

Chapter One

Introduction

1.1 Background to the Study

Maternal health remains a major public health concern globally, particularly in developing countries where maternal morbidity and mortality rates are unacceptably high despite decades of investment in reproductive, maternal, newborn and child health (RMNCH) services. It is an important indicator of a nation's overall health status and development. A society that ensures safe pregnancy and childbirth for its women invests not only in its mothers but also in the survival and future well-being of its children. Over the past two decades, global health initiatives such as the Millennium Development Goals (MDGs) and now the Sustainable Development Goals (SDGs) have placed maternal health at the center of development discourse. Despite these efforts, maternal mortality remains a major challenge in many developing countries, including Nigeria. The global maternal mortality ratio (MMR) fell by about one-third between 2000 and 2020, but progress has been uneven. An estimated 287,000 women still died worldwide from pregnancy-related causes in 2020, most of them from preventable complications. Sub-Saharan Africa alone contributed nearly 70% of these deaths, underscoring the disproportionate burden borne by low- and middle-income countries.^{1,2}

Nigeria has one of the highest maternal mortality ratios globally, accounting for roughly 12% of all maternal deaths worldwide. The Nigeria Demographic and Health Survey (NDHS) 2018 reported an MMR of 512 deaths per 100,000 live births, a figure that is unacceptably high compared to global averages. This reality reflects persistent gaps in access to, and utilisation of,

essential maternal health services, especially delivery care by skilled health personnel in adequately equipped facilities. Institutional or facility-based delivery, defined as childbirth attended by skilled health workers within a recognized health institution, is universally acknowledged as one of the most effective interventions for preventing maternal and neonatal deaths. Such facilities provide access to sterile environments, skilled personnel, and emergency obstetric care when complications arise.^{3,4}

However, utilisation of facility delivery services in Nigeria remains far from optimal. Nationally, less than half of births take place in health institutions, with sharp urban-rural disparities. According to NDHS 2018, while 61% of urban women deliver in health facilities, only 39% of their rural counterparts do so. These figures are troubling because they suggest that a large proportion of Nigerian women remain outside the protective coverage of skilled delivery services. Ekiti State, located in southwestern Nigeria, fares relatively better than some states but still faces significant challenges. In Ado Local Government Area, which hosts the state capital and several healthcare facilities, a substantial number of women continue to deliver at home or with traditional birth attendant. Several factors explain this low utilisation of facility delivery services. Knowledge of the benefits of facility delivery is often inadequate. Some pregnant women fail to recognize the risks associated with home delivery or are unaware of the advantages of giving birth in a health facility. Studies in Nigeria have shown that women with higher knowledge levels are more likely to seek skilled delivery services than those with limited knowledge. Perception also plays a central role. Negative experiences with healthcare workers, cultural beliefs, and perceptions that health facilities are unfriendly or unnecessary often discourage women from delivering in hospitals. Some women perceive facility delivery as costly, stressful, or culturally inappropriate, especially when traditional norms encourage home births^{1,2, 3}. The

utilization of healthcare facilities for delivery remains a significant issue in many parts of the world, especially in low-resource settings. Despite the availability of healthcare services, a large proportion of pregnant women opt for home births or choose unskilled attendants due to various factors, including socio-economic, cultural, and infrastructural constraints¹⁰. The decision to avoid facility delivery is often influenced by the perception that home births are safer or more affordable, despite the increased risks of complications during childbirth⁸. Home delivery complications can be severe and life threatening, contributing significantly to maternal mortality. The magnitude of this complication is substantial, with studies indicating that home deliveries account for a high percentage of maternal deaths due to obstetrics complications such as, hemorrhage, excessive bleeding during or after delivery, infection to the reproductive tract. In some area, home delivery rates remain alarmingly, with approximately 73% of deliveries occurring at home nationally, and 74% in certain area. Again, associated factors reveals complication during pregnancy, lack of skilled birth attendance, and limited access to healthcare facilities contribute to the risks of home deliveries, Other studies have shown that maternal and neonatal outcomes are significantly better in healthcare facilities, but many women continue to avoid these services due to perceived barriers such as cost, distance, and lack of trust in healthcare providers^{2, 6, 8}.

Beyond knowledge and perception, structural barriers remain powerful determinants of service utilisation. These include financial limitations, distance to facilities, poor transportation systems, inadequate health infrastructure, and shortage of skilled personnel. Women often face delays in making decisions to seek care, in reaching a health facility, and in receiving appropriate treatment once at the facility. This situation is captured in the well-known “three delays” model developed by Thaddeus and Maine, which continues to be highly relevant in explaining maternal

deaths in low-resource settings like Nigeria.⁵ Moreover, socio-economic and gender-related barriers such as poverty, low decision-making autonomy among women, and lack of spousal or family support further limit access to skilled delivery.

The context in Ekiti State is particularly interesting. Ado Local Government Area is semi-urban, with better access to healthcare services than many rural parts of Nigeria. It hosts tertiary, secondary, and primary health facilities, yet challenges persist. Anecdotal evidence and previous research suggest that even in areas with available health facilities, many women choose alternative delivery options. Some rely on traditional birth attendants because of trust, cultural familiarity, or dissatisfaction with health workers' attitudes. Others cite cost and convenience as major factors, while a few attribute their choices to previous negative hospital experiences. These patterns reveal that the barriers are not only structural but also deeply rooted in perceptions and socio-cultural contexts. The consequences of underutilization of facility delivery services are grave. Women who deliver outside health institutions face higher risks of complications such as obstructed labor, postpartum hemorrhage, sepsis, and hypertensive disorders of pregnancy. These conditions require timely intervention that is only reliably available in health facilities. For newborns, delivery outside a health facility increases the risk of stillbirth, birth asphyxia, neonatal infections, and other preventable causes of death. Therefore, the utilisation of facility delivery is not just a matter of preference but a life-saving necessity.

This study focuses on three key variables: knowledge, perception, and factors influencing facility delivery. Knowledge refers to pregnant women's awareness and understanding of the importance, availability, and benefits of health facility delivery. Perception captures their attitudes, beliefs, and experiences regarding facility delivery and the healthcare system. Factors influencing include, socio-economic, cultural, infrastructural, and health system-related obstacles that hinder

women from utilizing facility delivery services. Together, these variables provide a comprehensive framework for analyzing the low uptake of health facility deliveries in Ado Local Government Area. Understanding these dynamics is critical for public health planning and interventions. If women have knowledge but still perceive facility delivery negatively, strategies must focus on improving quality of care and provider attitudes. If perceptions are positive but barriers remain insurmountable, policies must address affordability, accessibility, and infrastructure. Conversely, if knowledge itself is poor, community-level health education and awareness campaigns are essential. By systematically examining knowledge, perception, and barriers, this study will contribute evidence that can guide interventions to increase institutional delivery and, ultimately, reduce maternal and neonatal morbidity and mortality in Ekiti State and Nigeria at large.

1.2 Statement of the Problem

Maternal morbidity and mortality remain significant public health concerns in Nigeria, yet many pregnant women in Ado continue to deliver outside health facilities. This trend persists despite the well-established benefits of facility-based delivery with skilled birth attendants, which reduces the risk of complications such as hemorrhage, obstructed labour, infections, and neonatal deaths. Local observations indicate that a considerable number of women still opt for home deliveries or rely on traditional birth attendants, raising questions about their knowledge, perceptions, and attitudes toward facility delivery.

In the Ado area, factors such as limited awareness of the importance of skilled delivery care, perceived quality of services, financial constraints, accessibility challenges, and cultural norms may influence women's choices regarding delivery location. Socio-demographic characteristics, including education level, economic status, parity, and previous childbirth experience may

further shape their utilisation of health facility delivery services. However, there is insufficient research within the selected facilities in Ado to clearly understand how these factors interact to affect women's decisions. Consequently, it is necessary to examine pregnant women's knowledge and perceptions of facility delivery and to identify the factors that influence their utilisation of such services. Insights from this study will support the development of targeted strategies to promote safe delivery practices and improve maternal and neonatal health outcomes in Ado.

There is significant gap in the literature regarding the specific factors that influence the utilization of facility delivery among pregnant women in Nigeria, while studies have been conducted in different regions on the general barriers to healthcare facility use during delivery, there is limited research focused on the local context. Existing studies highlight the importance of socio-economic status, cultural beliefs, and healthcare infrastructure in the decision-making process of pregnant women, but the specific combination of these factors in Ado Local Government Area remains poorly understood. Understanding the perceptions and barriers of pregnant women in this particular area will provide valuable insights into how facility delivery utilization can be improved, helping to bridge the gap between the ideal and the current situation.

Therefore, this study seeks to address these gaps by examining the Pregnant Women's knowledge, Perceptions and utilization of Primary Health Centers in Ado Local Government, Ekiti State.

1.3 Aim and Objectives of the Study

The aim of this study is to investigate the Pregnant women's knowledge, perception and Utilization of Primary Health Centre in Ado local government area, Ekiti State. The Objectives are to:

1. assess the level of knowledge of pregnant women on the utilisation Primary Health Centre in Ado Local Government Area, Ekiti State.
2. assess the perception of pregnant women towards Utilisation of Primary Health Centers In Ado Local Government Area, Ekiti State.
3. identify the barriers that hinder pregnant women from utilizing Primary Health Centers, in Ado Local Government Area, Ekiti State.
4. determine the relationship between perception and utilisation of Primary Health Centers in Ado Local Government Area, Ekiti State.
5. identify strategies and interventions that could enhance the utilisation of Primary Health Centers, In Ekiti State.

1.4 Research Questions

1. What is the level of knowledge of pregnant women on the benefits and importance of facility delivery in Ado Local Government Area?
2. What are the perceptions of pregnant women towards facility delivery in selected facilities in Ado Local Government Area, Ekiti State?
3. What socio cultural, economic, and institutional barriers hinder pregnant women from utilizing facility delivery in the study area?

4. What strategies can be suggested to improve the utilisation of facility delivery among pregnant women in Ado Local Government Area?

5. Is there a relationship between knowledge and the utilisation of facility delivery among pregnant women?

6. Is there a relationship between perception and the utilisation of facility delivery among pregnant women?

1.5 Hypothesis Testing

Ho1 There is no significant relationship between Knowledge and the utilisation of facility delivery among pregnant women in selected facilities in Ado Local Government Area

Ho2 There is no significant relationship between Perception and utilisation of facility delivery among pregnant women in selected facilities in Ado Local Government Area

1.6 Significance of the Study

This study is significant in several dimensions academically, socially, medically, and policy-wise. The research will add to the growing body of literature on maternal and child health, particularly in Nigeria and sub-Saharan Africa, where maternal mortality and morbidity remain high. By focusing on knowledge, perception, and barriers, this study provides nuanced insights into why many women still prefer home deliveries despite the availability of skilled birth attendants in health facilities.

Findings from the study will highlight critical gaps in awareness, cultural perceptions, and systemic barriers that hinder the optimal utilisation of facility-based deliveries. This evidence will be useful for health educators, midwives, and public health practitioners in designing

targeted health promotion strategies that encourage more pregnant women to embrace facility delivery.

For policymakers at the local and state levels, the study provides evidence-based data to strengthen maternal health policies and programs. It can guide the allocation of resources, training of healthcare personnel, improvement of health infrastructure, and implementation of community-based interventions aimed at reducing maternal and neonatal mortality..

Improvement of Maternal and Neonatal Outcomes, By identifying barriers whether financial, geographical, cultural, or attitudinal the study paves the way for practical interventions that can increase facility-based deliveries. In turn, this could contribute to reducing complications of childbirth, maternal deaths, and preventable neonatal mortality in Ado Local Government Area and beyond.

Academic and Research Utility, For researchers and students, the findings will serve as a reference material and a foundation for further studies on maternal health. It will stimulate future research on innovative solutions to improve facility delivery utilisation in Ekiti State, Nigeria and similar low-resource settings.

1.7 Scope of the Study

This research work significantly examines the Pregnant Women's knowledge, perception and utilization of primary health centers in Ado Local Government Area of, Ekiti State. Hence the study will be delimited to selected Primary Health Centers in Ado Local Government Area, Ekiti State.

1.8 Operational Definition of Terms

Facility Delivery: refers to the act of giving birth in a healthcare facility, such as a hospital, clinic, or maternity home, where medical personnel with professional training in childbirth (such as doctors, midwives, and nurses) are present.

Factors influencing Utilization of facility delivery: refers to Obstacles, barriers, or challenges that discourage or prevent: Pregnant women from utilizing health facility delivery services, Influence decision-making, Factors that shape pregnant women's choices about where to deliver, leading them to opt for alternatives to health facility delivery These factors can include, Socio-economic factors: Cost, distance, transportation, and accessibility, Cultural and social factors, Traditional practices, family or community preferences. Healthcare system factors, Quality of care, staff attitude, equipment, and facilities, Personal factors, Previous experiences, fear, or anxiety.

Healthcare Facility: is defined as any institution equipped with necessary medical infrastructure and skilled personnel for providing maternal and neonatal care, including hospitals, clinics, or maternity homes within Ado Local Government Area, Ekiti State. These facilities are capable of managing deliveries and complications that may arise during childbirth.

Knowledge: In this context, knowledge refers to Pregnant women's understanding and awareness of benefits of health facility delivery. Understanding the advantages of delivering in a healthcare facility, such as access to skilled healthcare providers, emergency care, and improved maternal and neonatal outcomes. Risks of home delivery: Awareness of the potential risks and complications associated with delivering at home, such as increased risk of maternal and neonatal mortality and morbidity, availability and accessibility of health facility delivery services:

Knowledge of the location, cost, and quality of health facility delivery services in their area.

Importance of skilled birth attendants: Understanding the role and benefits of skilled healthcare providers in ensuring a safe and healthy delivery.

Perception: In this study, perception refers to the way pregnant women in Ado Local Government Area understand, interpret, and form attitudes towards facility delivery services. It encompasses their feelings, beliefs, opinions, and judgement about the safety, accessibility, and quality of care provided in health facilities.

Pregnant Women: In the context of this study, pregnant women refer to women who are carrying a fetus or embryos in their womb, specifically those in the later stages of pregnancy, defined as 20 weeks gestation or more.

Selected Primary Health Centers in Ado Local Government Area, Ekiti State: This refers to Healthcare facilities chosen for: Data collection, investigating perceptions, knowledge, and utilization of health facility delivery services among pregnant women attending antenatal clinics in Ado Local Government Area, Ekiti State. The selected facilities are; Okesa Comprehensive Health Centre, Irona Basic Health Centre, Oke Oniyo Basic Health Centre, BHC Adeere, BHC Odo Ado, BHC Housing, BHC Opopogbooro, BHC Emirin.

Utilization of Delivery Facilities: Utilization of delivery facilities refers to the decision of pregnant women to access healthcare facilities for childbirth. This includes both the act of delivering in these institutions and the decision -making process involved in choosing to deliver in a healthcare setting rather than at home or with traditional birth attendants.

Endnotes

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Chapter Two

Literature Review

This Chapter discusses literature review. Literature was reviewed under the following sub - headings:

2.1 Conceptual Review

2.1.1 Knowledge of Pregnant Women Towards Facility Delivery

2.1.2 Dimension of knowledge in Facility Delivery

2.1.3 Global Evidence on Knowledge of Facility Delivery

2.1.4 Knowledge Gaps and Misconceptions

2.1.5 Perception of Pregnant Women Towards Facility Delivery

2.1.6 Dimensions of Perception in Facility Delivery

2.1.7 Concept of Facility Delivery

2.1.8 Factors Influencing the Utilisation of Facility Delivery

2.2 Theoretical Framework

2.2.1 Andersen's Behavioral Model of Health Services Utilisation

2.2.2 Health Believe Model

2.3 Review of Empirical Studies

2.3.1 Empirical Studies on Knowledge of Pregnant Women Towards Facility Delivery

2.3.2 Empirical Studies on Perception of Pregnant Women Towards Facility Delivery

2.4 Conceptual Framework

2.5 Summary of Gaps Literature Reviewed

2.6 End Notes

2.1 Conceptual Review

2.1.1 Knowledge of Pregnant Women Towards Facility Delivery

The level of maternal knowledge regarding facility delivery is a key determinant of health-seeking behavior and maternal outcomes and a central focus in understanding the utilization of maternal health services. In maternal health literature, knowledge is not limited to awareness of pregnancy and childbirth but extends to an informed understanding of the importance of skilled birth attendance, recognition of obstetric danger signs, awareness of available health services, and appreciation of women's rights to respectful maternity care. The World Health Organization WHO (2023), underscores knowledge as a fundamental factor influencing maternal health-seeking behavior, noting that insufficient awareness significantly contributes to preventable maternal and neonatal deaths. Facility delivery, defined as childbirth occurring in a health institution with trained personnel and necessary resources, is widely recognized as a life-saving intervention, yet its utilization remains suboptimal in many low-resource settings largely because of inadequate maternal knowledge^{2.1}. In the context of this study, knowledge of facility delivery is conceptualized as the ability of a pregnant woman to identify danger signs, underset women

and the benefits of skilled attendance, recognize available services, and appreciate her rights during childbirth.

2.1.2 Dimensions of Knowledge in Facility Delivery

- **Awareness of Danger Signs:** One critical aspect of maternal knowledge is the ability to recognize obstetric danger signs. These include symptoms such as prolonged labor, convulsions, severe vaginal bleeding, and high fever, all of which may signal life-threatening complications if not managed promptly in a health facility. Studies in sub-Saharan Africa show that women who cannot identify at least three key danger signs are significantly less likely to seek institutional care during childbirth³. In Nigeria, the 2018 Nigeria Demographic and Health Survey (NDHS) revealed that fewer than 60% of women could mention three or more obstetric danger signs, indicating considerable knowledge gaps⁴. This lack of awareness often results in delayed decisions to seek care, one of the well-known “three delays” leading to maternal mortality⁵.

