

Delivery Preferences and Barriers to Institutional Births Among Women of Reproductive Age in Nigeria: A Qualitative Study

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ORIGINAL ARTICLE

Article title here: **Delivery Preferences and Barriers to Institutional Births Among Women of Reproductive Age in Nigeria: A Qualitative Study.**

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ABSTRACT

Background: Maternal mortality remains disproportionately high in low- and middle-income countries (LMIC), driven by weak health systems, inadequate infrastructure, and persistent poverty. Despite ongoing efforts to expand access to skilled birth attendance, only about 43% of births in Nigeria occur in health facilities, contributing to the country's first place ranking in the number of maternal deaths globally. Understanding women's delivery preferences is critical to improving institutional delivery uptake and maternal health outcomes.

Methods: This qualitative study explored factors influencing women's delivery choices using the Theory of Planned Behaviour as a conceptual framework. Forty-eight focus group discussions and sixty key informant interviews were conducted between July and September 2024 with women of reproductive age, spouses, mothers-in-law, traditional and skilled birth attendants, health administrators, and community leaders across six Nigerian states representing the country's six geopolitical zones. Data were transcribed, translated where necessary, and analyzed thematically using Braun and Clarke's framework.

Results: Women's delivery preferences were shaped by the interplay of perceived quality of care, economic constraints, social influences, and access-related barriers. Institutional delivery was often discouraged by experiences of provider disrespect, prolonged waiting times, hidden costs, distance, and transportation challenges. In contrast, traditional and mission birth attendants were valued for their accessibility, empathy, cultural familiarity, and spiritual support. Family members, particularly husbands and mothers-in-law, also played important roles in delivery-related decision-making.

Conclusion: Women's childbirth preferences reflect a balance between perceived clinical safety and respectful, culturally responsive care. Efforts to increase institutional delivery uptake should combine health system strengthening with respectful maternity care, improved affordability, community engagement, and stronger provider-client relationships.

Keywords:

Maternal health; delivery preferences; institutional delivery; qualitative research; Nigeria; Theory of Planned Behaviour; respectful maternity care.

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1. INTRODUCTION

Maternal mortality remains a major global public health challenge. Although the maternal mortality ratio (MMR) declined by 40%, from 328 to 197 deaths per 100,000 live births between 2000 and 2023^[1,2], progress remains insufficient to achieve the Sustainable Development Goal target of fewer than 70 deaths per 100,000 live births by 2030^[3]. Most maternal deaths are preventable^[2,4], and using a skilled birth attendant (SBA) during delivery is among the most effective interventions for reducing maternal mortality^[2,5]. SBAs can provide life-saving interventions during obstetric complications, including surgery, blood transfusion, and antibiotic treatment. Nevertheless, millions of women in LMICs continue to give birth without skilled assistance^[6].

Nigeria remains at the centre of this challenge. Despite accounting for a relatively small proportion of the global population, Nigeria has the highest burden of maternal deaths, contributing approximately one-quarter of global maternal deaths. In 2023, the country recorded one of the world's highest maternal mortality ratios, estimated at 993 deaths per 100,000 live births^[2]. Deliveries taken by SBA increased from 32% in 2003 to 52% in 2024^[7]. Still, substantial disparities persist across regions, states (particularly in northern Nigeria), and rural settings where access to maternal health services remains limited^[6,7].

1.1 Background of the Study

Previous studies have identified several determinants of institutional delivery in Nigeria, including poverty, maternal education, geographic accessibility, and sociocultural and religious beliefs that favour traditional/mission birth attendants (T/MBAs)^[8,9]. Women's autonomy in healthcare decision-making also varies considerably across settings, with poor levels particularly in northern Nigeria and rural settings. However, much of the existing evidence is derived from quantitative studies that identify statistical predictors of facility-based delivery^[10] while providing limited insight into the lived experiences and decision-making processes underlying childbirth preferences. Other qualitative studies also examine this topic in limited settings.

This study explores delivery preferences and barriers to institutional childbirth among women across Nigeria's six geopolitical zones, by rural-urban setting, prior childbirth status and age group. The study is guided by the Theory of Planned Behaviour (TPB) ^[11], which posits that behavioural intentions are shaped by attitudes, subjective norms, and perceived behavioural control. In the context of childbirth, attitudes reflect perceptions of institutional delivery; subjective norms capture the influence of family, community, and religious expectations; and perceived behavioural control relates to a woman's perceived autonomy and ability to take action towards accessing and utilizing institutional skilled care.

