This suggests that social and cultural attitudes and practices are profoundly ingrained in the brains of many persons living in rural villages within the study area, negatively impacting women's decisions regarding home birthing. Economic considerations like as financial status and transportation expenses affect women's selection of delivery locations. The distance to health clinics, the availability of traditional birth attendants, and the poor quality of roads connecting communities to health centres are geographical factors that influenced women's choice of delivery locations. Expectant mothers are generally satisfied with the services offered by healthcare facilities. Despite respondents expressing a preference for health centres as their delivery location, persisting societal and cultural attitudes around pregnancy and childbirth, together with economic and geographic factors, persist in driving individuals to deliver at home and in spiritual institutions. If neglected, these issues may continue to jeopardise the health of women and children in the research town.

**Consent**

As per international standards or university standards, Participants’ written consent has been collected and preserved by the author(s).

Disclaimer (Artificial intelligence)

Option 1:

Author(s) hereby declare that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc.) and text-to-image generators have been used during the writing or editing of this manuscript.

Option 2:

Author(s) hereby declare that generative AI technologies such as Large Language Models, etc. have been used during the writing or editing of manuscripts. This explanation will include the name, version, model, and source of the generative AI technology and as well as all input prompts provided to the generative AI technology

Details of the AI usage are given below:

1.

2.

3.

**Reference**

Abbey, M. (2008). Midwives attitudes to women in labour in Ghana. 1d21Health Highlights. Vol. 23: p1

Abrahams, N. (2001). Health seeking practices of pregnant women and the role of midwife in Cape Town, South Africa. Journal of Midwifery & Women’s health. Vol.46 (4): pp 240-247.

Abyot, A. and Asres, N. (2010). Assessment of factors associated with safe delivery service utilization among women of childbearing age in Sheka Zone, SNNPR, South West Ethiopia School of Public Health Faculty of Medicine, Addis-Ababa University for Uttar Pradesh.

Acharya, L. and Cleland, J. (2000). Maternal and child health services in Nepal: Does access or quality matter more? Health policy and Planning. Vol. 15(2): pp 223- 229.

Adam, M. and Salihu, H. (2002). Barriers to the use of antenatal and obstetric care services in rural Kano, Nigeria. Journal of Obstetrics and Gynaecology. Vol. 22 (6): pp 600-603.

Adeyemi, E. (2007). Socio-economic differentials in health care choices: implications for maternal mortality in Nigeria; PhD Thesis; Department of Sociology, Lagos State University, Nigeria.

Adeyemi, E. (2012). Socio-economic differentials in health care choices: implications for maternal mortality in Nigeria; PhD Thesis; Department of Sociology, Lagos State University, Nigeria. p34

Alastair, A. and Pepper, K. (2005). Patterns of health service utilization and perceptions of needs and services in rural Orissa. Health Policy and Planning. Vol. 20: pp 76 – 184.

Amooti, K. B. and Nuwaha, F. (2000). Factors influencing choice of delivery sites in Rakai district of Uganda. Soc. Sci Med. Vol. 50: pp 203 – 213

Babalola, S. and Fatusi, A. (2009). Determinants of use of maternal health services in Nigeria -looking beyond individual and household factors. BMC Pregnancy Childbirth. Vol. 9: p43.

Bashour, H. and Abdulsalam, A. (2005). Syrian women’s preferences for birth attendant and birth place. Birth. Vol. 32: pp20-26.

Bassoumah, B. (2010). Maternal Health in Awutu-Senya District of Ghana

Berman, P. (2000). Organization of ambulatory care provision: a critical determinant of health system performance in developing countries. Bulletin of World Health Organization. Vol. 78(6): pp791 – 802.

Beth, D. and Robert, G. (2001). Basic and Clinical biostatistics. USA: Lange Medical Books / McGraw-Hill Medical Publishing division.

Birungi, H. and Ouma, W. O. (2006). Acceptability and Sustainability of the WHO Focused Antenatal Care package in Kenya, Frontiers in Reproductive Health Program, Population Council, Institute of African Studies, University of Nairobi. p25

Borghi, A. Nauman, J. and Thomas, K. (2006). Mobilising financial resources for maternal health, Lancet. Vol. 368: pp 1457–65,

Campbell, O. M. R. and Graham, W. J. (2006). Strategies for reducing maternal mortality: getting on with what works, Lancet. Vol. 368: pp 1284–99

Cotter, K. Hawken, M. and Temmerman, M. (2006). Low use of skilled attendants’ delivery services in rural Kenya; J Health Population Nutrition. Vol. 24: pp 467-71.