Beyond danger signs, knowledge also entails understanding the benefits of skilled birth attendance. Skilled health personnel are trained to manage normal deliveries and complications, provide emergency obstetric care, and ensure timely interventions such as cesarean sections or blood transfusions⁶. Pregnant women who understand these benefits are more likely to deliver in facilities. Adeyemi and colleagues found that women in southwest Nigeria who could identify three or more benefits of facility delivery were more than twice as likely to utilize such services compared to those with limited understanding⁷. Another dimension of knowledge is awareness of the availability and location of services. Pregnant women must not only know that health facilities exist⁸ but also be aware of the types of services offered, their proximity, and whether skilled attendants are present. Inadequate knowledge about service points contributes to non-

utilization even where facilities exist⁸. In Ekiti State, health facility mapping has revealed that rural wards often lack functional maternity units, limiting women's awareness of actual service availability.

Knowledge also extends to awareness of women's rights to respectful maternity care. Recent literature has emphasized that women's knowledge should encompass not just biomedical information but also awareness that they are entitled to dignity, privacy, informed consent, and non-discriminatory treatment during childbirth.¹⁰ Women who are aware of these rights are more empowered to demand quality care and are more likely to utilize health facilities¹¹.

Women must recognize obstetric danger signs such as severe vaginal bleeding, convulsions, prolonged labor, severe abdominal pain, or retained placenta. According to the World Health Organization, delays in recognizing such warning signs constitute the first of the well-known 'three delays' that contribute to maternal mortality (Thaddeus & Maine, 1994).¹ The 2023 Nigeria Demographic and Health Survey (NDHS) reported that less than 60% of women could mention at least three key obstetric danger signs¹

- **Sources of Knowledge:** The primary source of maternal knowledge is antenatal care (ANC) services. ANC provides a structured platform where women are educated on the importance of facility delivery, danger signs, and birth preparedness. A multi-state Nigerian survey showed that women who attended four or more ANC visits were 2.3 times more likely to have correct knowledge of obstetric danger signs compared to those with fewer visits¹². ANC is consistently reported as the most influential source of knowledge. A 2024 multi-state Nigerian survey indicated that women attending four or more ANC visits were 2.3 times more likely to have correct knowledge of danger signs than those with fewer visits.¹³ Antenatal care also extends knowledge to family members,

reinforcing women's decision-making capacity. Nurses, midwives and CHEWs serve as the primary conduits of accurate maternal-health information (Adebayo 2023). In rural Ekiti, community health workers often serve as the first point of contact, bridging gaps between formal health facilities and community members. Their influence is particularly significant in contexts where traditional birth attendants (TBAs) dominate maternal health services¹⁶.

Various communication channels especially radio, television, and mobile-health tools now complement facility-based education. Radio and television programs have been effective in raising awareness about maternal health, while mobile health (mHealth) initiatives have demonstrated success in disseminating reminders and educational messages. Recent pilot work in Lagos reported notable improvements ($\approx 35\%$)¹⁵ in recall after SMS reminders (Lawal 2025). Social relations spouses, older female relatives and peers also shape women's understanding, sometimes reinforcing traditional norms favor home delivery or TBAs¹⁶.

2.1.3 Global Evidence on Knowledge of Facility Delivery

Globally, maternal knowledge and health literacy differ markedly between countries of varying income levels. In most high-income nations, widespread health education and access to care have resulted in almost universal facility-based deliveries, leading to very low maternal mortality rates.¹⁷ Conversely, many low- and middle-income countries continue to face substantial knowledge gaps that hinder facility delivery. A Nepalese study, for instance, found that fewer than half of the surveyed women could identify three key obstetric danger signs, which strongly predicted their likelihood of home delivery.¹⁸ Similarly, in Tanzania, lack of awareness about the availability of skilled care contributed significantly to home births¹⁹.

- African Context of Knowledge of Facility Delivery:** Within the African context, inadequate maternal knowledge continues to present a major challenge. In Ethiopia, for example, less than half of expectant mothers possessed sufficient understanding of facility delivery services, and this limited knowledge was found to significantly influence their use of skilled care. In Kenya, a qualitative study showed that many women delivered at unintended locations due to poor knowledge of available facilities and their preparedness for emergencies.²¹ In Ghana, Ampofo et al. found that inadequate knowledge, coupled with reliance on TBAs, led to higher maternal risks. Collectively, the findings emphasize that maternal knowledge extends beyond basic awareness it encompasses women's trust and confidence in the health system's ability to provide safe and respectful care²².
- Nigerian Context of Knowledge of Facility Delivery:** In Nigeria, utilisation of facility-based delivery services remains suboptimal, largely because of inadequate maternal awareness and understanding of skilled birth practices. According to the NDHS (2018), only 39% of rural women delivered in facilities, compared to 61% of urban women, with knowledge strongly mediating this disparity.⁴ Regional studies confirm this trend. In northern Nigeria, Sulaiman et al. reported that poor knowledge of obstetric danger signs and overreliance on TBAs contributed to low uptake of facility services. In the southwest, Akinyemi et al. found that women who received structured education during ANC were significantly more likely to choose institutional delivery²⁴.

- Rural–Urban Disparities in Maternal Knowledge**

Knowledge of facility delivery differs notably across geographic and socio-economic groups.

Urban women generally benefit from better access to healthcare infrastructure, wider media

exposure, and higher literacy levels all factors that enhance their awareness of safe delivery options, which enhance their knowledge levels. Rural women, on the other hand, are more likely to rely on informal information sources such as TBAs or family elders, which often perpetuate misconceptions. A Nigerian study by doctor et al. highlighted that rural women were less likely to attend antenatal care and, consequently, had poorer knowledge of obstetric danger signs compared to their urban counterparts¹. Similarly, the NDHS (2018) reported that 61% of urban women delivered in facilities, while only 39% of rural women did so, reflecting a knowledge and accessibility divide⁴.

In Ekiti State, which is semi-urban, this disparity is evident in Ado Local Government Area. While the state capital offers several health facilities, women in peri-urban and rural wards often lack adequate knowledge of available services. Anecdotal evidence suggests that women in communities outside the core urban centers are more likely to depend on TBAs due to limited access to accurate information. This reinforces the importance of designing knowledge interventions that are context-specific, bridging gaps between urban and rural populations¹⁴.

2.1.4 Knowledge Gaps and Misconceptions

Despite numerous awareness initiatives, certain misconceptions remain widespread. Some women attribute pregnancy complications to spiritual causes rather than medical conditions, prompting them to rely on traditional or faith-based care instead of modern facilities²⁵. Others perceive TBAs as equally skilled as trained midwives due to their cultural familiarity and longstanding community presence. Misunderstandings about costs also persist, with some women assuming that facility delivery is unaffordable even when subsidies exist²⁷.

- **Knowledge Gaps Among Adolescents and Young Mothers**

Young mothers and adolescents often display the poorest levels of knowledge regarding facility delivery. This is due to limited exposure to ANC, low educational attainment, and social stigma surrounding adolescent pregnancy. A Nigerian study by Odetola found that adolescents were significantly less likely to recognize obstetric danger signs compared to older women²⁸. This knowledge gap is particularly concerning because adolescents face higher biological risks during childbirth, making them more vulnerable to complications. Addressing knowledge deficits among this group is therefore essential to reducing maternal mortality rates.

- **Misconceptions and Cultural Beliefs Affecting Knowledge**

Knowledge deficits are often compounded by misconceptions and cultural beliefs. In many Nigerian communities, childbirth is perceived as a natural process that does not require medical supervision, leading women to undervalue facility delivery²⁹. Spiritual explanations for complications also persist, with some women attributing maternal deaths to witchcraft or divine will rather than medical causes²⁸. Such beliefs undermine biomedical knowledge and perpetuate reliance on TBAs. Additionally, the perception that facility delivery is expensive discourages women even when free services are available under national health insurance or donor-supported programs. These findings emphasize the importance of not only improving knowledge but also addressing entrenched misconceptions through culturally sensitive health education.

- **Knowledge of Availability and Location of Services**

Awareness of the nearest facility, its services, and the presence of skilled attendants strongly influences utilization²⁹. In Ekiti State, 2023 health facility mapping revealed that some rural wards lacked functional delivery units, limiting women's knowledge of actual service points. Furthermore, safety knowledge encompasses trust in the hospital's layout, including its

cleanliness and hygiene, as well as its general physical infrastructure. Confidence in facility-based delivery is also shaped by perceptions of the environment and infrastructure. Women are more likely to choose institutional delivery when they perceive the facility as hygienic, adequately equipped, and capable of performing emergency interventions such as caesarean sections. High standards of cleanliness and infection control help build trust and reinforce the belief that facility delivery is safer than home birth. Women are more confident that these facilities will avoid non-sterile postoperative infections, which is a real danger in dirty places, if they believe that such facilities maintain high standards of cleanliness and infection control. Knowledge of cleanliness is crucial in areas where local or domiciliary births are predominant because these women might be more aware of the contrasts between informal and formal delivery settings. Thus, such facilities that have an outstanding reputation in the cleanliness of the environment and other medical ward equipment prove to enhance safety regarding facility deliveries, which appear as safer options for women³¹.

- **Understanding the Benefits of Skilled Attendance**

The knowledge stems from the belief that healthcare practitioners in these facilities have adequate skills and the ability to manage complications and can provide prompt interventions that may arise during delivery such as active management of the third stage of labor, timely referral, and access to emergency obstetric care (EmOC).³ The presence of experts and life-saving equipment, including blood transfusion and surgical centers, enhances the safety women feel when giving birth at the health facilities.

Studies show that women who understand these benefits are more likely to deliver in facilities. For instance, Adeyemi et al. found that women who could identify three or more benefits of facility-based delivery were twice as likely to use such services in Southwest Nigeria⁷.

- **Awareness of Rights and Respectful Maternity Care (RMC)**

Recent maternal health literature (2022–2025) expands knowledge beyond biomedical facts to include awareness of rights such as dignity, privacy, and respectful treatment during labor. Women who know they are entitled to respectful care are more likely to demand and utilize facility services³². Also, knowledge of safety among other tangible elements is germane. Interactions with healthcare professionals can provide or undermine a strong sense of safety. Effective communication, compassion, and the inclusion of women in decision-making processes enhance care perception. Notably, respect and adequate information empower women to consider the delivery process safe. On the other hand, incivility and poor communication, irrespective of the quality of care, can deteriorate one's safety. The interpersonal trust that develops with time between a pregnant woman and her healthcare provider is crucial in feeling safe during the procedure of giving birth. Ultimately, a woman's trust in her caregivers and confidence in the health system play a decisive role in her preference for facility-based childbirth.

Pregnant woman's knowledge of delivering in health facilities is an important determinant of seeking institutional care. As safe perceive them to possess trained healthcare personnel, essential medical equipment, The knowledge stems from the belief that healthcare practitioners in these facilities have adequate skills and the ability to manage complications that may arise during the delivery process. Women who regard health facilities and the ability to undertake emergency surgery. Such a perception deals with the reassurance women try to obtain regarding potential risks during delivery, which could be too much bleeding, infections, or obstructed labor. The presence of experts and life-saving equipment, including blood transfusion and surgical centers, enhances the safety women feel when giving birth at the health facilities. Pregnant women must

perceive safety positively, as it might lead to making facility-based delivery decisions to safeguard their health and that of their newborns³³.

Furthermore, safety knowledge encompasses trust in the hospital's layout, including its cleanliness and hygiene, as well as its general physical infrastructure. A clean and well-maintained facility containing a well-stocked supply of clean anesthetic, surgical, and other medical consumables promotes confidence that a safe caesarean section can be performed. Women are more confident that these facilities will avoid non-sterile postoperative infections, which is a real danger in dirty places, if they believe that such facilities maintain high standards of cleanliness and infection control. Knowledge of cleanliness is crucial in areas where local or domiciliary births are predominant because these women might be more aware of the contrasts between informal and formal delivery settings. Thus, such facilities that have an outstanding reputation in the cleanliness of medicaments and other medical ward equipment prove to enhance safety perception regarding institutional deliveries, which appear as safer options for women³³. Along with the more tangible elements, social dynamics also contribute to the perception of safety among women who've reached the stage of pregnancy. Interactions with healthcare professionals can provide or undermine a strong sense of safety. Effective communication, compassion, and the inclusion of women in decision-making processes enhance care perception. Notably, respect and adequate information empower women to consider the delivery process safe. On the other hand, incivility and poor communication, irrespective of the quality of care, can deteriorate one's safety. The interpersonal trust that develops with time between a pregnant woman and her healthcare provider is crucial in feeling safe during the procedure of giving birth. Women are more likely to view giving birth in a medical facility as a

positive and beneficial choice when they trust their caregivers and believe that their health and safety will be prioritized.

In addition, societal and cultural factors determine the perception of safety regarding health facilities. Cultural traditions also shape women's understanding of safe delivery. In some communities, childbirth at home is viewed as the norm, while hospitals are perceived as unfamiliar or intimidating environments. Health workers who respect these cultural perspectives and engage women through community leaders can help reshape beliefs toward safer, facility-based delivery. Nonetheless, healthcare workers and community leaders who interface with women based on their cultural frameworks, providing information that aligns with their belief systems, have the potential to transform their perceptions regarding safety mechanisms for delivering at the facility. Informing women about the sophisticated medical services offered at health facilities as well as the presence of skilled personnel can improve safety perception and, thus, strengthen attempts to counter traditional beliefs and promote acceptance of institutional care. This type of culture has to be modified and translated for pregnant women to shape their perception on the safety of delivering at health facilities³⁴.

A pregnant woman's knowledge of safety also has a bearing healthcare service experienced previously. Women who have had positive experiences with facility-based deliveries in the past view these settings as secure. Conversely, past experiences such as perceived neglect or mistreatment can contribute to the perception that the facilities are unsafe. For first-time mothers, perceptions of safety are often influenced by the experiences and narratives shared within their social circles. Positive accounts from peers or relatives who had supportive facility deliveries can enhance trust, whereas stories of neglect or mistreatment may discourage service use. Hence, improving women's personal experiences is essential to fostering community-level confidence in

institutional care. This underscores the impact of social relationships on the need to improve the experiences of all women seeking care at health facilities because such experiences affect perceptions of safety and care-seeking behavior for years to come ³⁵.

2.1.5 Perception of Pregnant Women Towards Facility Delivery Services

The Perception of pregnant women towards facility delivery services is of great importance for them to consider institutional care. Perception refers to how pregnant women interpret and give meaning to their experiences, beliefs, and understanding regarding childbirth and the use of health facilities. Unlike knowledge, which is based on information, perception is influenced by personal experiences, social norms, culture, religion, and interactions with healthcare providers. A woman's perception of health facilities can either encourage or discourage her from seeking institutional care during childbirth. ¹ A pregnant woman's perspective is based on personal experience, around influences and culture regarding the healthcare services. This perception often includes the overall ambiance of the establishment, the staffing and interpersonal relations of the health professionals, and the availability of critical supplies during the period of delivery. Critical factor influencing facility utilization is the perceived safety of health institutions.

Globally, research has consistently shown that women's perceptions of health facility services are highly predictive of their utilization of maternal healthcare. Women are more likely to deliver in hospitals if they believe these facilities provide timely and effective care for complications. ² Negative perceptions such as fear of mistreatment, anticipated high costs, or distrust in the competence of healthcare workers often discourage women from accessing institutional delivery.²⁷ In the same vein, negative perceptions about overcrowding, lack of essential equipment, or inadequate emergency care discourage utilization.

However, positive perceptions regarding safety, professionalism, and respectful maternity care encourage uptake.¹¹ Understanding perception is therefore crucial, as it often mediates the relationship between knowledge and actual health-seeking behavior. Women who regard health care facilities with a high level of hygiene, modern equipment, and professional personnel will tend to regard the facility delivery as safe and a necessary option for childbirth. On the other hand, low perceptions, for instance, lack of trust on the service provider and unsatisfactory service provision, deter eastern women from using these services. This demonstrates the way in which the perceptions directly influence the decision around the use of the care and thus determine the outcome of maternal health.

What also remains as a perceptual phenomenon is the interface pregnant women have with their healthcare practitioners. How healthcare practitioners treat patient showing concern, and listening to them can cause a woman to have a positive or negative perception about the care she is likely to receive. The attitude of healthcare workers shapes women's perceptions and their decisions to seek care. Respectful and empathetic care fosters trust and encourages repeated use of health services.³ Reports of neglect, verbal abuse, or unprofessional behavior, however, push women toward traditional birth attendants (TBAs) or home delivery. Trusting and favorable experiences with the healthcare provider enhance the women's perception of the health institution. On the other hand, if women feel they are being disregarded and their needs are neglected, dissatisfaction and an unfavorable perception of the hospital set in. There is some evidence indicating that how healthcare providers' attitudes are perceived determine to a great extent whether pregnant women will keep coming back or recommend this type of care to others.³⁴ Thus, the perception of caring motivates actions towards the relations of healthcare providers and pregnant women.

Expectant women's perceptions of service quality appreciate the contribution of the infrastructure within health care facilities. The hygiene, convenience, committal of privacy, required medical supplies, and overall facilities within the rooms significantly enhance women's perceptions regarding the quality of facility delivery services. Women feel greater sense of security and confidence regarding the delivery process when the maintenance of the facility's resources is up to standard. Besides these concrete aspects, women evaluate the other features such as the ability to perform blood transfusions or cesarean sections, which enhance the perception of the facility's ability to manage complications, to be essential. Properly equipped facilities evoke a perception of readiness which enhances the perception that safety and comfort of women is valued, therefore, promotes the utilization of the service Getachew^{36, 37}.