Although the TPB has been widely applied to health-seeking behaviour, its application to childbirth decision-making in LMICs is limited. By examining how cultural beliefs, spirituality, family authority, a woman's agency, and healthcare experiences shape delivery preferences, this study extends the application of the TPB and contributes contextual evidence relevant to maternal health research in LMICs (Figure 1).

1.2 Objectives of the Study

This study explores delivery location preferences and constraints to institutional delivery among women during childbirth in Nigeria.

Specific Aims

Specifically, the objectives were to: (1) examine the factors influencing women's choice of delivery location; (2) explore the reasons for the continued utilization of traditional birth attendants and religious homes despite the availability of health facilities; (3) assess how previous childbirth experiences influence future delivery intentions; and (4) examine variations in delivery preferences across socio-demographic, cultural and geographic contexts.

2. METHODS

This study employed a descriptive qualitative design using focus group discussions (FGDs) and key informant interviews (KIIs), following established journal article reporting standards for qualitative research ^[12].

Data were collected from six States representing Nigeria's six geopolitical zones: Adamawa (North East), Akwa Ibom (South South), Ebonyi (South East), Federal Capital Territory (FCT, North Central), Kano (North West), and Oyo (South West). All study States were receiving funding through the United States Agency for International Development (USAID) to implement Maternal and Child Health and/or Health Systems Strengthening programs and were selected to capture diverse sociocultural and regional experiences.

The primary study participants were women of reproductive age (WRA) aged 18 - 49 years. Additional participants included spouses, mothers-in-law (MILs), health administrators, healthcare providers, and community and religious leaders. These provided complementary perspectives and facilitated triangulation of findings.

A total of 48 FGDs were conducted across the six study locations (eight per site), with 8 - 10 participants per group. Discussions were organized in separate groups: among younger women (18 - 29 years), older women (30 - 49 years), and first-time pregnant women (18 - 49 years), and stratified by rural and urban groups. In addition, KIIs (approximately 10 per State) were conducted with health administrators, service providers, spouses, MILs, and community and religious leaders from both rural and urban settings. Data collection continued until thematic saturation was reached, with no substantially new themes emerging.

Data were collected between August and September 2024 by trained USAID and implementing partner staff using semi-structured interview guides ^[13] translated into the major local languages. Interviews were conducted in English or local languages, digitally recorded, transcribed verbatim, and translated into English where necessary. Transcripts were managed in Trint software, while descriptive participant characteristics were summarized using SPSS.

Data were analyzed by the USAID Monitoring, Evaluation, and Learning Support Activity. Descriptive statistics were used to summarize participants' socio-demographic characteristics, while qualitative data were analyzed thematically following the approach described by Braun and Clarke ^[14]. The TPB provided the analytical framework for organizing and interpreting the findings ^[11]. An independent review of coded transcripts and thematic interpretations was undertaken to enhance analytical rigor. Trustworthiness was

strengthened through investigator triangulation, independent coding review, inclusion of diverse participant groups, and regular team debriefings to minimize bias and ensure findings remained grounded in participants' experiences.

2.1 Study Variables

The study is exploratory, based on factors influencing maternal health choices. Themes were examined in relation to attitudes toward institutional delivery, subjective norms, and perceived behavioural control.

Outcome Variable:

The main outcome of interest is women's delivery location preferences, conceptualized as the behavioural intention regarding where a woman chooses to give birth.

Independent Variables:

These are defined based on the TPB framework and include:

Relational/experiential, economic, structural and logistical, and socio-cultural factors.

Demographic and Descriptive Variables:

Age: Categorized as younger women (18–29) and older women (30–49).

Educational attainment: The level of schooling completed by the participants.

Occupational status: Whether the women were traders, self-employed, civil servants, unemployed or students.

Prior birth experience: Never delivered or delivered in the past.

Geographic location: Across six states/geopolitical zones in Nigeria.

Residential setting: Categorized as urban or rural.