Emmanuel, A. and Amenyah, M. (2014). Determinants of places of delivery of expectant mothers in Adidwan in the Mampong municipality of Ashanti region.

Envuladu, E. Agbo, H, Mohammed, A. Chia, L. Kigbu, J. and Zoakah, A. (2012). Utilization of modern contraceptives among female traders in Jos South LGA of Plateau State, Nigeria. Int J Med Biomed Res. Vol. 1: pp224-231.

Filippi, V. Ronsmans, C. Campbell, O. Graham, W. Mills, A. Borghi, J. Koblinsky, M. and Osrin, D. (2006). Maternal survival-Maternal health in poor countries: the broader context and a call for action.

Ghana Health Service Annual Report (2010). Health Facts and Figures. p40.

Hazemba, A. and Siziya, S. (2010). Choice of place for childbirth: prevalence and correlates of utilization of health facilities in Chongwe district. Zambia. Med J Zambia. Vol. 35: pp53 -57.

Hiluf, M. Fantahun, and M. (2007). Birth Preparedness and Complication Readiness among Women in Adigrat Town, North Ethiopia. Ethiop. J. Health Dev. Vol. 22(1): pp14-20.

Hodgkin, D. (1996). Household characteristics affecting levels and additional risks from poor accessibility in two districts of Northern Province, Zambia. Int J. Epidemiol. Vol. 26: pp 357 – 26

Hulton, L. (2007). A forgotten priority: Maternal health service infrastructure. Id21 Insights health.Vol. 11: p 6.

Idris, S. Gwarzo, U. and Shehu, A. (2006). Determinants of place of delivery among women in semi-urban settlement in Zaria, Northern Nigeria. Annals of African Medicine. Vol. 5: pp 68-72.

Institute of Public Health (2006). Health System Reforms in Uganda. Processes and outputs. Kampala: Institute of Public Health Makerere University.

Institute of Public Health. (2006). Health System Reforms in Uganda. Processes and outputs. Kampala: Institute of Public Health Makerere University.

Kamga, H, Assob, N, Nsagha, D. Njunda, A. and Njimoh, D. (2012). A community survey on the knowledge of neglected tropical diseases in Cameroon. Int J Med Biomed Res. Vol.1: pp131-140.

Khalid, S. Daniel, W. and Lale, S. (2006). WHO analysis of causes of maternal death: a systemic review. The Lancet Maternal Survival Series. Vol. 367: pp 1066-74.

Kirigia, U. (2011). Effects of maternal mortality on gross domestic product (GDP) in the WHO African region.

Kombian, B. (2013). Factors associated with choice of place for delivery in Builsa north district in the Upper East Region of Ghana.

Kowalewski, M. Mujinja, P. and Jahn, A. (2002). Can mothers afford maternal health care costs? User costs of maternity services in rural Tanzania. Afr J Reprod Health. Vol. 6: pp 65–73.

Kyomuhendo, G. (2009). Low use of rural Maternity service in Uganda: Impact of women’s Status, traditional Lancet. Vol. 368(9546): pp1535-1541.

Madi, B. and Crow, R. (2003). A qualitative study of information about available options for childbirth venue and pregnant women’s preference for a place of delivery. Midwifery. Vol.19:pp323-338.
Kabakyenga, J. K. Ostergren, P. O. Turyakira, E. and Pettersson, K. O. (2012). Influence of Birth Preparedness, Decision-Making on Location of Birth and Assistance by Skilled Birth Attendants among Women in South-Western Uganda. PLoS ONE. Vol. 7(4).

Mahdi, S. and Habib, S. (2010). A study on preference and practices of women regarding place of delivery. East Mediterr Health J. Vol. 16: pp 874-878.

Marjolein, D. (2003). Identifying factors for job motivation of rural health workers in North Viet Nam. Human Resources for Health.Vol. 1: p10.