Hence, facility infrastructure is vital in forming women's perception of service quality in relation to the infrastructure. In addition, pregnant women's perceptions regarding the cost and the proximity of a delivery facility significantly influences their decision to seek healthcare services. Accessibility includes transportation, location of the facility, and time spent waiting. Women's perception of accessible facilities with reasonable traveling and waiting times enhances their valuation of the services provided. In contrast, difficult-to-reach facilities or those with long waiting periods have negative implications on the perception of service quality. The cost of health resources is equally important because women who consider these resources as too expensive may resort to informal alternatives to childbirth. With the right financial and geographical provisions, these perceptions can be changed, increasing the utilization of facility-based delivery services. Enhanced access to these services improves healthcare perceptions and their usage.

In addition, pregnant women's perceptions are influenced by societal and cultural factors, which affect how they view healthcare facilities. In many communities, cultural norms and traditional beliefs play a significant role in shaping attitudes toward facility-based delivery. Women may perceive hospital deliveries as an unfamiliar or even unnecessary practice, particularly if they come from communities where traditional birth practices dominate. In contrast, positive cultural reinforcement, such as support from family members or religious leaders, can positively influence perceptions of healthcare facilities. When facility-based delivery is framed within a culturally acceptable context, it increases its perceived value, and women are more likely to seek care in these settings. The influence of social networks and community leaders highlights the importance of integrating cultural sensitivities into maternal health promotion strategies to improve perceptions of service quality and increase utilization³⁷.

2.1.6 Dimensions of Perception in Facility Delivery

- **Perceived Quality of Care:** One of the strongest determinants of perception is women's view of the quality of maternal services provided in health facilities. Quality of care is evaluated through multiple dimensions including the availability of skilled personnel, adequacy of infrastructure, cleanliness of facilities, and responsiveness of staff. Studies have shown that women are more likely to choose facility delivery if they believe that the institution can provide timely and effective interventions in case of complications¹⁹. In contrast, perceptions of overcrowding, long waiting times, poor hygiene, and lack of equipment discourage utilization³⁸.

In Nigeria, Mbachu et al. reported that negative perceptions of quality such as inadequate privacy during labor and lack of essential supplies were significant deterrents to facility use³⁹. Similarly, Oladapo et al. noted that women's perceptions of poor infrastructure and limited emergency

readiness often pushed them towards home delivery⁴⁰. These findings highlight that perceptions are not simply based on objective service quality but also on subjective expectations and comparisons with alternative delivery options such as TBAs²⁶.

- **Perceptions of Healthcare Providers' Attitudes: Women's** perceptions of healthcare providers' attitudes significantly influence their delivery choices. Respectful and empathetic care fosters trust and encourages women to return for facility-based services, while experiences of neglect, verbal abuse, or discrimination result in negative perceptions. In sub-Saharan Africa, reports of mistreatment during childbirth including scolding, shouting, or physical abuse have been widely documented and remain a major barrier to facility utilization. In Nigeria, studies consistently show that women's perceptions of provider attitudes determine their comfort with institutional delivery. For instance, Okafor et al. found that women who reported being treated with dignity and respect were three times more likely to recommend facility delivery to others.³¹ Conversely, women who anticipated mistreatment often preferred TBAs, who were perceived as more caring and supportive²⁸.

- **Cultural and Social Perceptions**

Perceptions are also strongly shaped by cultural norms and social expectations. In many Nigerian communities, childbirth is viewed as a natural process that does not necessarily require medical intervention. Women may therefore perceive hospital delivery as unnecessary unless complications arise. Additionally, cultural emphasis on privacy and modesty during childbirth sometimes creates discomfort with institutional delivery, particularly when male health workers are involved²⁶.

Social networks also influence perceptions. Women often rely on the experiences of friends, relatives, and neighbors in forming their perceptions of health facilities. Positive stories of safe deliveries can encourage utilization, while accounts of neglect or poor outcomes reinforce negative perceptions. In many Nigerian settings, mothers-in-law and husbands exert strong influence over delivery decisions, meaning that their perceptions also indirectly shape women's choices¹².

- **Perceptions of Cost and Accessibility:** Financial and geographical factors also affect perceptions of facility delivery. Even where services are subsidized or offered free, women may perceive facility delivery as expensive, considering the hidden costs of transportation, supplies, or informal payments²⁷. If facilities are perceived as inaccessible due to long distances, poor road networks, or lack of transport, women often regard them as impractical choices³. These perceptions interact with broader socio-economic realities and often outweigh knowledge of the potential benefits of facility-based delivery¹¹.
- **Perceptions of Safety and Trust:** Safety perception is a key motivator of maternal health-seeking behavior. Women are more likely to deliver in facilities when they believe that these settings provide a secure environment with competent professionals capable of handling complications⁶. Conversely, if women perceive health facilities as unsafe due to poor hygiene, lack of emergency readiness, or stories of maternal deaths occurring within hospitals, they may opt for home births despite having higher medical risks. Trust in the health system also underpins perceptions. When women believe that healthcare workers are competent and committed to safeguarding their lives, they develop positive perceptions that encourage utilization. However, mistrust whether from personal negative experiences or community narratives undermines confidence in facility delivery¹¹.

- **Global Evidence on Perceptions of Facility Delivery:** Globally, women's perceptions of health facilities vary widely depending on the level of health system development and cultural context. In high-income countries, where respectful maternity care is institutionalized, perceptions of facility delivery are generally positive, contributing to near-universal institutional delivery rates². In contrast, in low- and middle-income countries, negative perceptions remain widespread due to weak health systems, poor infrastructure, and entrenched cultural norms.

For example, in Nepal, women reported negative perceptions of facility delivery because of poor staff attitudes and lack of privacy¹⁸. In Tanzania, women's perceptions of health facilities were shaped by stories of neglect and poor quality, which discouraged many from seeking institutional delivery¹⁹. Similarly, in Ghana, perceptions of hospitals as "unfriendly" spaces, combined with positive cultural perceptions of TBAs, limited facility utilization.²² These findings emphasize that perception is a universal challenge but manifests differently across cultural and institutional contexts.

- **African Context on Perceptions of Facility Delivery**

In many African countries, perceptions of facility delivery are often tied to experiences of mistreatment and distrust in health systems. In Ethiopia, for example, studies revealed that women often viewed facilities as "unfriendly" environments characterized by long waits and unsympathetic staff. In Kenya, Naanyu et al. found that women often delivered at unintended locations due to negative perceptions of hospital accessibility and responsiveness²¹. In Uganda, Kakaire et al. noted that women perceived TBAs as more approachable and supportive compared to formal health providers, reinforcing reliance on traditional care. Across these contexts, women's perceptions are shaped by interpersonal interactions, health system responsiveness, and

cultural familiarity. Importantly, interventions that improved women's perceptions such as community engagement, respectful maternity care training, and facility upgrades were associated with significant increases in institutional deliveries¹¹.

- **Nigerian Context on Perceptions of Facility Delivery:** In Nigeria, negative perceptions of facility delivery remain a significant barrier to utilization. Studies consistently highlight that women's decisions are shaped by their perception of how they will be treated, the affordability of services, and the safety of facilities. For instance, Akinyemi et al. found that women in southwest Nigeria who perceived health workers as caring and competent were significantly more likely to deliver in facilities²⁴. Conversely, in northern Nigeria, Sulaiman et al. reported that negative perceptions of hospital staff attitudes contributed to persistently low uptake of facility delivery despite knowledge of its benefits²³.

In Ekiti State, Oyedeji et al. revealed that women often perceived health facilities as more reliable for complicated deliveries but preferred TBAs for uncomplicated births due to perceptions of cultural familiarity, cost, and emotional support. This dual perception that hospitals are for emergencies and TBAs for routine deliveries undermines proactive facility utilization. It reflects a broader challenge in Nigeria, where perceptions of health facilities are often shaped by community norms rather than individual preferences alone.

- **Perception and Health-Seeking Behavior Among Pregnant Women:** Health-seeking behavior among pregnant women regarding health services is informed and shaped by several internal and external perceptions. Perception means a pregnant mother's appraisal, comprehension, judgement, and perspective regarding her pregnancy and the care services offered to her. Women's perceptions are directly linked to their health-seeking

behavior. Positive perceptions encourage early ANC attendance, birth preparedness, and facility delivery, while negative perceptions lead to delays, avoidance, or reliance on TBAs²⁵. Perceptions also influence women's willingness to return to facilities for subsequent births, making them critical not only for individual outcomes but also for long-term maternal health patterns.

These perceptions are informed and constructed on the basis of past experiences and also guided by the socio-cultural milieu of the family and society. A woman's appraisal of the potential risks of pregnancy, the value of attending antenatal visits, and the professionalism of health care providers greatly influence her overall attitude toward seeking care. This orientation is in line with the health-seeking behavior theory which stresses the importance of need and benefit perception in the decision to use healthcare services⁴⁶. It has been noted that good perception regarding healthcare facilities and personnel are often associated with increased facility-based care seeking among pregnant women.⁴⁷ Moreover, women who view pregnancy as a condition that requires medical management are more likely to actively seek skilled care throughout the pregnancy period⁴⁸.

Perception is closely linked with health literacy, which significantly influences the health-seeking behavior of pregnant women. Health literacy is defined as the ability of individuals to access, comprehend, and process relevant health information to enable them make important decisions. Well educated pregnant women through community health education, health campaigns or antenatal education are likely to appreciate the value of preventive maternal care services further systematic maternal care. This creates a conscious shift towards formal healthcare services rather than alternative or informal care pathways. For example, Women who are knowledgeable about potential complications or the advantages of skilled birth attendance

tend to seek timely care and empower their social contacts to do the same. It can be concluded that health literacy serves as a mediating variable that enhances perception and behavior synergistically with worsening maternal health outcomes.

Perceptions are dynamic and can change based on personal experiences, exposure to information, or community influences. For example, women who initially preferred home delivery may shift to facility use after positive ANC experiences or hearing favorable stories from peers. Conversely, negative encounters such as neglect or high out-of-pocket costs can transform positive perceptions into distrust, discouraging future facility use.²⁸ Seeking healthcare services concerning pregnancy care is strongly conditioned by the dynamics and power relations in the household and community, which also affect the woman's decision-making. In some cultures, the woman does not single handedly decide on parental healthcare options; she usually consults her partner, relatives, and some other important people. This societal impact can serve to either enhance or mitigate a woman's prior mental evaluation of health services. For example, if some critical members of the family have favorable attitudes toward health care practitioners and have had positive experiences with facility-based deliveries, they are bound to promote institutional care-seeking during pregnancy³³. On the other hand, if such health care decision-makers are cynical and dismissive, even a woman with positive perceptions may postpone or forgo facility-based care. That is, the actions of pregnant women cannot be analyzed in isolation devoid of the wider social networks and cultural norms that influence personal choices⁴⁶. The already positive family perceptions toward health are even more reinforced and as such enhance the likelihood of using maternal services in a timely and attended to the needed level.

Sociocultural norms influence the ways in which women perceive their pregnancy experiences and subsequently, the decisions they make regarding care. Cultural factors inform what is

socially considered a “normal” progression of pregnancy and delivery, for instance, and affects the extent to which women seek medical assistance. In some cultures, where pregnancy is viewed as an event that needs no medical supervision, women may choose to wait longer to seek care, or utilize Traditional Birth Attendants (TBAs) even when modern healthcare facilities are available.⁴⁸ Still, when aligned with religious or communal beliefs, certain cultural values may promote health-seeking behavior particularly when there is focus on the preservation of maternal life. Perception in this instance is influenced by widely accepted cultural narratives that position healthcare access as a communal expectation alongside individual obligation.⁴⁷ Sharp shifts toward positive maternal health-seeking behaviors have been observed when culturally appropriate information is used together with measures to improve perception, demonstrating the effectiveness of the interventions⁴⁹.

While using antenatal services, socializing with their peers, or even responding to community health prompts, women’s perception changes, which at times catalyzes reaffirming, or alters care seeking intentions. This change explains why a woman who prefers avoiding healthcare facilities may subsequently choose to deliver in one, guided by new risks or benefits understanding. Thus, these behavioral trends among pregnant women do not exist in a state of equilibrium, rather it is a state of interplay between perception, knowledge, social influence, and past and present experiences.³³ In devising healthcare strategies aimed to enhance service utilization, understanding maternal behavioral patterns is critical because the reasoning provides a framework through which interventions can be crafted to address the rational and emotional aspects of the decisions women make.⁵² Therefore, maternal health and pregnancy outcomes improvement requires focused work on perception and health-seeking behavior.

- **Concept of Maternal Healthcare**

Maternal healthcare is defined as the range of services offered to women during pregnancy, childbirth, and the postpartum period, including physical, emotional and psychological aspects of wellness. It includes the preventive, promotive, and curative healthcare services necessary to protect the health of mothers and newborns. These services aim at monitoring the health conditions of mother and fetus, ensuring safe delivery, and adequate postpartum care. Maternal healthcare also encompasses services such as antenatal care (ANC), skilled attendance at birth, emergency obstetric care, and postnatal care which all mitigate reproductive cycle risks¹². In maternal healthcare, the core focus is to provide women services that are timely, appropriate, and considerate of cultural practices prior to, during, and after childbirth. This holistic approach is accessible and accepted as a very essential and fundamental component of reproductive rights and enhancement of public health.

Maternal healthcare encapsulates the overarching definition of continuity of care, which integrates antenatal, intrapartum, and postnatal services. This continuity safeguards the delivery of skilled support to women in addition to monitoring them throughout pregnancy and providing follow-up care in the postpartum period. Recognizing maternal healthcare as a continuum reinforces the idea that each phase of care is interdependent, thus optimizing the health outcomes of mothers and newborns. Services provided during pregnancy include routine examinations, health education, dietary guidance, and screening of expectant mothers, all of which contribute to risk reduction in preparation for childbirth. During childbirth, skilled birth attendants implement active management of labor, monitoring for potential complications, and immediate postpartum care for mother and baby. Postnatal care emphasizes the promotion of exclusive breastfeeding alongside the early detection of postpartum complications and family planning.

While defining maternal healthcare, it is equally important to consider the World Health Organization's (WHO) guidelines on respectful maternity care. This part of maternal healthcare emphasizes the right of women to receive care that is respectful, non-discriminatory, and compassionate care at all stages of service delivery. It underscores the need to regard women as active participants in their care and in decisions affecting their health so as to build trust in the healthcare systems and encourage utilization of services. The provision of respectful maternity care also includes the guarantees of privacy, informed consent, and freedom from abuse or neglect during the provision of services⁵³. Thus, to care for a woman from a maternal perspective goes beyond the interventions required, to the attitude and manner in which those services are given which speaks of health equity and social justice concerns⁵⁵.

Thus, maternal healthcare functions within a system that aims to promote maternal well-being not only by decreasing mortality and morbidity, but also by improving the experience of maternity through supportive, safe, and inclusive care (Micah).⁵⁷ This definition also expands beyond the provision of services to include access, acceptability, and appropriateness of care as important constituents of the maternal health systems framework.⁵⁸ By giving attention to comprehensive care, it is positioned as a critical cornerstone in achieving universal health coverage and increasing the Sustainable Development Goals on Health and Gender Equality. Therefore, this serves as a primary reference for planning, implementing, and evaluating maternal health services in various settings¹⁶.

2.1.7 Concept of Facility Delivery

Facility delivery refers to childbirth that occurs within a recognized healthcare setting such as a hospital, clinic, or maternity center where trained professionals and the necessary medical infrastructure are available¹. The World Health Organization identifies delivery in health

facilities as a key component of safe-motherhood strategies and a critical intervention for lowering maternal and newborn deaths⁶². Such deliveries are attended by qualified practitioners including midwives, nurses, and obstetricians who are equipped to manage uncomplicated births and identify complications promptly². “Beyond routine delivery care, skilled attendants are capable of providing emergency obstetric interventions such as caesarean sections, transfusions, and newborn resuscitation when complications occur²⁶. Facility delivery places equal importance on the quality, preparedness, and functional capacity of the health system supporting childbirth services⁶³.

Conversely, home births typically supervised by traditional birth attendants or family members remain common in several low-income regions, including parts of Nigeria⁵⁴. Although TBAs offer cultural comfort and emotional reassurance, most lack formal training and essential tools to handle emergencies, thereby contributing to avoidable maternal and newborn deaths. Consequently, promoting a transition from home to facility births is viewed globally as a core strategy for meeting the SDG target of reducing maternal mortality to below 70 deaths per 100,000 live births by 2030²⁹. Facility delivery aims to achieve the public health goal of decreasing maternal and neonatal mortality by making sure births take place in the presence of medical supervision, as well as the possibility for immediate emergency aid if needed. It marks the transition from traditional home or unassisted deliveries to medically managed childbirth to fulfill international standards concerning safe motherhood and maternal healthcare.

A core characteristic of facility childbirth is its connection to the entire spectrum of maternal care, which starts from attending to expectant mothers and ends with follow-up visits postpartum. Delivering within a health facility represents not a final outcome but a crucial link in ensuring continuity of maternal and postnatal care³⁵. The concept implies more than the presence of a

physical structure; it requires supporting services such as clean water, sterile equipment, reliable emergency transport, and an effective referral network. More than the mere presence of a health personnel, facility-based delivery includes access to essential medicines like oxytocin, the ability to perform cesarean sections, and the presence of monitoring apparatus such as fetal heart rate monitors. Together, these elements create an adaptable and supportive environment capable of handling both normal and complicated deliveries⁶³. Thus, facility childbirth remains one of the pillars of contemporary interventions in maternal health as it integrates preventive measures with expectation and acute intervention⁶⁵.