2.2 . Statistical Analysis

Descriptive statistics were used to summarize participants' socio-demographic characteristics using SPSS. Audio recordings from the FGDs and KIIs were transcribed verbatim and, where necessary, translated into English using Trint software. The qualitative data were subsequently analyzed using a thematic analysis approach guided by the framework proposed by Braun and Clarke ^[14]. The analysis involved familiarization with the data, generation of initial codes, identification and review of themes, and interpretation of findings within the

constructs of the TPB. Independent review of coded transcripts and emerging themes was undertaken to enhance the credibility and consistency of the analysis.

3. RESULTS

Themes related to delivery location preferences were broadly consistent across geographic settings and age groups, reflecting the key constructs of the TPB. Although institutional delivery was mostly preferred in all states and in both rural and urban communities, participants described a range of social, economic, and experiential factors that shaped their final decisions.

3.1 Sociodemographic Characteristics

A total of 279 WRA participated in the FGDs. Of these, 145 (52%) were aged 18–29 years and 134 (48%) were aged 30–49 years. Nearly half (128; 46%) were traders or businesswomen, 64 (23%) were self-employed, 42 (15%) were unemployed, 30 (11%) were civil servants, and two (1%) were students. Most (56%) had completed at least secondary education, 30% attaining tertiary education, and 14% had no or only primary education. Most women (77%) had previous childbirth experience. See Table 1.

Fifty-eight key informants were interviewed during the KIIs; eight in Oyo state, and ten in all the other 5 States.

3.2 Delivery Preferences and Influencing Factors

Perceived quality of care emerged as a major determinant of delivery preferences. Participants widely acknowledged the technical competence of health facilities in managing obstetric complications. One participant in Adamawa observed, “*During delivery at home, there is no guidance, while at the hospital, skilled health care staff give guide and support during delivery*”. However, many expressed concerns about provider attitudes, disrespectful treatment, long waiting times, high cost of delivery, unofficial charges and sometimes unavailability of health providers. One woman in Ebonyi said, “*The disadvantage of the hospital is that when the delivery is at night there is no available nurse to attend to you*”. In contrast, T/MBAs were valued for their empathy, hospitality, accessibility, and respect for cultural and religious practices.

Family influence played an important role in decision-making. Husbands and mothers-in-law frequently influenced delivery choices through financial control, cultural expectations, and household authority. In southern Nigeria, spiritual beliefs and the perceived value of faith played a greater role in preferences for religious delivery settings. Participants also identified barriers that limited their ability to access institutional delivery, including long distances to health facilities, lack of emergency transportation, high delivery costs, and hidden fees. These constraints often increased reliance on TBAs, who were perceived as more affordable and accessible. A woman in FCT said, *“they will tell you to pay 10,000 (7 USD) or more than 15,000 naira (11 USD), so if someone doesn’t have that, it will discourage them from going to the hospital to deliver.”*

Previous childbirth experiences strongly influenced future delivery intentions. Women who reported disrespectful treatment, neglect, transportation difficulties, or unexpected costs during earlier facility deliveries were more likely to consider home births or TBAs for subsequent pregnancies. See Table 2.

3.3 Variations by Sociodemographic Characteristics

While the major themes influencing delivery preferences were consistent across study locations, some variations emerged by region, residence, age, and pregnancy status. Although health facilities were generally the preferred delivery location, participants in Southern States (Akwa Ibom and Oyo) expressed stronger preferences for T/MBAs. In rural Kano, preferences were more evenly divided between home and facility-based delivery.

Differences also emerged between rural and urban participants. Rural women frequently cited long distances, poor road networks, security concerns especially traveling at night, and the absence of emergency transportation as barriers to institutional delivery. Conversely, urban participants emphasized traffic congestion, high transportation costs, and unexpected facility charges as barriers. Urban women also associated institutional delivery with cleanliness, hygiene, and professional standards, while some rural women, particularly in Kano, preferred home delivery because it allowed traditional birthing positions and greater privacy.

Family authority influenced delivery decisions across settings but varied by participant group. MILs exerted greater influence over first-time pregnant women, while husbands often played the final decision-making role more in rural communities due to greater influence of financial and cultural considerations in these settings. One MIL in urban Kano explained, “*I am the eldest here. They obey me and give me respect just like it should be in our Hausa tradition.*”

Age-related differences were less pronounced; however, younger women in Adamawa and Kano, and first-time pregnant women in Kano expressed a greater preference for home delivery, suggesting that traditional norms remain influential among younger women in these settings.

See Table 3.