Marjolein, D. Jurrien, T. Hamadassalia, T. and Martineau, T. (2006). The match between motivation and performance management of health sector workers in Mali. Human Resource for Health. Vol. 4(2).

Maureen, M. and Peter, M. (2008). Determinants of skilled birth attendant utilization in Afghanistan. Am J Public Health. Vol. 98(10): pp1849–1856.

Mbaruku, G. Msambichaka, B. Galea, S. Rockers, P. and Kruk, M. (2009). Dissatisfaction with traditional birth attendants in rural Tanzania. Int J Gynaecol Obstet. Vol. 107: pp 8-11.

McDonagh, M. (1996). Is antenatal care effective in reducing maternal morbidity and mortality? Health Policy and Planning. Vol. 11(1): pp1-15.

Mesfin, A. Nigussie, U. Damen H. M. O. and Getnet M. K. (2002). Assessment of save delivery service utilization women of child bearing age in Northern Gonder Zone, Northwest Ethiopia.

Mesko, N. (2004). Keeping it in the family: care during childbirth rural Nepal. Id21 Health Highlights.Vol. 13: p2

Moses, L. Nanang, and Albert, A. (2014). Factors predicting home delivery among women in Bosomtwe-Atwim –Akwanwoma District of Ghana: A case study.

Mpembeni, B. and Daud, K. (2007). Use pattern of maternal health services and determinants of skilled care during delivery in Southern Tanzania: implications for achievement of MDG -5 targets. BMC Pregnancy and Child birth. Vol. 7: p 29.

Mulusew, M. (2003). Preference and factors affecting mothers as to the site of delivery in Shebe town, south –western Ethiopia. Jimma University, in press.

Nwakoby, B. (1994). Use of obstetric services in rural Nigeria. J Reprod Soc Hlth.Vol. 114: pp 132-136

Ochako, M. (2011). Utilization of maternal health services among young women in Kenya: Insights from the Kenya Demographic and Health Survey 2003.

Ogunlesi, T. A. (2005). The pattern of utilization of prenatal and delivery services in Ilesa, Nigeria. IJE. Vol.2 (2): pp 1540-2614.

Olatunji, A. and Sule-Odu, A. (2001). Maternal mortality at Sagamu, Nigeria-a ten-year review (1988–1997) Niger Postgrad ed J. Vol.8: pp 12-15.

Singh, S. (2004). Adding it up: The Benefits of investing in sexual and reproductive health care. New York: The Alan guttmacher institute and UNFPA.

Thind, A. Mohani, A. Banerjee, K. and Hagigi, F. (2008). Where to deliver? Analysis of choice of delivery location from a national survey in India. BMC Public Health.Vol. 8: p29.

Tsinuel, G. and Hailu, N. (2008). Traditional new born care in Jimma town South West Ethiopia.

Tukur, J. Jido, T. and Awolaja, B. (2008). Maternal mortality in rural Northern Nigeria. Trop Doct. Vol. 38: pp 35-36.

United Nations (2007). Millennium Development Goals Report, United Nations, New York, NY, USA

Wanjira, C. Mwangi, M. Mathenge, E. Mbugua, G. and Ng’ang’a, Z. (2011). Delivery practices and associated factors among mothers seeking child welfare services in selected health facilities in Nyandarua South District, Kenya. BMC Public Health.Vol. 11: p360.

WHO (2005). Make every mother and child count. Geneva; 2005

WHO (2010). World Health Statistics. Maternal mortality ratio in developing countries.

WHO World Health Report (2012). What is the effectiveness of antenatal care? (Supplement). Copenhagen, WHO Regional Office for Europe, health Evidence Network. World Health Report

Awoonor-Williams, J. K., et al. (2013). *BMC Pregnancy and Childbirth, 13*(1), 1-12.

Dalinjong, P. A., & Laar, A. S. (2012). *BMC Health Services Research, 12*, 1-11.

Ganle, J. K., et al. (2015). *Reproductive Health, 12*(1), 1-15.

Ghana Statistical Service (GSS), Ghana Health Service (GHS), & ICF. (2018). *Ghana Maternal Health Survey*.

Moyer, C. A., et al. (2014). *Social Science & Medicine, 100*, 8-16.

Sakeah, E., et al. (2014). *BMC Pregnancy and Childbirth, 14*(1), 1-10.