Facility delivery also entails an organized approach to preventing avoidable deaths through the use of established clinical protocols, skilled supervision, and standardized care pathways. The presence of a trained health worker is vital not only for routine tasks but also for the active monitoring of possible complications like hemorrhage, sepsis, or obstructed labour³⁰. It is further understood as a risk-management strategy that ensures childbirth occurs in environments where advanced medical assistance is immediately accessible when complications arise.⁶⁴ This defining element serves to distinguish facility delivery from other forms of childbirth care offered, which is the recommended practice by global health bodies and policy strategies/frameworks²⁹. Thus, facility delivery is designed as both a proactive measure and immediate action within an institutional healthcare system.

Moreover, the concept of facility delivery aligns closely with the pursuit of equity and universal health coverage in maternal and child health. It reflects not only access to care but also the rights-based principle that every woman deserves a safe and dignified childbirth experience.³⁵ The institutional setting supports a multidisciplinary model of care where obstetricians, pediatricians, anesthetists, and nurses collaborate to ensure optimal outcomes for both mother

and child.⁶³ Furthermore, the presence of health records, surveillance systems, and standardized reporting within facilities enhances continuity of care and data-driven decision-making, which are essential for national health planning⁶⁶. Therefore, facility-based delivery extends beyond the physical act of giving birth in a hospital, it embodies a comprehensive, system-wide framework that combines safety, dignity, continuity of care, and responsive health services tailored to every mother and infant³⁰.

2.1.7.1 Importance of Facility Delivery

Delivering within a health facility improves maternal and newborn outcomes by providing an organized setting equipped with trained professionals and essential delivery resources. Facility delivery ensures that skilled attendants are available to handle both normal deliveries and potential complications during labor. Healthcare providers follow established clinical protocols to minimize risks and provide prompt medical intervention whenever needed⁶³. In addition, Standard practices associated with facility delivery include active management of the third stage of labor, use of the partograph for monitoring, and immediate newborn resuscitation when required³¹. The facility environment allows continuous observation of both mother and baby during and after delivery, thereby increasing postnatal survival rates⁶⁴. This method of delivery enhances safety, protects maternal health, and achieves designated international goals by eliminating unnecessary delays resulting from lack of skilled care and facilitating early recognition and management of complications³⁵.

In addition to clinical supervision, facility delivery ensures the availability of critical infrastructure such as operating theatres, blood transfusion services, and neonatal intensive care unities. The proximity to emergency resources within these facilities greatly improves response times in times of crisis, thereby enhancing maternal and newborn prognosis ³². Furthermore,

health facilities provide a controlled environment with sanitized tools, containing potential post-delivery infections.

Routine measures like administering uterotonics to prevent postpartum hemorrhage, maintaining strict infection control, and treating eclampsia with magnesium sulfate illustrate the integrated care available in facilities.²⁹ These institutions also extend non-clinical psychosocial support during the delivery process, enhancing the mother's emotional wellbeing. Facilities also provide emotional and psychological support during childbirth, contributing to a mother's sense of safety and comfort.³⁵ This array of supportive care illustrates the critical role of facility delivery as an all-encompassing intervention for safe childbirth³¹. An added advantage of facility-based birth is that it promotes continuity of care and proper documentation of both maternal and newborn health records. Detailed record-keeping captures the mother's medical history, delivery outcomes, and newborn condition, supporting informed follow-up care. These sorts of information ensure tailored attention for future health visits, while at the same time enhancing public health information systems for devising policies and plans. Well defined trends, complications, or gaps in service provision enable healthcare practitioners and governments to make informed decisions to improve maternal healthcare over a time. The influence of documentation in facility-based settings also enhances responsibility, provides assurance of the quality, and the assessment of maternal and child health services. Thus, delivery in a healthcare institution becomes the focal point for integration of clinical service delivery, public health services, and health system strengthening. It, thus, places the care beyond a clinical alternative towards a crucial approach to building resilient healthcare systems. Delivering in a health institution promotes fairness in access to essential maternal healthcare and reinforces women's right to safe childbirth. Regardless of the economic class of a woman, all woman is given the opportunity to receive the

same standard of care during facility delivery⁶⁴. This helps to narrow the gaps with regards to health outcomes among women from marginalized groups who might have hitherto skilled services that were beyond their reach.⁶³ Health facilities uphold the principles of dignity, choice, and informed consent, ensuring that every woman receives respectful and equitable care during childbirth, which is in line with international humanitarian approaches to maternal healthcare in the world. Additionally, facility delivery offers opportunities for healthcare workers to educate mothers on family planning, breastfeeding, and newborn care benefits that extend beyond childbirth itself³¹. Health systems that place facility delivery within a context of overall maternal assistance offer a protective environment for birth and a continuous life course pathway for health to mothers and infants by facility delivery⁶³.

2.1.7.2 Maternal Health and Safe Motherhood Initiatives

According to the World Health Organization, maternal health refers to the wellbeing of women throughout pregnancy, childbirth, and the postnatal phase³⁰. The Safe Motherhood Initiative, introduced in 1987 through collaboration between WHO, UNFPA, and the World Bank, advocates for improved maternal outcomes through interventions like antenatal care, skilled birth attendance, emergency obstetric services, and comprehensive postnatal care.³² Within this framework, facility-based delivery remains pivotal because it enables women to give birth in safer environments, thereby lowering the risks of maternal and newborn complications

In Nigeria, several national programmes including the National Maternal and Child Health Policy and the Midwives Service Scheme (MSS) were developed to advance safe-motherhood goals¹³. However, maternal mortality rates remain elevated, largely because of inconsistent policy implementation, insufficient health infrastructure, and persistent socio-cultural obstacles.

Consequently, the extent to which women use facility delivery services serves as a vital measure of how effectively maternal-health initiatives are functioning in Nigeria.

2.1.8 Factors influencing the Utilisation of Facility Delivery Services

Several factors militate against the utilization of facility delivery services among pregnant women, significantly influencing their decisions to opt for home births or deliver with traditional birth attendants instead of skilled professionals at healthcare facilities. One key factor is the geographical accessibility of health facilities. In many rural areas, healthcare facilities may be located far from communities, making it difficult for women to travel long distances, particularly in regions with poor infrastructure and limited transportation options. This geographic barrier creates a perception of inaccessibility, as pregnant women may struggle to reach health facilities in time for delivery. When facilities are too far, the risks associated with labor and delivery may deter women from seeking institutional care, favoring home births instead. This spatial distance remains one of the most significant challenges in encouraging women to utilize healthcare services, despite the availability of skilled personnel at these institutions⁴⁸.

Another significant factor is the perceived high cost of healthcare services, which often acts as a deterrent to facility-based delivery. In many low-income regions, the cost of accessing care, whether through direct fees or indirect costs such as transportation and medical supplies, can be prohibitively expensive. Women from poor socioeconomic backgrounds often find it challenging to afford the cost of facility-based delivery, leading them to seek alternative options, such as home deliveries, which may seem more financially accessible. Even when services are subsidized or partially covered by health insurance, the perception that institutional delivery is unaffordable can prevent many pregnant women from utilizing these services. Financial

constraints, therefore, play a crucial role in reducing the utilization of healthcare facilities, particularly in resource-poor settings⁶¹.

Furthermore, the lack of awareness and information about the benefits of facility delivery services can be a significant barrier. Many pregnant women are either unaware of the services available at health facilities or lack adequate knowledge of the benefits of skilled care during delivery. In some communities, women may rely on traditional birth attendants who are more accessible and culturally familiar, even though they may not be equipped to handle complications during childbirth. Misconceptions about the quality of care at health facilities and a lack of trust in medical staff can reinforce the decision to avoid institutional delivery. Education and awareness programs are essential to bridge this knowledge gap, but when these are insufficient or unavailable, women may remain unaware of the advantages and importance of professional care during childbirth.⁵² This lack of information ultimately limits their utilization of healthcare services during labor and delivery.

Cultural beliefs and societal norms play a significant role in shaping the choices women make regarding where they give birth. In some cultures, there is a strong preference for home births, as it is seen as a more natural and familiar setting. The belief that childbirth is a private and personal experience often leads women to avoid health facilities, where they may feel uncomfortable with the formalized, clinical environment. Traditional beliefs about childbirth, coupled with a lack of trust in medical institutions, can drive women to rely on family members or community-based midwives who follow traditional practices. These cultural norms and beliefs are deeply ingrained, and changing them requires a concerted effort from healthcare providers, community leaders, and policymakers to foster a positive perception of health facilities and their role in ensuring safe deliveries.⁶³

The quality of care provided at health facilities is another critical factor influencing the utilization of these services. Women who perceive that healthcare providers lack professionalism, empathy, or are overburdened may hesitate to seek institutional delivery services. In some settings, women report experiences of poor communication, neglect, or mistreatment by healthcare staff, which can reduce their trust in the facility. When women do not feel respected or adequately supported by healthcare providers, they are less likely to choose facility-based delivery. This perception of poor-quality care can stem from inadequate staffing, insufficient resources, or negative past experiences. Improving the quality of care at health facilities is crucial to increasing utilization, as women are more likely to seek services in environments where they feel valued and well cared for.³⁵

The availability and readiness of medical facilities and skilled personnel significantly influence the decision to deliver in health facilities. In some areas, health facilities may be understaffed or lack essential medical supplies, which reduces their perceived reliability and safety. When women perceive that hospitals or clinics are ill-equipped to handle complicated deliveries or emergencies, they may opt to deliver at home or with traditional birth attendants, where they feel more in control and secure. The presence of trained and compassionate healthcare professionals, adequate medical equipment, and emergency response capabilities is essential in building trust and encouraging women to deliver in health facilities. Inadequate resources and infrastructure can thus severely limit the utilization of facility-based delivery services, despite their potential benefits.⁶⁴

- **Perception and Utilisation of Facility Delivery**

Perception is not only an independent determinant of maternal health-seeking behavior but also a critical mediator between knowledge and the actual utilization of facility delivery. While

knowledge equips women with awareness of risks and benefits, perception shapes how this knowledge is interpreted and acted upon. A woman may be knowledgeable about obstetric danger signs and the importance of skilled attendance, but if her perception of facility delivery is negative characterized by fear of mistreatment, cost concerns, or distrust in healthcare providers she may still choose home delivery.²⁷ Conversely, positive perceptions foster trust, confidence, and willingness to use facility-based services.¹¹

Utilization of facility delivery refers to the actual uptake of skilled attendance at birth, typically measured by the proportion of women delivering in health facilities. Globally, utilization rates are highest in high-income countries, where perceptions of safety, professionalism, and respect dominate, but remain suboptimal in many low- and middle-income settings.² In Nigeria, utilization is persistently low, especially in rural and northern regions, with women's perceptions strongly shaping these trends.⁴ This section explores how perceptions of quality, safety, cost, cultural appropriateness, and provider attitudes directly influence the utilization of facility delivery.

2.1.8.1 Linking Perception and Utilisation

- **Perceived Quality of Care and Utilisation**

Perceived quality of care is perhaps the most direct link between perception and utilization. Women's willingness to use facilities is heavily influenced by whether they believe these institutions can provide effective, timely, and respectful care. Poor perceptions of quality such as

long waiting times, lack of drugs, or poor hygiene discourage facility use even when women are aware of its benefits.¹⁹ In a study conducted in Enugu State, Onah et al. found that women who perceived facilities as well-equipped and staffed with competent providers were significantly more likely to utilize facility delivery⁶⁹. Conversely, those with negative perceptions of readiness were more likely to opt for home delivery. Similarly, in rural Ethiopia, Shiferaw et al. noted that positive perceptions of facility quality were among the strongest predictors of skilled birth attendance.²⁰

- **Perceived Attitudes of Healthcare Providers**

Women's perceptions of healthcare workers' attitudes strongly influence utilization. If women expect respectful, supportive, and empathetic care, they are more likely to deliver in health facilities⁴¹. However, negative perceptions of provider behavior including verbal abuse, neglect, or lack of privacy lead many women to avoid facilities. In Nigeria, Okafor et al. reported that women who perceived health providers as caring were three times more likely to deliver in facilities compared to those who anticipated mistreatment.³¹ In Ekiti State, Oyediji et al. highlighted that negative perceptions of provider attitudes led many women to seek TBAs, despite knowing the risks.⁴⁵ These findings underscore that respectful maternity care is essential not only for rights-based reasons but also as a determinant of utilization.

- **Cultural Perceptions and Utilisation**

Cultural norms shape how women perceive childbirth and influence their utilization decisions. In many Nigerian communities, facility delivery is perceived as unnecessary unless complications arise. This cultural perception normalizes home births, particularly under the care of TBAs, who are often viewed as more culturally aligned and emotionally supportive²⁵.

In southwest Nigeria, women's utilization of facilities was significantly lower among those who perceived hospital delivery as incompatible with cultural practices such as herbal treatments and postpartum rituals.²⁶ In northern Nigeria, cultural restrictions on women's mobility further reinforced negative perceptions of hospital care, leading to low utilization. These findings demonstrate how cultural perceptions directly translate into health-seeking behavior.

- **Perceptions of Cost and Accessibility**

Perceptions of cost both direct and hidden strongly influence utilization. Even when free services are available, women who perceive hospital delivery as expensive often opt for home births. These perceptions are shaped by prior experiences, community narratives, and visible expenses such as drugs, supplies, and transport²⁷. Yaya et al. found that in sub-Saharan Africa, women who perceived delivery services as affordable were 2.5 times more likely to utilize them compared to those who perceived them as expensive. In Nigeria, Akinyemi et al. similarly reported that cost perceptions accounted for a significant portion of the gap between knowledge and utilization.²⁴. In Ekiti, Oyedemi et al. noted that women who perceived health facilities as financially demanding avoided them, even when subsidies were in place, suggesting that perceptions often outweigh reality⁴⁵.

- **Perceptions of Safety and Trust**

Trust in the health system underpins women's perceptions of safety and strongly affects utilization. Positive perceptions of safety believing that facilities are equipped to handle complications encourage utilization, while perceptions of risk or neglect within hospitals discourage it²¹. Kruk et al. argued that perceptions of safety were a critical determinant of maternal healthcare use in low-resource settings, with distrust in facility capacity significantly

reducing utilization⁶. In Nigeria, Mbachu et al. found that women's trust in healthcare providers and facilities strongly predicted their likelihood of facility delivery.³⁹ These findings highlight that improving technical quality alone may not suffice unless women perceive facilities as safe and trustworthy.

- **Global Evidence on Perception–Utilisation Link**

Globally, the relationship between perception and utilization has been documented across diverse settings. In Nepal, Karkee et al. reported that women with negative perceptions of staff attitudes and facility readiness were significantly less likely to deliver in hospitals¹⁸. In Tanzania, Gabrysch and Campbell found that perceptions of poor facility responsiveness discouraged institutional deliveries.¹⁹ In Ghana, Ampofo et al. observed that positive perceptions of health facilities encouraged women to switch from TBAs to hospital deliveries²². These studies confirm that perceptions consistently predict utilization across varied cultural and systemic contexts.

- **African Evidence on Perception–Utilisation Link**

Across Africa, the link between perception and utilization is well established. In Ethiopia, Tura et al. noted that women's perceptions of respectful care significantly influenced their likelihood of delivering in facilities.⁴⁸ In Kenya, Naanyu et al. found that negative perceptions of accessibility and affordability contributed to low utilization rates.²¹ In Uganda, Kakaire et al. highlighted that women who perceived TBAs as more supportive were less likely to use formal health services, even when aware of their findings underscore that improving perceptions is as important as expanding knowledge and access⁴⁵.

- **Nigerian Evidence on Perception–Utilisation Link**

In Nigeria, multiple studies confirm that perception strongly shapes utilization patterns. According to the NDHS (2018), only 39% of rural women delivered in facilities compared to 61% of urban women, with perceptions of cost, quality, and cultural alignment mediating much of this disparity. In Enugu State, Onah et al. found that women with positive perceptions of facility quality were 3.5 times more likely to utilize institutional delivery.⁶⁹ In Oyo State, Doctor et al. noted that women who perceived TBAs as more supportive were less likely to deliver in hospitals.¹² In Ekiti, Oyediji et al. observed that perceptions of cost, accessibility, and provider attitudes were central to utilization decisions. Collectively, these studies reveal that perception is one of the strongest predictors of utilization in Nigeria.⁴⁵

- **Knowledge and Perception of Pregnant Women Towards Facility Delivery Services**

Access to care and their corresponding attitudes formed by constituents like transportation and distance are critical for care seeking within health care services. Perception or attitude here refers to a region, place or area's health facilities infrastructure or service frame features like the level of services rendered, social and economic resources as well as the geographical features. Women are likely to select healthcare facilities that are perceived to be within easy geographical reach and convenient for them. Where health facilities are located within close proximity or accessible within a reasonable period of time, these places are regarded as convenient alternatives. On the opposite side, rural areas far away from megalopolis are often deemed as inaccessible. Distance, as a geographical barrier, along with availability of services has an integrated relationship with pregnant women's decision making when provided care services at health facilities. This suggests reasons why location plays vital roles of shaping the perception of access⁴⁷.

The presence of dependable modes of transportation greatly influences the perception of access. Especially in remote areas, the unavailability of public transport can greatly impede access to

health care services. If pregnant women can access good healthcare transport services, then they consider facility-based delivery as accessible and prefer having it done at the hospital. Their perception of the delivery services is influenced significantly by the absence of great delay or a high cost associated with traveling to the health services. In some places, women might use public transport, family, or community volunteer drivers from the area to access health services. If transport is expensive or difficult to acquire, women will have to change their booking from a hospital or clinic to a home or traditional birth attendants because they find those options more accessible. In other words, transport helps to determine the level of accessibility of healthcare services by women.

Alongside transportation, skilled personnel, and the quality of services also shape perceptions of accessibility. When expecting women perceive that health facilities are adequately staffed with skilled healthcare professionals, they regard them as more accessible. The perception of competence of the healthcare providers shapes the overall perception of whether the facility can provide safe, effective, and timely care during childbirth. Healthcare workers who are perceived to be competent enhance the perception of accessibility and usefulness of the service. Women's awareness of qualified midwives, obstetricians, and other medical staff makes them consider the health facility as a secure and competent environment for childbirth. Perceptions of staffing and expertise enhance the appeal of the health facilities for reliable delivery care.