4. DISCUSSION

This qualitative multi-site study across the six geopolitical zones of Nigeria is broadly consistent with established literature but challenges and adds important nuances in certain areas. With the importance of Nigeria in reducing global maternal mortality, this study provides useful granular information to policy makers and development partners in Nigeria and other comparable LMICs.

Bad attitude of healthcare providers was the leading perceived barrier to facility delivery. This is consistent with existing literature in Sub-Saharan Africa (SSA) that record experiences of disrespect, verbal abuse and untimely care ^[15, 16]. A study of healthcare provider’s perspectives in Nigeria found that while providers were aware of this issue, they rationalized some of the practices as “well-intended” ^[17], underscoring the need for continuous training on respectful maternity care (RMC).

The study found financial barriers and informal and unexpected costs for basic supplies as deterrents to institutional delivery. This is consistent with other studies in Nigeria ^[18] and across SSA ^[19] where informal payments for services that were reportedly announced as “free” create contradictions that deterred

women. This study found difference in perception of financial barrier, where urban women perceived costs as “hidden and unexpected”, versus rural women reporting complete unaffordability. This difference has not been reported in previous literature. The very low expenditure on health proportional to the national budget ^[20] and low health insurance coverage ^[7] in Nigeria could be strong factors fuelling this.

This study extends the prevailing evidence that confirms distance and lack of emergency transport services as a significant barrier especially in rural settings ^[21]. Distance was explicitly mentioned in only 5% of responses, suggesting that relational and quality-of-care factors appeared more dominant in women’s perception in this study.

This study found relational care (empathy, cultural familiarity, spiritual support and dignity) as the major reason why women choose T/MBAs. Other literature from Nigeria ^[22] and Ghana ^[23] cites cost and geographic proximity as the major reasons. This has implications for programs, suggesting that improving health facility access alone will not shift preference towards institutional deliveries. Specific preference for delivery in religious homes was recorded in southern Nigeria (Akwa and Oyo States). A 2023 article documented the Christ Apostolic Church delivery homes’ activities providing childbirth support to women since the 1950s ^[24], suggesting that this old practice persists.

The findings from this study that husbands play dominant final decision-making roles especially in rural settings strongly aligns with other studies where women with greater decision-making autonomy and earnings had higher odds of facility delivery ^[25]. This study’s finding that MIL influence is strongest for first-time pregnant women, is largely new within Nigeria literature. This has direct implications for program design especially during the antenatal period.

Previous evidence documents rural women facing structural barriers while urban women have better access. This study found that urban women equally

face distinct structural barriers: traffic congestion, high transport costs, unexpected and “hidden” facility charges as well. This supports a 2023 study in Enugu which found urban primary health centre users in areas announced to be receiving “free” maternal health services encountering unexpected charges [18].

This study’s use of the TPB aligns with other literature that found that the decision for where to deliver extends beyond considerations of medical risk and is embedded within broader social and cultural contexts. The TPB has been applied in studies from Tanzania [26] to predict couples’ intention for facility birth, and Iran [27] as an intervention framework for mode of delivery among primigravids. This demonstrates the usefulness of the TPB in understanding child-birth decision-making. Azjen also cautioned that the model may not hold in unforeseen or unanticipated situations such as during emergencies in childbirth [11]. This study’s use of TPB was more interpretive rather than a test of the model’s predictive validity. Further work to formally test TPB in Nigerian context is recommended.

4.1 Strengths and Limitations of the Study

Strengths:

A key strength of this study is its broad geographic and sociocultural coverage, encompassing all six geopolitical zones of Nigeria and both rural and urban settings. This enabled the capture of diverse perspectives on childbirth preferences across different contexts. The use of the TPB provided a robust analytical framework for examining how attitudes, subjective norms, and perceived behavioural control influence delivery decisions. Additionally, the study benefited from methodological triangulation through focus group discussions and key informant interviews, incorporating perspectives from family members, community leaders, and healthcare providers. The qualitative design allowed for an in-depth exploration of the lived experiences, social norms, and contextual factors underlying delivery preferences that are often overlooked in quantitative studies.

Limitations:

As a qualitative study using purposive sampling, the findings are not statistically generalizable to the wider population. Discussions on sensitive issues, such as provider disrespect and informal payments, may have been influenced by social desirability bias. While efforts were made to ensure accurate translation and interpretation, nuances in local languages and dialects may have resulted in some loss of meaning. Furthermore, the study relied on participants' recollections of past experiences and is therefore subject to recall bias.