Financial factors play a crucial role in shaping the perception of accessibility to facility-based delivery services. If the cost of care is seen as affordable, women are more likely to perceive health facilities as accessible. However, high out-of-pocket expenses or the perception that healthcare is expensive can deter pregnant women from seeking institutional care, especially in low-income communities. The affordability of care directly influences the decision-making

process, with women from wealthier backgrounds perceiving delivery services as more accessible than those from lower-income groups. In many regions, women may prefer home births or traditional delivery practices due to the perceived affordability and the lack of financial resources to pay for hospital-based services. As a result, financial accessibility is closely tied to overall perceptions of the ease of obtaining healthcare during pregnancy and childbirth, which affects whether women will choose to deliver in a health facility.

The level of awareness and information about available services can also influence perceptions of accessibility. In many areas, pregnant women may not be fully aware of the healthcare services available to them, including delivery options at nearby health facilities. Education campaigns and outreach efforts are essential to informing women about the availability and benefits of facility-based delivery. When women are well-informed about where to go for delivery, what services are offered, and how to access them, they are more likely to perceive these services as accessible. Access to information through community health workers, media campaigns, and educational programs can reduce barriers to accessing facility-based delivery services. As women become more informed about the resources available to them, their perceptions of accessibility improve, and they are more likely to utilize the services offered by healthcare facilities⁶¹.

- **Socio-Cultural, Economic, and Institutional Barriers to Facility Delivery**

Despite global progress in reducing maternal mortality, significant barriers continue to hinder the utilization of facility-based delivery in many low- and middle-income countries, including

Nigeria. Facility delivery, attended by skilled personnel, is a key strategy for preventing maternal and neonatal deaths. However, its uptake remains suboptimal, with multiple socio-cultural, economic, and institutional barriers preventing women from accessing or utilizing these services.^{2.1.} These barriers operate at individual, household, community, and systemic levels, often intersecting to form complex challenges. Understanding these constraints is essential for designing interventions that effectively address maternal health inequities. This section explores the major socio-cultural, economic, and institutional barriers that impede facility delivery among pregnant women, with particular reference to Nigeria and sub-Saharan Africa.

2.1.8.2 Socio-Cultural Barriers

- **Traditional Beliefs and Practices:** Cultural norms and traditions heavily influence childbirth decisions. In many Nigerian communities, childbirth is perceived as a natural process that does not necessarily require medical intervention²⁵. Traditional practices often emphasize home births attended by family members or TBAs, who are culturally trusted and seen as accessible. Women may believe that complications are spiritual in origin and best managed through prayers, rituals, or herbal remedies rather than biomedical interventions.²⁶

In Ekiti State, ethnographic accounts suggest that some families continue to value traditional rituals during childbirth, such as herbal steaming and postpartum seclusion, which are incompatible with hospital settings. These beliefs reduce the perceived necessity of facility delivery and reinforce reliance on TBAs.

- **Influence of Family and Social Networks:** Family members, especially husbands, mothers-in-law, and elders, often play a decisive role in determining delivery location. In patriarchal settings, women's autonomy in healthcare decisions is limited, with husbands

or male relatives making the final choices.¹² Mothers-in-law, who often have strong influence due to their prior childbirth experiences, may discourage facility delivery in favor of traditional practices.

Research in northern Nigeria found that women's decisions to deliver at home were strongly influenced by husbands who perceived hospitals as unnecessary or costly. Similarly, in southwest Nigeria, community narratives celebrating successful home births reinforced social acceptance of non-institutional deliveries, discouraging younger women from seeking facility care.²⁶.

- **Gender Norms and Modesty Concerns:** Gender norms also act as barriers to facility delivery. In conservative communities, women may perceive facility delivery as culturally inappropriate due to exposure of their bodies to male healthcare workers.⁶⁹. This preference for modesty often outweighs perceived medical benefits, particularly where female staff are unavailable. Even in southern Nigeria, some women avoid facilities for fear of being examined by male doctors, preferring TBAs who are often female and culturally familiar.
- **Social Stigma and Adolescent Pregnancy:** For adolescent mothers, stigma around pregnancy outside marriage can prevent them from seeking facility-based care. Fear of judgment from health workers or community members may push young women toward home births, often under unsafe conditions. This reinforces cycles of poor maternal outcomes among vulnerable groups.

2.1.8.3 Economic Barriers

- **Direct Costs of Delivery Services:** Economic constraints are among the most frequently cited barriers to facility delivery. Direct costs such as consultation fees, delivery charges, medications, and supplies can be prohibitive for low-income households. Even where services are subsidized, unofficial or informal fees often emerge, increasing financial burden.

In Nigeria, Akinyemi et al. reported that perceived high costs discouraged facility utilization even among women who recognized its benefits. The NDHS (2018) similarly highlighted that cost was a leading reason why rural women avoided health facilities.⁴ For many households in Ekiti State, where incomes are low and irregular, facility delivery costs compete with other pressing needs such as food and school fees, making home delivery a rational financial choice.

- **Hidden and Opportunity Costs**

Beyond direct expenses, hidden costs such as transportation, food for accompanying relatives, and unofficial charges further discourage facility delivery. Women also face opportunity costs, such as time away from household or income-generating activities. For subsistence farmers and traders, the loss of income during facility stays can be a significant deterrent.¹⁹ A study in Oyo State found that women often opted for home births because of the expense of arranging emergency transportation and the expectation of “gratitude payments” to health staff.¹² These economic realities reinforce the perception that hospital delivery is unaffordable.

- **Poverty and Socio-Economic Inequality**

Structural poverty exacerbates maternal health disparities. Poor women are disproportionately excluded from facility delivery due to inability to afford services, limited insurance coverage, and poor geographic access. Wealthier women, by contrast, are more likely to utilize private or better-equipped facilities.³ In Nigeria, wealth-related disparities in maternal health utilization

remain stark, with the poorest women significantly less likely to deliver in facilities compared to the richest quintile⁴.

2.1.8.4 Institutional Barriers

- **Weak Health Infrastructure:** Inadequate infrastructure remains a major institutional barrier to facility delivery. Many facilities lack essential equipment, drugs, and blood supplies required for emergency obstetric care⁸. Poor physical environments, including unhygienic wards, insufficient beds, and unreliable electricity or water supply, discourage women from seeking facility delivery. In Ekiti State, reports indicate that rural clinics often lack basic delivery equipment, forcing women to either travel long distances to urban centers or resort to home delivery⁹. Inadequacies erode trust in health facilities and reinforce cultural preferences for TBAs.
- **Shortage and Maldistribution of Skilled Health Workers**

The shortage of skilled health personnel is another significant barrier. Nigeria faces a critical shortfall of doctors, nurses, and midwives, particularly in rural areas.¹ Women often perceive health facilities as unreliable due to frequent absenteeism or lack of qualified staff. Even where workers are present, heavy workloads may result in rushed or inattentive care, reinforcing negative perceptions.³⁹

In some rural Nigerian communities, women arrive at facilities only to be referred elsewhere due to absent staff or lack of capacity, creating frustration and mistrust.²⁸. These experiences discourage future utilization.

- **Provider Attitudes and Mistreatment**

Institutional barriers are not only structural but also interpersonal. Mistreatment during childbirth, including verbal abuse, neglect, or lack of privacy, remains a widespread problem. Women who anticipate or experience disrespectful care are unlikely to return to facilities. In Nigeria, studies consistently report that women perceive TBAs as more compassionate and supportive than hospital staff. Institutional reforms that address respectful maternity care are therefore critical.³¹. However, weak accountability systems often mean that mistreatment persists without redress, undermining women's confidence in facility delivery.

- **Policy and Systemic Barriers**

Policy gaps and weak implementation also hinder facility delivery. Although Nigeria has adopted free maternal healthcare policies in some states, implementation is inconsistent, with many facilities continuing to charge fees. Lack of insurance coverage for maternal services under the National Health Insurance Scheme (NHIS) further limits access for poor women. Weak referral systems and inadequate emergency transport exacerbate barriers. Women experiencing complications may delay seeking care if they perceive facilities as unable to handle emergencies or lacking functional referral networks³⁸.

- **Intersections of Barriers**

Socio-cultural, economic, and institutional barriers rarely operate in isolation but often intersect. For instance, a woman with adequate knowledge may still avoid facility delivery due to cultural norms discouraging exposure to male providers and financial constraints. Similarly, poor infrastructure reinforces negative cultural perceptions that hospitals are unsafe or unreliable. These intersections underscore the complexity of maternal health challenges and the need for multifaceted solutions¹⁹.

- **African and Nigerian Evidence**

Across sub-Saharan Africa, similar barriers persist. In Ghana, perceptions of cost and mistreatment discouraged women from institutional delivery despite awareness of risks.²² In Tanzania, distance and poor transport were major barriers, compounded by mistrust of facility care.

In Nigeria, evidence consistently highlights a combination of cultural norms, poverty, and weak health systems as key barriers. For example, Onah et al. identified lack of autonomy, cost, and negative provider attitudes as major constraints in Enugu State. In the north, cultural restrictions on women's mobility and low female education levels further entrenched reliance on home delivery. In Ekiti, Oyedemi et al. noted that institutional weaknesses such as absent staff and poor facility conditions reinforced socio-cultural reliance on TBAs, highlighting the interconnected nature of barriers.⁴⁵

- **Strategies to Improve Facility Delivery Uptake:** Increasing the utilization of facility delivery remains a priority for improving maternal and neonatal health outcomes in Nigeria and other low- and middle-income countries. Despite evidence that skilled birth attendance significantly reduces maternal and newborn mortality, utilization remains low due to socio-cultural, economic, and institutional barriers.¹ As outlined in previous sections, these barriers include inadequate knowledge, negative perceptions, traditional beliefs, financial constraints, poor infrastructure, and mistreatment by providers. To address these challenges, diverse strategies have been developed globally, regionally, and nationally, with varying degrees of success.

Improving the uptake of facility-based delivery services requires a multifaceted approach, addressing both the demand and supply sides of healthcare. Strategies that have been employed to improve utilization of facility delivery. It groups them into five broad categories: health

education and awareness interventions, community engagement and cultural reorientation, financial and economic strategies, health system strengthening measures, and policy and governance approaches. Evidence from global, African, and Nigerian contexts is analyzed to highlight lessons and implications for Ekiti State.

- **Health Education and Awareness Interventions:** One essential strategy is increasing awareness about the importance of institutional delivery and the risks associated with home births. Health education is one of the most direct strategies for improving utilization. By equipping women and their families with knowledge about the risks of home births and the benefits of skilled care, health education interventions can positively shape attitudes and promote utilization.
- **Antenatal Care (ANC) Education:** ANC services are widely recognized as a critical entry point for educating women on facility delivery. Studies have shown that women who receive comprehensive education during ANC are significantly more likely to deliver in health facilities.¹² In Nigeria, Odetola reported that structured ANC sessions emphasizing danger signs and birth preparedness increased women's intentions to deliver in hospitals.²⁸
- **Mass Media and mHealth Interventions:** Mass media campaigns have been used to raise awareness and change social norms. Radio dramas, television programs, and print campaigns have successfully increased knowledge of facility delivery in Ghana, Ethiopia, and Nigeria^{20, 22}. Recently, mobile health (mHealth) interventions have gained prominence. In South Africa, the MomConnect program sends maternal health messages via SMS, significantly improving knowledge and facility delivery uptake. In Lagos, a similar pilot program increased ANC attendance and facility deliveries by 35%.¹⁵

- **School and Adolescent Programs:** Given the vulnerability of adolescent mothers, school-based programs that provide reproductive health education have been effective in changing attitudes toward facility delivery. These interventions prepare young women before their first pregnancies, reducing reliance on unsafe practices²⁸.
- **Community Engagement and Cultural Reorientation**

Because socio-cultural barriers remain among the strongest determinants of non-utilization, strategies must involve communities to reshape norms and attitudes.

- **Male Involvement Programs:** Husbands and fathers play critical roles in decision-making. Interventions targeting men through community meetings, peer groups, and media campaigns have been shown to improve support for facility delivery.¹² In Tanzania, a male involvement program increased the proportion of men accompanying their wives to ANC, which correlated with higher facility delivery rates.¹⁹ In Nigeria, involving men in birth preparedness discussions significantly improved spousal support for institutional delivery.⁶⁹
- **Community Health Workers and Peer Education:** Community health workers (CHWs) are effective in bridging the gap between facilities and households. In rural Ethiopia, CHW home visits increased facility delivery by addressing misconceptions and providing referral support.²⁰ In Nigeria, CHWs who engaged with TBAs and mothers-in-law improved acceptance of hospital delivery in rural areas.
- **Engaging Traditional Birth Attendants (TBAs):** Rather than excluding TBAs, some strategies have sought to integrate them into health systems. In Ghana, TBAs were trained to encourage referrals to hospitals, leading to improved utilization.²² In Nigeria,

pilot programs that reoriented TBAs into birth companions and referral agents showed promising results, though sustainability remains a concern.⁸

Education campaigns that target pregnant women, families, and communities can emphasize the benefits of skilled birth attendance, such as the reduction of maternal and neonatal mortality. Such campaigns should also highlight the availability of services at healthcare facilities, including emergency care and professional support during delivery. Ensuring that pregnant women understand the importance of skilled care can create a shift in attitudes towards institutional delivery, leading to higher utilization rates. Public health campaigns can leverage various media platforms, including radio, television, and social media, to reach a broad audience and promote positive perceptions of healthcare facilities and professional birth attendants.⁴⁸

2.1.8.5. Financial and Economic Strategies

Economic barriers are a major determinant of utilization, making financial interventions essential.

- **Free Maternal Health Services:** Several Nigerian states have adopted free maternal healthcare policies. Evidence suggests that these policies increase facility delivery uptake, though inconsistent implementation undermines effectiveness.⁷¹ In Ondo State, the “Abiye” program, which removed fees and improved infrastructure, increased facility delivery rates and reduced maternal mortality.⁸
- **Conditional Cash Transfers (CCTs):** CCT programs provide financial incentives for women to attend ANC and deliver in facilities. In India, the Janani Suraksha Yojana program significantly increased institutional deliveries. In Nigeria, a pilot CCT program in rural communities also showed positive effects, though funding sustainability was a challenge.

- **Health Insurance Schemes:** Expanding health insurance coverage for maternal services can improve utilization. In Ghana, the National Health Insurance Scheme increased facility deliveries. In Nigeria, however, maternal health coverage under the National Health Insurance Scheme (NHIS) remains limited, particularly for the poor and rural women. Expanding insurance access could significantly reduce cost barriers.

2.1.8.6 Health System Strengthening Measures: Even when women have positive knowledge and perceptions, weak health systems discourage utilization. Strengthening health systems is therefore essential.

- **Improving Infrastructure and Equipment:** Facility upgrades improve perceptions of quality and encourage utilization. In Ekiti State, upgrading rural maternity centers with clean delivery rooms, electricity, and essential drugs could improve trust and uptake. Ekiti state
- **Human Resources for Health:** Addressing shortages and maldistribution of health workers is critical. Deploying midwives to rural communities under Nigeria's Midwives Service Scheme improved utilization temporarily, though sustainability issues emerged Abimbola et al. Training health workers in respectful maternity care can also improve women's perceptions and willingness to return to facilities.⁴¹.
- **Emergency Transport and Referral Systems:** Delays in reaching facilities remain a major cause of maternal deaths. Community-based transport schemes, ambulance services, and functional referral networks have improved facility delivery in Ethiopia and Nigeria.^{20,8}. Expanding such systems in Ekiti could reduce delays and increase confidence in facility delivery.

- **Policy and Governance Approaches:** Effective policy frameworks and governance are essential for scaling up facility delivery.
- **National and State-Level Programs:** Nigeria has implemented several maternal health initiatives, including the Saving One Million Lives Initiative and the National Primary Health Care Development Agency reforms. While these programs aimed to improve utilization, their impact has been uneven due to weak implementation and accountability.
- **Respectful Maternity Care Policies:** Global advocacy for respectful maternity care emphasizes the need for dignity, privacy, and empathy during childbirth.⁴¹ Policies institutionalizing respectful care can improve women's perceptions and utilization. In Nigeria, some states have begun adopting training modules on respectful maternity care, though widespread implementation remains limited.
- **Community-Based Health Insurance and Partnerships:** Decentralized health financing models, such as community-based health insurance, have been effective in Rwanda and Ghana in increasing facility delivery utilization.⁶ In Nigeria, pilot projects in Kwara State showed that subsidized community health insurance improved access to maternal services³⁹.

Additionally, enhancing the physical accessibility of healthcare facilities is crucial in increasing facility delivery uptake. Improving transportation infrastructure and ensuring that healthcare facilities are within a reasonable distance from communities can significantly reduce the barrier of distance. In regions with limited transport options, establishing community-based transportation systems or mobile clinics could provide women with easier access to care during labor. These systems could also help to mitigate the financial burden of traveling long distances to health facilities. Providing free or subsidized transport services for pregnant women could

incentivize them to choose facility delivery. By improving the physical accessibility of health services, it becomes more feasible for pregnant women to reach healthcare facilities promptly and safely, which is essential for timely interventions during childbirth²⁴.

Alongside improving access, there must be a focus on enhancing the quality of care provided at healthcare facilities. One effective strategy to improve facility delivery uptake is ensuring that health workers are adequately trained, both in technical skills and in providing compassionate, respectful care. Women are more likely to seek facility delivery if they feel respected and valued during their interactions with healthcare professionals. Healthcare workers who communicate effectively with patients, provide emotional support, and maintain a professional and empathetic approach can significantly improve the experience of childbirth. Training programs aimed at fostering respect and improving patient-provider relationships are vital in creating a positive environment for childbirth. Additionally, providing facilities with adequate medical equipment, ensuring proper hygiene standards, and offering sufficient postnatal care can contribute to enhancing the overall experience and safety of facility delivery²⁵.

Another vital strategy is strengthening the health system by ensuring the availability of resources, such as medicines, equipment, and skilled healthcare providers. Inadequate resources, including a shortage of skilled personnel and medical supplies, can undermine the quality of care provided at health facilities, discouraging women from seeking institutional delivery. Governments and healthcare organizations should prioritize the allocation of resources to maternal and newborn health services. This can involve increasing funding for health facilities, improving the supply chain for essential drugs, and ensuring that healthcare staff are well-equipped and adequately compensated. The presence of skilled healthcare providers and the availability of necessary

medical resources will improve the safety and efficiency of deliveries, making women more likely to seek care in healthcare facilities²⁶.

Moreover, involving community leaders and local influencers in promoting facility-based delivery is a powerful strategy. These figures often hold significant sway over community members and can help to break down cultural barriers to institutional delivery. Collaborating with community leaders to organize awareness campaigns and educational sessions can foster a cultural shift towards seeking care in health facilities. By integrating traditional knowledge with modern healthcare practices, community leaders can help bridge the gap between home births and facility-based deliveries. They can also work to counter negative perceptions about healthcare facilities and encourage women to trust the services available. Community-based health programs, led by respected local figures, can help normalize facility delivery and empower women to make informed choices about their care²⁷.

Integrating financial incentives and insurance schemes can also play a role in improving the utilization of facility delivery services. The cost of healthcare services, including delivery fees, can be a significant barrier to accessing institutional care. Offering financial incentives, such as conditional cash transfers or subsidized delivery services, can motivate pregnant women to seek care at health facilities. Insurance schemes that cover the cost of delivery and associated services can also reduce the financial burden on families. Ensuring that the costs of delivery are not a deterrent will help make facility deliveries more accessible, particularly for women from low-income households. A combination of these financial strategies can ensure that economic barriers do not prevent women from accessing the care they need during childbirth.⁶⁴

2.1.8.6 Global and Regional Lessons

Evidence from global and African experiences shows that multi-pronged strategies are most effective. For example, in Ethiopia, combining community education, CHW engagement, transport systems, and free delivery services significantly improved facility delivery rates.²⁰ In Ghana, integrating TBAs as referral agents while expanding insurance coverage improved utilization.²² These lessons suggest that no single intervention suffices; strategies must be comprehensive, addressing both demand- and supply-side barriers.

- **Nigerian Lessons**

In Nigeria, successful strategies include Ondo State's Abiye program, which combined free services, infrastructure upgrades, and community engagement, leading to measurable declines in maternal deaths.⁸ By contrast, the Midwives Service Scheme improved utilization temporarily but collapsed due to weak funding and poor retention of midwives.⁷¹ These cases highlight the importance of sustainable financing, community ownership, and systemic strengthening.

For Ekiti State, strategies must address specific local barriers, including cultural reliance on TBAs, cost perceptions, and weak rural infrastructure. Community engagement programs involving men and elders, combined with facility upgrades and respectful care training, could transform perceptions and utilization. Expanding insurance coverage or subsidy programs to rural women would reduce cost barriers, while integrating TBAs into referral systems could leverage cultural acceptance. Ultimately, sustainable strategies must combine health education, financial access, system strengthening, and governance reforms.

2.2 Theoretical Framework

2.2.1 Andersen's Behavioral Model of Health Service Utilization and Its Application to Facility Delivery Utilisation

The Andersen Behavioral Model of Health Service Utilization (BMHSU) is one of the most influential frameworks for explaining health service use. Originally introduced by Ronald Andersen in 1968, the model sought to explain the determinants that shape whether or not families in the United States obtained medical care.⁷⁵ Subsequent refinements broadened the model to capture individual, household, and contextual influences on healthcare use across both developed and developing nations.^{76,77}

In contrast to psychological theories such as the Health Belief Model, Andersen's approach highlights broader structural, economic, and social determinants of care-seeking while still accounting for individual characteristics. "Researchers across Africa, Asia, and Latin America have applied the model extensively to maternal-health studies, as it offers an integrated framework for examining disparities in facility-based delivery utilisation. The model has been widely applied to maternal health studies across Africa, Asia, and Latin America, providing a comprehensive lens through which to understand disparities in the use of facility-based delivery services. Its multidimensional nature makes it especially suited to exploring the interactions between knowledge, perceptions, barriers, and utilization, which form the core objectives of this study.

- **Key Domains of the Andersen Model**

The BMHSU explains health-service use as the outcome of three main categories predisposing, enabling, and need factors while later versions also include system-level and contextual influences.

- **Predisposing Factors**

These are socio-demographic characteristics that predispose individuals to use or not use health services. They include age, gender, marital status, education, religion, occupation, and health beliefs. Within maternal-health contexts, education serves as a critical predisposing factor, as educated women are better informed about the advantages of skilled delivery and more inclined to seek such care.³ Religion and cultural beliefs also play significant roles; for example, in northern Nigeria, restrictive cultural norms often discourage women from seeking facility delivery.²³

- **Enabling Factors**

Enabling conditions refer to the logistical and financial resources that facilitate or constrain access to healthcare services. Examples include household income, insurance coverage, transport availability, proximity to health facilities, and the presence of essential services. For pregnant women in Nigeria, enabling factors are often decisive. Even where awareness and favorable perceptions exist, barriers such as poor transport, high expenses, or inadequate staffing can still hinder utilisation. Doctor et al. demonstrated that rural women were less likely to use facility delivery due to financial and infrastructural barriers, even when they attended antenatal care.¹²

- **Need Factors**

Need factors relate to a person's actual or perceived state of health, shaping the extent to which services are deemed necessary. These can be perceived needs (a woman feels she may experience complications) or evaluated needs (a medical provider identifies risks). In maternal health, perceived need strongly influences delivery decisions. Women who recognize danger signs or who had prior negative birth experiences are more likely to seek skilled delivery.²⁰ However, cultural beliefs often minimize the perceived need, framing childbirth as a normal event rather than a potential medical emergency.²⁵

- **System and Contextual Factors**

Later refinements of the model incorporated health system and community-level influences. These include health policy, quality of care, provider attitudes, and cultural norms. For maternal health, system weaknesses such as staff shortages, lack of privacy, and disrespectful care discourage women from using facilities, even when they recognize the need.⁴¹

2.2.1.1 Applications of Andersen's Model in Health Service Research

The BMHSU has been used globally to study patterns of health service utilization, particularly for vulnerable populations. In maternal health, the model has been applied to explain why some women use facility delivery while others rely on traditional birth attendants (TBAs). In Ethiopia, Shiferaw et al. found that enabling factors (distance, cost, transport) and predisposing factors (education, parity) significantly predicted institutional delivery.²⁰ In Ghana, Ampofo et al. confirmed that enabling factors such as income and distance were stronger predictors than knowledge alone.²² In India, Lim et al. demonstrated that removing financial barriers through conditional cash transfers significantly increased utilization, underscoring the role of enabling factors.⁸⁸ In Nigeria, Onah et al. applied Andersen's model to analyze maternal health utilization in Enugu State.⁶⁹ They found that while predisposing factors such as education increased

likelihood of facility use, enabling factors such as poverty and institutional barriers were decisive. Similarly, Akinyemi et al. reported that poor women without health insurance were least likely to deliver in facilities, regardless of knowledge levels.²⁴. These findings highlight how the Andersen model captures the interplay of structural and personal determinants.

- **Strengths and Limitations of the Andersen Model:** The strengths are the following:

Multidimensional Framework: The model integrates personal, social, economic, and systemic determinants, making it more comprehensive than purely psychological models.

Flexibility: It has been successfully applied across different countries and health systems, including maternal health.

Policy Relevance: The model points directly to structural barriers such as affordability, infrastructure, and provider attitudes, offering actionable insights for policymakers.

Dynamic Adaptability: Revised versions of the model incorporate system and community influences, making it more suited for low-resource settings.

- **Limitations are the following:** Underrepresentation of Psychological Factors: Unlike the

HBM, it does not deeply explore individual perceptions, attitudes, and beliefs.

Complexity: Its multidimensional nature can make operationalization difficult, especially in small-scale studies.

Risk of Overgeneralization: While structural determinants are critical, the model may underemphasize how individual perceptions mediate utilization.

2.2.1.2 Application of the Andersen Model to This Study

In the present study on knowledge, perception, barriers, and utilization of facility delivery in Ado Local Government, Ekiti State, Andersen's model provides a useful framework to situate the findings.

- **Objective 1 (Knowledge):** Knowledge functions as a predisposing factor, shaping health beliefs and initial attitudes toward facility delivery. Women with higher education or ANC attendance are more likely to have greater knowledge, predisposing them toward utilization.
- **Objective 2 (Perception):** Perception represents a blend of predisposing factors (beliefs, values) and system/contextual factors (provider attitudes, cultural compatibility). Positive perceptions predispose women to utilize facilities, while negative perceptions act as deterrents.
- **Objective 3 (Barriers):** Socio-cultural, economic, and institutional barriers map directly onto enabling factors (financial resources, access, transport) and system/contextual factors (health worker attitudes, facility infrastructure). These barriers often determine whether women who are predisposed to facility use can actually realize that intention.
- **Objective 4 (Perception and Utilization):** The relationship between perception and utilization can be analyzed as an interaction between predisposing and enabling factors. For example, a woman may perceive facility delivery positively but fail to utilize it due to financial constraints or distance. Conversely, positive perceptions combined with strong enabling conditions (e.g., free maternal care, nearby facilities) lead to higher utilization.

2.2.2. Health Belief Model

One theory that is particularly suitable for the study is the Health Belief Model (HBM). The Health Belief Model (HBM) is one of the most widely used theoretical frameworks in health behavior research. Developed in the 1950s by social psychologists Hochbaum, Rosenstock, and Kegels in the U.S. Public Health Service, the model was originally designed to explain why individuals failed to participate in programs aimed at preventing and detecting disease, such as tuberculosis screening⁸⁰. Over time, the model was expanded and refined by Becker and others, and it has since been applied to a wide range of health behaviors, including vaccination uptake, chronic disease management, reproductive health, and maternal health service utilization⁸¹.

At its core, the HBM posits that individuals' engagement in health-related behaviors is shaped by their beliefs about health threats and the perceived benefits and barriers of taking preventive action. The model assumes that health behavior is primarily determined by individual perceptions rather than by objective reality. For maternal health, and specifically facility delivery, this implies that women's decisions are influenced not only by the actual risk of complications but also by how they perceive such risks and the benefits of seeking skilled care.

The enduring strength of the HBM lies in its simplicity and adaptability across different cultural and epidemiological contexts. It provides a psychological lens for understanding why some pregnant women adopt safe maternal practices, such as delivering in health facilities, while others persist with risky traditional practices despite the availability of biomedical care.

- **Perceived Susceptibility:** This refers to an individual's belief about their likelihood of experiencing a health problem. In the context of childbirth, a pregnant woman who believes she is at risk of complications (such as obstructed labor or hemorrhage) is more

likely to seek skilled delivery services. However, empirical evidence suggests that many women, especially in rural Africa, underestimate their susceptibility and view childbirth as a natural process that rarely requires medical intervention.²⁵

It aims to explain and predict health-related behaviors by focusing on the attitudes and beliefs of individuals. The basic assumption of the HBM is that a person's health behaviors are influenced by their perceived susceptibility to a health issue, their perceived severity of that issue, the benefits of taking a preventive action, and the barriers to taking that action. Additionally, the model incorporates the concept of cues to action, which are factors that can prompt an individual to engage in health-promoting behavior.

- **Perceived Severity:** Perceived severity concerns beliefs about the seriousness of a health condition and its potential consequences. In maternal health, this includes recognition that complications can lead to death, disability, or long-term health problems for the mother and baby. When women perceive childbirth complications as severe, they are more likely to take preventive measures by delivering in facilities. However, cultural beliefs sometimes frame maternal deaths as acts of fate or divine will, which diminishes perceived severity²⁶.

The key argument of the Health Belief Model is that individuals are more likely to engage in health-related behaviors if they perceive a health threat as severe and believe that taking preventive action will reduce that threat. In the context of pregnant women, this means that a woman's decision to deliver in a health facility may be influenced by her perceived risk of complications during childbirth, as well as her belief in the efficacy of medical interventions provided in these settings. For instance, if a woman perceives childbirth as a dangerous event, she may be more inclined to seek the safety and professional care offered at a healthcare facility.

On the other hand, if she believes that the risk of complications is low or that home births are equally safe, she may opt to deliver outside of a facility.

- **Perceived Benefits:** This construct highlights the individual's belief in the effectiveness of a health action in reducing risk or severity. For pregnant women, perceived benefits may include safe delivery, availability of skilled attendants, access to emergency interventions, and improved neonatal survival. When women believe that facility delivery offers tangible health benefits, they are more likely to utilize it. Studies in Nigeria show that women who perceive health facilities as capable of handling complications have significantly higher institutional delivery rates¹².

The HBM suggests that women will weigh the perceived benefits of institutional delivery, such as the availability of skilled attendants and emergency interventions, against the perceived barriers, which may include cost, distance, or cultural beliefs. A critical assumption of the Health Belief Model is that the perceived severity of a health threat plays a vital role in the decision-making process. If a pregnant woman perceives childbirth as potentially life-threatening or believes that there is a significant risk to the health of either herself or her baby, she is more likely to seek facility-based care. This aligns with studies that show that women who are aware of the risks associated with home births, such as maternal and neonatal mortality, are more likely to choose healthcare facilities for delivery. Conversely, when women do not perceive childbirth as a risky event or are unaware of the potential complications, they may be less motivated to utilize available healthcare services. This illustrates the importance of raising awareness among pregnant women about the potential risks and complications of childbirth, as well as the benefits of institutional care.

- **Perceived Barriers:** Even when susceptibility, severity, and benefits are acknowledged, perceived barriers often inhibit action. These barriers can be financial (cost of services, transport), social (spousal or family opposition), cultural (preference for traditional birth attendants), or institutional (negative staff attitudes, long waiting times, lack of privacy). In Nigeria, barriers are among the strongest predictors of non-utilization of health facilities, particularly in rural communities⁶⁹.

The model also emphasizes the role of perceived benefits and barriers in influencing health decisions. For pregnant women, the perceived benefits of facility-based delivery include access to skilled care, medical interventions, and a safe environment for childbirth. These benefits can increase the likelihood of facility-based deliveries, especially when women are educated about the quality of care available. However, the barriers to utilizing healthcare services, such as financial costs, lack of transportation, or cultural norms that favor home births, can hinder women's utilization of these services. The Health Belief Model highlights that the greater the perceived barriers, the less likely an individual is to engage in a health-promoting behavior. Therefore, addressing these barriers such as providing affordable care, improving transportation, and addressing cultural misconceptions could enhance the uptake of facility-based delivery.

- **Cues to Action:** Cues to action are triggers that motivate individuals to adopt health behaviors. These may be internal (e.g., experiencing pain or fear of complications) or external (e.g., health education during antenatal care, advice from family, community campaigns, or media). In maternal health, ANC visits serve as major cues by providing women with critical information about the importance of facility delivery²⁰.

Cues to action is another important aspect of the Health Belief Model is the concept of cues to action, which refers to triggers that prompt individuals to take action. In the case of pregnant

women, cues to action may include advice from healthcare providers, encouragement from family members, or community-based health education programs. These cues can act as catalysts for women to seek professional care during delivery. For example, a woman who is informed by a healthcare provider about the importance of skilled care during childbirth may be more likely to choose a facility-based delivery. Similarly, community health campaigns that promote the safety and benefits of facility deliveries can serve as important cues to action that influence women's decisions. Thus, incorporating strategies that provide timely information and support from trusted sources can be effective in encouraging the use of facility delivery services.

In relation to the study on the perception of pregnant women towards facility delivery and factors militating against its utilization, the Health Belief Model can offer valuable insights into the decision-making process. By understanding the perceived susceptibility and severity of risks, as well as the benefits and barriers to facility delivery, healthcare providers and policymakers can design more targeted interventions to improve the utilization of facility-based delivery services. For instance, addressing perceived barriers such as transportation costs and cultural beliefs could help reduce the gap between the ideal situation of facility-based delivery and the current utilization rates.

Furthermore, the Health Belief Model can be applied to explore how cues to action, such as health education and support from community leaders, can encourage pregnant women to seek care in healthcare facilities. Women who receive timely information and support are more likely to perceive the benefits of facility delivery as outweighing the perceived barriers. Thus, interventions that enhance women's awareness of the risks associated with childbirth and the safety of institutional delivery could effectively increase the uptake of these services. The Health Belief Model highlights the importance of addressing both the cognitive and environmental

factors that influence health behavior, making it a valuable framework for understanding and improving maternal healthcare outcomes.

- **Self-Efficacy:** Self-efficacy, later added to the model, refers to the individual's confidence in their ability to perform the desired behavior. In facility delivery, self-efficacy includes a woman's belief that she can overcome barriers such as negotiating with her husband, arranging transport, or insisting on her right to respectful care. Women with high self-efficacy are more likely to plan for and complete institutional delivery despite obstacles.
- **Strengths and Limitations of the Health Belief Model:** The strength of the HBM are the following: Simplicity and Clarity: The HBM provides clear, measurable constructs that are easy to apply in survey research and intervention design.
- Flexibility: It can be adapted to a wide range of health behaviors, including preventive and curative actions.
- Predictive Value: Numerous empirical studies confirm that HBM constructs significantly predict maternal health behaviors.