Finally, as the study was conducted in locations supported by USAID-funded maternal health and health systems strengthening programs, participant experiences may not fully reflect contexts where such interventions are absent.

5. CONCLUSION AND GLOBAL HEALTH IMPLICATIONS

This study demonstrates that women's delivery preferences in Nigeria are shaped by a complex interaction of attitudes, subjective norms, and perceived behavioural control. While participants recognized the clinical benefits of institutional delivery, their decisions were heavily influenced by experiences of care, family expectations, economic constraints, and access barriers. These findings suggest that childbirth decisions are determined not only by medical risk perceptions but also by relational, cultural, and spiritual considerations. The results underscore the need to move beyond traditional supply-side approaches. While investments in infrastructure and skilled personnel are essential, they are insufficient if women continue to experience disrespect or social exclusion within health facilities. Improving the uptake of skilled delivery services requires integrated strategies that prioritize RMC, community engagement, and culturally responsive service delivery.

Furthermore, the study highlights the influential roles of husbands, MILs, community leaders, and religious actors. Maternal health interventions should engage these stakeholders to address social norms and strengthen trust in formal healthcare. These findings offer valuable lessons for other LMICs where biomedical and traditional systems coexist.

Future research should examine how delivery preferences evolve and assess interventions aimed at improving respectful care and community trust.

Ultimately, reducing maternal mortality requires ensuring that women are treated with dignity, respect, and compassion. Particular attention should be given to institutionalizing RMC through provider (re)training, supportive supervision, and accountability mechanisms that promote patient-centered care.

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COMPLIANCE WITH ETHICAL STANDARDS (all sections must be provided)

Conflicts of Interest: The authors declare no competing interests.

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Ethics Approval: Ethical review and approval were sought and obtained from the Health Research Committees of all six participating states. The approval numbers for each state are: Adamawa State (ADHREC 07/08/2024/029), Akwa Ibom State (AKHREC/15/8/24/268), Ebonyi State (EBSHREC 04/038), FCT Abuja (FHREC/2024/01/192/12-08-24), Kano State (NHREC/17/03/2018) and Oyo State (NHREC/OYOSHREC/10/11/22).

Declaration of Patient Consent: The purpose and objectives of the study were explained to all participants in English and the relevant local languages. Written or verbal informed consent, as appropriate, was obtained from all participants before data collection commenced.

Disclaimer: None.

Key Messages

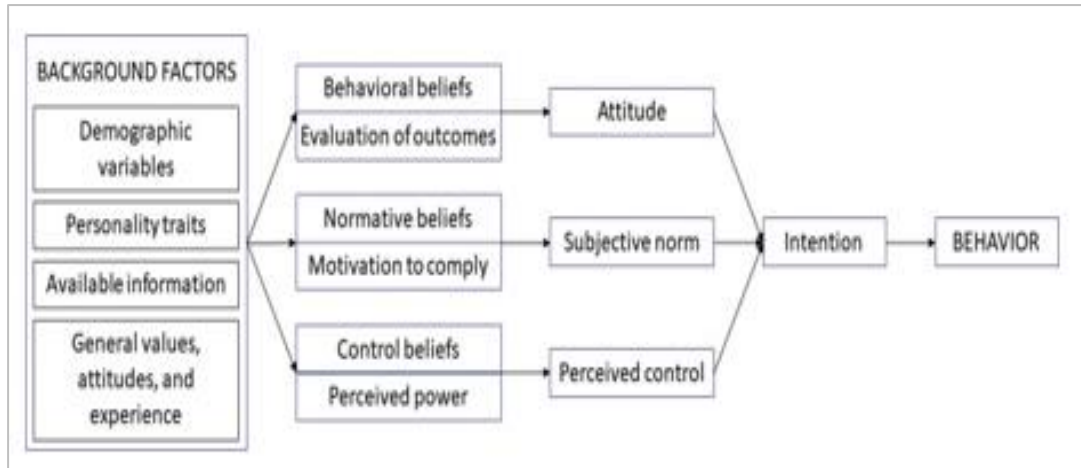
- A central finding is that women's delivery choices reflect a conscious trade-off between perceived technical safety and relational care. While women generally acknowledge that health facilities possess the technical competence to manage life-threatening complications, many choose traditional/Mission birth attendants (T/MBAs) because they prioritize the empathy, dignity, and cultural familiarity offered in traditional settings.
- Relational experiences, specifically provider disrespect and neglect, emerged as major non-structural barriers to institutional delivery. Participants reported unprofessional behaviours such as staff rudeness, verbal insults, and "punitive" waiting times, which turn childbirth into a traumatic rather than supportive experience.
- Beyond clinical concerns, hidden costs and logistical hurdles serve as potent deterrents to facility-based delivery. Even when services are advertised as free, women often face "hidden" expenses for medical supplies like cotton wool and bandages, or are pressured to provide unofficial payments and bribes to receive timely care. These economic burdens are exacerbated by structural failures, including poor road infrastructure and a lack of 24-hour emergency transport, making it physically and financially difficult for women to reach facilities, especially during nighttime labor.