Practical Utility: It offers a framework for designing educational interventions that target specific beliefs (e.g., increasing perceived severity or reducing barriers).

- **The Limitations are the following:** Individual Focus: The HBM emphasizes individual perceptions but underplays social, cultural, and structural determinants. For instance, even if a woman perceives high susceptibility, she may still be unable to act due to lack of resources or spousal opposition.
- Static Nature: The model does not account for behavior change over time or the influence of social dynamics.

- **Overemphasis on Rational Decision-Making:** The HBM assumes individuals make rational health decisions based on beliefs, but in reality, behavior is also influenced by emotions, habits, and power dynamics.
- **Limited Applicability in Low-Resource Settings:** In contexts like rural Nigeria, structural barriers such as poor infrastructure or absent health workers may override individual perceptions.

2.2.2.1 Applications of the Health Belief Model in Maternal Health

The HBM has been widely applied to explain maternal health behaviors in diverse contexts.

In Ethiopia, Tura et al. used HBM constructs to study institutional delivery and found that perceived susceptibility, perceived severity, and cues to action were significant predictors³⁸.

Women who believed in their vulnerability to complications and recognized the seriousness of childbirth risks were more likely to seek facility delivery.

In Ghana, Ampofo et al. reported that women who perceived high benefits from skilled care, such as reduced risk of complications, were more likely to deliver in health facilities.²² The study also noted that perceived barriers particularly costs and cultural preferences remained strong deterrents.

In Nigeria, Odetola studied adolescent mothers and found that low perceived susceptibility and severity contributed to low utilization of skilled delivery.²⁸ Similarly, Okafor et al. found that perceived provider attitudes strongly influenced perceptions of benefits and barriers, affecting women's delivery choices³¹.

Globally, Bohren et al. highlighted that mistreatment during childbirth undermines women's perceptions of benefits while reinforcing barriers, leading many to avoid facilities. These findings affirm the relevance of HBM in explaining not only utilization but also non-utilization of maternal health services⁴¹.

2.2.2.2. Application of the Health Belief Model to this Study

The present study in Ado Local Government, Ekiti State investigates knowledge, perception, barriers, and utilization of facility delivery. The HBM provides a strong theoretical foundation for interpreting these relationships:

- **Objective 1(Knowledge):** Knowledge is closely linked to perceived susceptibility and severity. Pregnant women who are aware of obstetric danger signs are more likely to feel vulnerable and recognize the seriousness of complications, which should increase their likelihood of delivering in facilities.
- **Objective 2 (Perception):** Perceptions align with perceived benefits and barriers. Women who perceive facility delivery as beneficial and safe are more likely to use it, while those perceiving barriers such as cost, distance, or negative provider attitudes are less likely.
- **Objective 3 (Barriers):** Barriers are explicitly part of the HBM, explaining why some women fail to act even when they have knowledge and positive perceptions.
- **Objective 4 (Perception and Utilization):** The HBM directly explains the link between perception and utilization by showing how perceived benefits, barriers, and cues to action translate into behavior.
- **Policy and Practice Implications:**

Health education campaigns should increase perceived susceptibility and severity by emphasizing real maternal mortality risks. Community outreach should highlight the benefits of facility delivery while addressing misconceptions. Reducing perceived barriers requires improving affordability, accessibility, and respectful maternity care. Strengthening cues to action (e.g., through ANC visits, media messages, or SMS reminders) can prompt women to choose facilities. Building women's self-efficacy through empowerment initiatives and involving husbands in maternal health education can enhance utilization.

The Health Belief Model provides a useful psychological framework for understanding facility delivery utilization. By focusing on women's beliefs about susceptibility, severity, benefits, and barriers, it explains why knowledge and perception shape behavior. While limited by its individual focus, the HBM remains relevant for interventions that target maternal health beliefs and behaviors in Nigeria. In Ado Local Government, Ekiti State, applying the HBM allows this study to uncover how women's knowledge and perceptions interact with barriers to influence their utilization of facility delivery services.

2.3 Review of Empirical Studies

2.3.1 Empirical Studies on Knowledge of Pregnant Women Towards Facility Delivery

A substantial body of research has examined women's knowledge as a determinant of facility delivery utilization. Empirical findings consistently highlight that adequate knowledge of obstetric danger signs, skilled birth attendance, and the benefits of institutional delivery are positively associated with uptake of maternal health services. For instance, Yaya et al. conducted a cross-sectional study using Demographic and Health Survey (DHS) data from 28 sub-Saharan African countries and found that women who demonstrated knowledge of

pregnancy complications were twice as likely to deliver in health facilities compared to those with limited awareness.³ This large-scale study underscores the regional importance of knowledge in shaping maternal health behaviors.

In Nigeria, empirical studies provide similar evidence. Oladapo et al., in a community-based study in Oyo State, revealed that only 42% of women could identify at least three obstetric danger signs, and this knowledge was strongly associated with institutional delivery.⁴⁰ The study used structured questionnaires with over 500 respondents, offering robust statistical validity. However, it was limited by its reliance on self-reported measures, which may have overestimated knowledge. In Sokoto State, Sulaiman et al. found that women with higher knowledge levels were four times more likely to utilize health facilities, suggesting that awareness of risks directly influences decision-making.²³ Evidence also points to antenatal care (ANC) as a major knowledge source. Doctor et al. analyzed ANC attendance data across multiple Nigerian states and found that women who attended four or more ANC visits had significantly higher knowledge of facility delivery benefits.¹² Similar patterns were documented in Ethiopia by Shiferaw et al., where ANC education increased both knowledge and actual delivery in facilities.²⁰ However, qualitative work by Oyediji et al. in Ekiti State highlighted that while many women expressed general awareness of facility delivery, their knowledge was partial often restricted to routine care and not extending to an understanding of obstetric emergencies.⁴⁵

Collectively, empirical studies demonstrate that while knowledge is a critical determinant, it is often unevenly distributed across regions, socio-economic groups, and age categories. Adolescent mothers, in particular, consistently show knowledge gaps, as seen in Odetola's study of young mothers in Nigeria. This highlights the need for targeted knowledge interventions²⁸.

2.3.2 Empirical Studies on Perceptions of Pregnant Women Towards Facility Delivery

Perception studies go beyond awareness, examining how women interpret and emotionally respond to health services. Globally, Bohren et al. conducted a systematic review across ³⁴ countries and reported widespread perceptions of mistreatment and lack of dignity in facility delivery, discouraging utilization.⁴¹ These perceptions were not only based on actual experiences but also community narratives and expectations.

In Nigeria, Okafor et al. found that women's perceptions of provider attitudes strongly predicted utilization³¹. Their survey in Anambra State showed that women who perceived care as respectful were three times more likely to use facilities. Conversely, those who expected verbal abuse or neglect preferred TBAs. Similarly, Mbachu et al. reported that negative perceptions of infrastructure such as lack of privacy and overcrowding discouraged women despite their awareness of risks³⁹.

Qualitative studies provide deeper insights into perceptions. Ononokpono and Odimegwu, using interviews in Akwa Ibom, highlighted that cultural perceptions of childbirth as a natural, non-medical event reduced institutional delivery.²⁵ Adedokun and Uthman further revealed that perceptions of TBAs as supportive and culturally aligned created competition for hospitals.²⁶ In Ekiti State, Oyediji et al. observed that women perceived facilities as necessary for emergencies but not for routine births, indicating a dualistic perception that undermines proactive facility utilization.⁴⁵ These findings demonstrate that perceptions of care whether about staff behaviour, cultural alignment, cost, or quality are powerful determinants of utilization. Importantly, they reveal that negative perceptions often outweigh knowledge, highlighting perception as a critical mediator.

- **Empirical Studies on Socio-Cultural, Economic, and Institutional Barriers**

Empirical evidence across Africa shows that barriers are multi-dimensional, intersecting socio-cultural norms, financial constraints, and weak health systems. Gabrysch and Campbell, in their seminal review of barriers to facility delivery, found that distance, cost, cultural beliefs, and perceptions of low quality were consistent predictors of home births¹⁹. Their review synthesized over ⁸⁰. Studies, making it a key reference for understanding the complexity of barriers.

In Nigeria, Onah et al. conducted a cross-sectional study in Enugu State and found that lack of decision-making autonomy, poverty, and poor provider attitudes were the strongest barriers to facility delivery.⁸⁶ Similarly, Okonofua et al., in evaluating maternal deaths in Edo State, identified weak referral systems, absent staff, and financial barriers as institutional challenges that discouraged utilization.⁸ These findings illustrate how systemic weaknesses reinforce cultural reliance on TBAs. Economic barriers are repeatedly highlighted in empirical research. Akinyemi et al., analyzing NDHS data, showed that perceived and actual costs significantly reduced utilization, particularly among poor and rural women.²⁴ Hidden costs, such as transportation and unofficial fees, were also reported in doctor et al.'s study.¹² In Ekiti, Oyediji et al. found that poor rural infrastructure and staff absenteeism compounded barriers, reinforcing traditional alternatives⁴⁵.

Cultural barriers remain particularly strong in northern Nigeria. Sulaiman et al. demonstrated that women's mobility restrictions, modesty concerns, and family decision-making norms severely limited facility utilization.²³ These findings highlight how socio-cultural barriers intersect with institutional weaknesses to sustain high maternal mortality rates

- **Empirical Studies Linking Perception and Utilisation of Facility Delivery**

Direct empirical evidence linking perception to utilization is growing. Shiferaw et al. in Ethiopia found that women with positive perceptions of facility quality were five times more likely to deliver in health facilities.²⁰ Similarly, Tura et al. reported that perceptions of respectful care significantly predicted utilization, independent of knowledge.^{43,48}

International studies also provide evidence. In Nepal, Karkee et al. reported that women's negative perceptions of staff attitudes discouraged facility use despite high awareness levels.¹⁸ In Ghana, Ampofo et al. noted that positive perceptions fostered shifts from TBAs to hospitals.²² Collectively, these studies confirm that perception is not only associated with but often decisive in determining utilization. In Nigeria, Onah et al. and Okafor et al. both found strong associations between perception and utilization, reinforcing that perceptions of quality, safety, and provider attitudes are decisive.^{69,31} Oyedepi et al. in Ekiti added nuance, noting that women's perceptions of hospitals as "places for emergencies only" reduced routine facility deliveries.⁴⁵ This shows how perceptions can redefine the role of institutions in community health-seeking practices.

- **Empirical Studies on Strategies to Improve Utilisation of Facility Delivery**

Intervention studies provide valuable insights into what works to improve utilization. In Nigeria, Ondo State's Abiye (Safe Motherhood) program is one of the most cited examples. Okonofua et al. evaluated the program, which combined free maternal care, facility upgrades, and community engagement, and reported significant increases in facility delivery and reductions in maternal mortality.⁸ However, sustainability remained a concern after donor funding ended.

The Midwives Service Scheme (MSS), introduced nationally in 2009, sought to deploy midwives to rural areas. Abimbola et al. found that the scheme initially increased utilization but struggled with retention, funding, and community acceptance.⁷¹ This highlights that health system strengthening must be paired with sustainable governance.

Global lessons are also instructive. In India, Lim et al. evaluated the Janani Suraksha Yojana conditional cash transfer program, which significantly boosted institutional deliveries.⁸⁸ In Ethiopia, Shiferaw et al. reported success from combining CHW outreach, free services, and transport systems.²⁰ In Ghana, Ampofo et al. noted that integrating TBAs into referral networks improved uptake.²² These interventions show that multi-pronged approaches yield the best outcomes.

In Nigeria, smaller pilot programs using mobile technology (mHealth) also show promise. Adetunji et al. in Lagos demonstrated that SMS reminders significantly improved ANC attendance and facility delivery.¹⁵ Such approaches are particularly relevant in states like Ekiti, where mobile phone penetration is high.

- **Study Conducted on Factors Influencing the Utilization of Facility Delivery**

One empirical study conducted Gelagay sought to understand the factors influencing the utilization of facility-based delivery in rural Ethiopia.⁵² The objective of the study was to examine how socio-economic, cultural, and health system factors affected pregnant women's perceptions and their decisions regarding the place of delivery. The research was carried out among 1,500 pregnant women in selected districts of Ethiopia, with the aim of identifying the key barriers and facilitators to the uptake of facility delivery services. The study concluded that the majority of women who delivered at home did so due to perceived financial constraints, lack of transportation, and cultural norms favoring home births. The researchers recommended

improving access to healthcare facilities by enhancing transportation options and providing more affordable delivery services. They also emphasized the importance of culturally sensitive health education campaigns to address misconceptions about facility delivery and its benefits.

In another study conducted²⁶ the researchers focused on assessing the perceptions of pregnant women towards facility-based delivery services in Northern Ethiopia.⁶³ The study included a sample of 1,200 pregnant women, with the primary aim of identifying the socio-cultural and individual factors that influence women's choices regarding delivery services. The research highlighted that many women perceived healthcare facilities as offering a higher level of safety during childbirth, but barriers such as long distances, high costs, and a lack of skilled personnel were significant deterrents. The study concluded that improving the quality of care in health facilities, along with policies that subsidize transportation and service costs, could significantly improve the uptake of facility deliveries. The authors recommended further strengthening the healthcare system by recruiting and training more skilled birth attendants and improving infrastructure in rural areas to make facilities more accessible to pregnant women.

Pathak and Ghimire conducted an empirical study to explore the factors influencing the utilization of facility-based delivery among pregnant women in rural Nepal.³⁵ The study aimed to identify the socio-economic, cultural, and health system-related barriers to institutional delivery. The researchers used a sample of 1,000 women who had recently given birth, with a focus on those who chose home deliveries over facility-based ones. The study found that women's perceptions of delivery safety in healthcare settings were influenced by the availability of skilled care, as well as the quality of care received. However, it also revealed that traditional beliefs and the fear of medical interventions were common reasons for avoiding facility-based deliveries. The researchers concluded that a more community-centered approach to maternal health,

including improved health education and the involvement of local leaders in promoting institutional deliveries, would be effective in overcoming barriers. The study recommended increasing public awareness of the safety and benefits of institutional deliveries.

In a study conducted by Bolarinwa the researchers aimed to investigate the factors influencing the decision to deliver in health facilities among pregnant women in rural Nigeria.⁶⁶ The study involved 1,200 women from various rural communities, with a particular focus on understanding how perceptions of healthcare quality and accessibility shaped their delivery choices. The study concluded that while many women acknowledged the benefits of facility delivery, such as access to skilled birth attendants and emergency obstetric care, they were deterred by logistical issues like transportation and the high costs associated with facility-based care. Additionally, cultural preferences for home births and a lack of trust in healthcare providers were significant barriers. The researchers recommended that the government increase investment in healthcare infrastructure and provide subsidies to pregnant women in rural areas to make healthcare services more accessible and affordable. They also suggested incorporating local traditional birth attendants into the healthcare system to increase trust in facility deliveries.

Guthrie conducted a study in Ethiopia to assess the perceptions of pregnant women regarding the safety and quality of facility-based delivery services.⁸² The study, which included 1,500 participants, aimed to determine how women's perceptions of healthcare quality and safety influenced their decision to deliver in a healthcare facility. The researchers found that most women perceived health facilities as offering a safer environment for delivery due to the availability of skilled professionals and medical equipment. However, logistical barriers, such as long travel distances, were significant obstacles to accessing facility-based care. The study concluded that increasing the number of healthcare facilities in rural areas and providing

transportation assistance would improve the utilization of institutional deliveries. The researchers recommended strengthening the healthcare workforce to ensure quality services and suggested that local communities be involved in the promotion of facility deliveries through awareness programs.

A study by Susanti examined the factors influencing the utilization of facility-based delivery among pregnant women in Indonesia.⁸³ The study included 1,000 women who had given birth in the past year and aimed to identify the socio-economic and cultural factors that affected their delivery choices. The research found that most women who opted for home deliveries cited cultural norms and perceived financial constraints as the main reasons for avoiding facility-based care. However, the study also noted that women who had previous positive experiences with healthcare services were more likely to choose institutional deliveries. The study concluded that improving the quality of care in health facilities, along with reducing financial barriers through insurance schemes, could increase the uptake of facility-based deliveries. The researchers recommended conducting more community-based education programs to address misconceptions about the safety misconceptions about the safety and advantages of institutional delivery.