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29. **Figure 1. Schematic Explanation of the Theory of Planned Behaviour**

30. Adapted from Ajzen I. *From intentions to actions: a theory of planned behaviour*. In:

Kuhl J, Beckmann J, ed. Action Control. Berlin, Heidelberg: Springer Berlin

Heidelberg; 1985. p. 11–39.

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32. **Tables and Figures (maximum 3)**

33. **Table 1. Summary of WRA participants' socio-demographic characteristics**

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Socio-demographic characteristic	Categories	Number	Percentage
Age group	Younger women (18 – 29 years)	145	51.97%
	Older women (30 – 49 years)	134	48.03%
Prior childbirth	Never	65	23.30%
	Ever	214	76.70%
Highest Educational attainment	No education	7	2.51%
	Primary	32	11.47%
	Secondary	155	55.56%
	Vocational training	1	0.36%
	Tertiary	84	30.11%
Occupation	Student	2	0.72%
	Unemployed	41	14.69%
	Trader/business/self employed	194	69.53%
	Civil servant	31	11.11%
	Others	11	3.94%
State (geo-political zone)	Adamawa (North east)	24	8.06%
	Akwa Ibom (South south)	68	24.37%
	Ebonyi (South East)	40	14.34%
	FCT (North Central)	60	21.51%
	Kano (North West)	25	8.96%
	Oyo (South West)	62	22.22%
Urban/rural	Urban	114	40.86%

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	Rural	165	59.14%
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Table 2. Summary of frequency of themes on perceived reasons why women deliver in places other than health facilities

Perceived issue with hospital delivery	Total times mentioned	Percent	Rural Occurrence	Urban Occurrence
Bad attitude of healthcare workers	79	47%	38 (55%)	41 (45%)
High cost of hospital delivery service	51	31%	24 (47%)	27 (53%)
Distance from health facility	8	5%	6 (75%)	2 (25%)
Inability to manage birth complications	6	4%	5 (83%)	1 (17%)
Poor/inadequate infrastructure at health facility	6	3%	3 (50%)	3 (50%)
No privacy of delivery	4	2%	3 (75%)	1 (25%)
Inadequate number of qualified staff	3	2%	3 (100%)	0 (0%)
Fear of caesarean delivery (CS)	2	1%	1 (50%)	1 (50%)
High cost of transportation to the HF	2	1%	1 (50%)	1 (50%)
Unhygienic delivery environment	5	3%	3 (60%)	2 (40%)
Rejection of unregistered pregnant women	1	1%	1 (100%)	0 (0%)
Total	167	100%	88 (53%)	79 (47%)

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62. Table 3. Summary of thematic differences by TPB constructs

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TPB Construct	Theme differing by co-variate	Co-variate influence
Attitude	Cleanliness and hygiene	Higher priority for urban women
	Spiritual comfort and safety	More influential in Southern Nigeria
	Birthing positions and privacy	Preference for kneeling and privacy is specific to rural areas in Northern Nigeria
Subjective norms	Family authority	MIL influence is stronger for first-time mothers.
		Husbands' influence is stronger in rural settings
Perceived behavioural control	Accessibility barriers	Distance and absence of emergency transport services in rural settings
		Traffic and the high cost of fares in urban settings
		Security challenges with fear of traveling far distances in the absence of emergency transport services especially at night in rural settings
	Financial exploitation	More frequently reported as “hidden costs” in urban settings.

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