2.4 Conceptual Model

INDEPENDENT VARIABLE

DEPENDENT VARIABLE

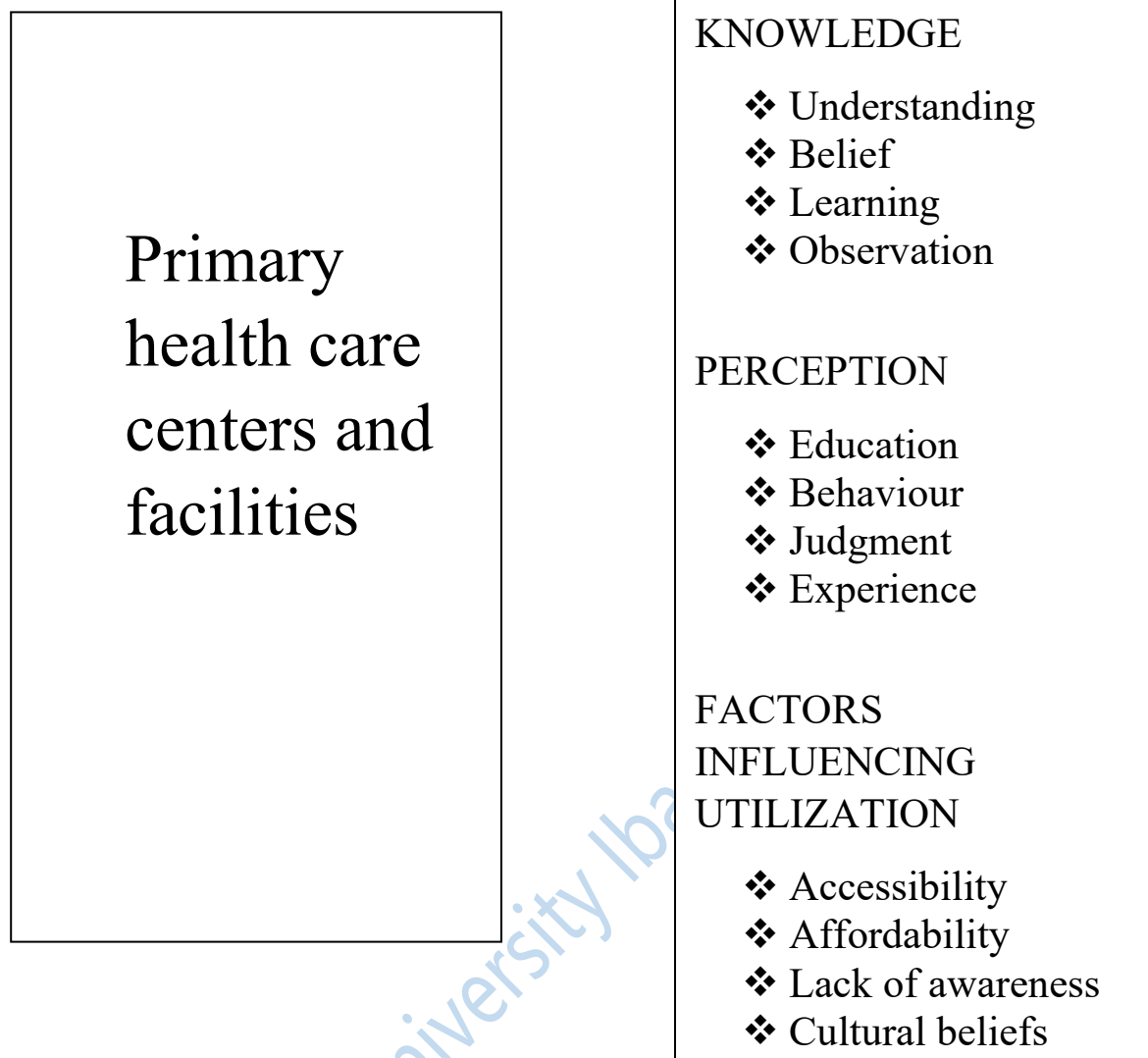


Figure 2.1 conceptual Model for the study.

Source: Researcher's conception, 2025

2.5 Summary of Gaps in the Literature Reviewed

The reviewed literature on the knowledge, perception of pregnant women towards facility delivery and the factors influencing its utilization highlights various factors influencing women's choices about childbirth. Several studies indicate that women's perceptions of safety,

accessibility, quality of care, and cultural beliefs significantly shape their decision to deliver in health facilities. Barriers such as financial constraints, distance to healthcare centers, lack of skilled personnel, and cultural preferences for home births are consistently cited as key deterrents. Additionally, research shows that the quality of healthcare facilities and trust in healthcare providers play critical roles in influencing pregnant women's delivery decisions.

However, despite the extensive research, gaps remain, particularly concerning the specific context of Ado Local Government Area, Ekiti State. Limited studies focus on this region, leaving a gap in understanding how local socio-cultural factors, healthcare infrastructure, and maternal health education influence the uptake of facility-based deliveries. This study aims to fill this gap by providing localized insights into the factors shaping pregnant women's perceptions and decisions in this area.

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Chapter Three

Methodology

3.1 Research Design

This study adopted descriptive survey research designs to investigate the Pregnant Women' knowledge, perception, and utilisation of facility delivery in Ado Local Government Area (LGA), Ekiti State. The design was considered appropriate because it allows data collection from a defined population at a single point in time to describe prevailing conditions and relationships among variables. The descriptive design facilitated the measurement of pregnant women's knowledge and perceptions regarding facility delivery, while the cross-sectional approach enabled an assessment of associations between socio-demographic, cultural, and institutional factors and the utilisation of health facilities for childbirth.

3.2 Population of the Study

Population of this study consists of pregnant women receiving antenatal care ANC services in selected health facilities or residing within Ado Local Government Area during the study period.

The study was conducted at Ado Local Government Area (LGA) of Ekiti State, located in the southwest geopolitical zone of Nigeria. Ado LGA serves as the state capital and is one of the most urbanized parts of Ekiti State. It has a population of approximately 156,122 people according to the 2006 National Population Census, with projections suggesting growth to over 250,000 by 2025.

It's a significant urban and industrial center, known for its high population density and diverse workforce. It is the most populous area in the state. The area is characterized by its Yoruba

culture and traditions, with Ado-Ekiti holding a central place in Ekiti's history and development. Ado-Ekiti Local Government is a one town local Government that doubles as Local Government and State headquarter which is about 200m above sea level in the south eastern part of Ireje stream and 500m above sea level in the North east limit.

Ado LGA lies between latitude $7^{\circ}35'N$ and longitude $5^{\circ}13'E$ and shares boundaries with Irepodun/Ifelodun, Ikere, and Ido-Osi LGAs. The area has both urban and semi-urban communities, including Ajilosun, Okeyinmi, Adebayo, and Irona. The population is largely composed of civil servants, traders, artisans, and farmers. Educational attainment is relatively high compared to many rural parts of the state, yet health-seeking behavior remains influenced by cultural and economic factors. Ado LGA hosts a range of public and private health facilities, including the Ekiti State University Teaching Hospital (EKSUTH), several general hospitals, primary health centers, and maternity homes. Despite this concentration of facilities, a proportion of women still patronize traditional birth attendants (TBAs) for childbirth due to factors such as cost, accessibility, and perception of care. Ado Local Government Area (LGA) in Ekiti State has 13 wards and 27 PHCs. Each ward has at least one Primary Health Centre (PHC). The facilities provide varying levels of maternal health services, referral services for obstetric emergencies.

Inclusion criteria: Women who were currently pregnant at the time of data collection, Women who had resided in Ado LGA for at least six months, Women who consented to participate.

Exclusion criteria: Women with serious medical or psychological conditions that could hinder participation, Visitors or non-residents of Ado LGA.

The estimated target population was drawn from records of antenatal attendance across selected health facilities for 3months which indicated a registration of approximately 3672 pregnant women across the LGA.

3.3 Sample and Sampling Technique

The sample size for this study was determined using Cochran's (1963) formula for sample size calculation, which is appropriate for large populations where the proportion of the population with the attribute of interest is unknown. The formula is expressed as:

Assumption

$$n_0 = \frac{Z^2 P(1 - P)}{e^2}$$

Where:

n_0 = desired sample size (for an infinite population)

Z = standard normal deviation at 95% confidence level (1.96)

p = estimated proportion of the target population (0.5 was used to maximize sample size)

e = margin of error (0.05)

$$n_0 = \frac{(1.96)^2 \times 0.5(1 - 0.5)}{(0.05)^2}$$

$$n_0 = \frac{3.8416 \times 0.25}{0.0025} = 384.16$$

Since the total population of pregnant women attending antenatal clinics in the selected Primary Health Care facilities within Ado Local Government Area was 3,672, the finite population correction (FPC) was applied using the formula:

$$n = \frac{n_0}{1 + \frac{n_0 - 1}{N}}$$

$$n = \frac{384.16}{1 + \frac{384.16 - 1}{3672}}$$

$$n = \frac{384.16}{1.104} = 348$$

Having known the minimum sample size calculated to be 348 To calculate the non-responses or incomplete response rate, making use of division formula method for possible attrition rate:

$$n_f = \frac{n}{(1-f)}$$

n_f = desired sample size

n = Minimum sample size calculated = (348)

1 = constant value

f = attrition rate (10% = 0.1)

$$n_f = \frac{348}{(1-0.1)}$$

$$n_f = \frac{348}{(0.9)} = 382.8 \text{ Approx } 383 \text{ participants}$$

Thus, the calculated sample size was **348**. To accommodate possible non-response or incomplete data, an additional **10%** (≈ 35 respondents) was added, resulting in a final sample size of **approximately 383 participants**.

A multistage sampling technique was employed:

Selection of wards – Out of the 13 political wards in Ado LGA, five wards were randomly selected using simple random sampling (see Table 3.1).

Selection of health facilities – PHCs of high flows were selected from each chosen ward using purposive sampling based on their ANC attendance (see Table 3.2.3.3)

Selection of respondents – Systematic random sampling was used to select pregnant women attending ANC. The sampling interval (k) was determined by dividing the estimated number of ANC attendees per week by the sample size required per facility.

Table 3.1: Distribution of Primary Health Care (PHC) Facilities by Political Wards in Ado Local Government Area

Political Ward	Primary Health Care Facilities (PHCs)	Number of PHCs per Ward
Ago Ward	PHC Ago Aduloju; PHC Emirin; PHC Erifun; PHC Temidire	4
Basiri Ward	PHC Basiri	2
Igirigi Ward	PHC High Court	1
Ekute Ward	PHC Oke Oniyo; PHC Igirigi	2
Ijigbo Ward	PHC Idolofin	1
Irona Ward	PHC Irona; PHC Oke Osun; PHC Oke Aso; PHC	4

Political Ward	Primary Health Care Facilities (PHCs)	Number of PHCs per Ward
	Adere	
Odo Ward	PHC Odo Ado; PHC Idolofin	2
Oke Ila Ward	PHC Housing; PHC Igbaye; PHC Ilamuo	4
Okesa Ward	PHC Okesa	1
Okeyinmi Ward	PHC FSP, PHC Market	2
Opopo Ward	PHC Opopo; PHC Olorunda Orungbe	3
Ureje Ward	PHC Moferere; PHC Olujoda;	2

Source: Researcher's Field work 2025

Table 3.2: Selected Health Facilities by Political Ward in Ado Local Government Area

Ward	Selected Health Facility
Okesa Ward	Okesa Comprehensive Health Centre (CHC)
Irona Ward	Basic Health Centre (BHC) Irona
	Basic Health Centre (BHC) Adere

Ward	Selected Health Facility
Ago Ward	Basic Health Centre (BHC) Emirin
Ekute Ward	Basic Health Centre (BHC) Oke Oniyo
Odo Ward	Basic Health Centre (BHC) Odo Ado
Oke Ila Ward	Basic Health Centre (BHC) Housing
Opopo Ward	Basic Health Centre (BHC) Opopogbooro

Source: Researcher's Fieldwork, 2025.

Table 3.3: Antenatal Care Attendance Records from May to July 2025

Health Facility	May	June	July
Basic Health Centre (BHC) Adere	27	24	29
Basic Health Centre (BHC) Irona	134	104	113
Comprehensive Health Centre (CHC) Okesa	660	577	703
Basic Health Centre (BHC) Emirin	66	69	103
Basic Health Centre (BHC) Oke Oniyo	111	136	165
Basic Health Centre (BHC) Odo Ado	127	101	148

Health Facility	May	June	July
Basic Health Centre (BHC) Opopogbooro	57	52	62
Primary Health Centre (PHC) Housing	26	28	50
Sub-total	1208	1091	1373
Total			3672

Source: Author's Computation (2025).

The selected health facilities include Okesa Comprehensive Health Centre, Irona Basic Health Centre, Oke Oniyo Basic Health Centre, Emirin Basic Health Centre, Odo Ado Basic Health Centre, Housing Basic Health Centre, Adere Basic Health Centre, Opopogbooro Basic Health Centre, within Ado Local Government Area, Ekiti State.

3.4 Description of the Research Instrument

A validated structured questionnaire was used for this study. A survey containing series of questions was administered to the enrolled respondents in relation to the variables to be measured in this research study. The questionnaire was divided into four sections.

Section A: This section enquires about the response's demographic or personal data, and it contains nine -number of questions items

Section B; This section was used to elicit information on knowledge of pregnant women on facility delivery, and it contained six number of questions items

Section C: This section elicits information on perception of pregnant women of facility delivery, and it will contain seven number of question items.

Section D: This section elicits information on factors Influencing the utilisation of facility delivery, it contained eight number of question items while the other sections were in line with the study objectives, aimed at providing answers to the research questions. Participants were required to respond by placing a tick at the appropriate column.

3.5 Validity of the Research Instrument

The instruments were validated through content and face validation. Draft versions of the questionnaire were reviewed by three experts in maternal and child health, public health, and research methodology from Ekiti State University. Their feedback was used to refine ambiguous items, ensure cultural appropriateness, and align questions with the study objectives. A pre-test was also conducted among 30 pregnant women in Irepodun/Ifelodun LGA (outside the study area). The pre-test helped to assess clarity, sequence, and respondent understanding. Modifications were made accordingly to improve the instrument's validity.

3.6 Reliability of the Research Instrument

Reliability was established using the Cronbach's Alpha method to measure internal consistency of the Likert-scale items. A pilot test involving 30 respondents produced a reliability coefficient of $\alpha = 0.82$, indicating good reliability (values above 0.70 are considered acceptable).

3.7 Method of Data Collection

Ethical Approval

A letter of introduction was collected from the Head of Nursing Department, Lead City University, Ibadan. Ethical approval for the study was obtained from the Ethical Review Committee of the Ekiti State Ministry of Health. Permission was also sought from heads of the selected health facilities before data collection. Participants were informed about the purpose of

the study, confidentiality of responses, voluntary participation, and their right to withdraw at any point without consequences. Verbal and written informed consent were obtained prior to participation. A validated structured questionnaire was used to collect data from pregnant women in selected facilities in Ado Local Government Area, Ekiti State. The questionnaire was designed in English, respondents were allowed to fill the questionnaire independently, with the help of a research assistants who had been trained along the study variables. Questionnaire was administered by the principal investigator and two trained research assistants. The purpose of the study was explained to the respondents and consent from each participant was obtained before questionnaire are administered. The respondents were given 10-15 minutes to fill the questionnaire and the research was carried out for a period of 4 weeks. The questionnaire was retrieved on the spot after completion to avoid loss and ensure 100% response rate. The researcher met the study participants in the Ante natal clinic in All data was anonymized and securely stored; access will be restricted to the research team. The study adhered to the principles of respect for persons, beneficence, and justice as outlined in the Belmont Report

3.8 Method of Data Analysis

The collected data was coded and imputed into the computer using the Statistical Package for the Social Sciences (SPSS) version 26. Results were analyzed using both descriptive statistics in form of frequency counts, percentage, mean, and standard deviation and were used to summarize socio-demographic data and responses on knowledge, perception, and utilisation. Inferential statistics like Chi-square was used to assess relationships among variables (example, between perception and utilisation). The significance level will be set at $p < 0.05$

Endnote

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Chapter Four

Results and Discussion of Findings

This chapter presents the results of the study. The findings are organized to address the study objectives, which sought to assess the level of knowledge of pregnant women on utilisation of facility delivery, assess the perception of pregnant women towards facility delivery identify the factors that influence utilisation. Data were analyzed using descriptive and inferential statistics, including frequencies, percentages Chi square tests. The results were presented in tables and narratives to provide a clear understanding of the knowledge, perception and factors influencing the utilisation of health facility for delivery.

The chapter is presented under the following sub-headings:

4.1 Presentation of demographic information of respondents

4.2 Data analysis and presentation based on research questions

4.3 Inferential Statistics

4.1 Demographic Data Analysis

This section comprises of the research summary examined from the demographic details of the respondents, and the major variables the demographic details of the respondents were captured.

Table 4.1aAge Group

		Frequency	Percent	Cumulative Percent
Valid	0-15years	1	.3	.3
	16-25years	108	28.2	28.5
	26-40years	260	67.9	96.3
	41-45years	14	3.7	100.0
	Total	383	100.0	

Source: Survey field 2025

Table 4.1a reveals the age group of the respondents, in which 258 (67.9%) fall within the 26–40 years age group (that is the highest proportion), followed by 108(28.2.%) aged 16–25 years, 14 (3.75.%) aged 41-45 years, and 0-15(0.3%) years. This distribution indicates that most participants are within the prime reproductive age, which aligns with typical maternal health demographic patterns. The smaller representation of older women could indicate reduced fertility or completed family size.

Table 4.1b: Marital Status of Respondents

		Frequency	Percent	Cumulative Percent
Valid	Divorced	25	6.5	6.5
	Married	281	73.4	79.9
	Separated	8	2.1	82.0
	Single	69	18.0	100.0
	Total	383	100.0	

Source: Survey field 2025

According to the table 4.1b, 281 respondents (73.4%) are married, 69 (18.0%) are single, 8 (2.1%) respondents are separated, and 25 (6.5%) are divorced. This distribution reveals that the overwhelming majority of respondents are married, reflecting the social norm of childbirth within marriage in Nigerian society. Marital status influences women's access to decision-making support and financial resources, which are vital for facility delivery. Conversely, single, separated, and divorced women may face challenges such as limited support or stigma, which could affect their delivery choices. The findings therefore suggest that maternal health interventions should involve spouses to sustain positive family support systems and also target single mothers to ensure inclusive access to safe facility delivery options in Ado LGA.

Table 4.1c: Religious Affiliation of Respondents

		Frequency	Percent	Cumulative Percent
Valid	Christianity	299	78.1	78.1
	Islam	78	20.4	98.4
	None	1	.3	98.7
	Traditional	5	1.3	100.0
	Total	383	100.0	

Source: Survey field 2025

Table 4.1c reveals that 299 respondents (78.1%) identified as Christians, 78 (20.4%) as Muslims, and 5 (1.3%) practice traditional religion. This distribution shows that Christianity and Islam are the predominant faiths in Ado LGA, with more than three-quarter as Christians consistent with Ekiti State's religious demographics. Religious orientation can influence maternal health behavior, especially beliefs about childbirth practices, healing, and medical intervention. The small proportion of traditional religion adherents suggests a minimal but relevant group that may still uphold traditional birthing norms.

Table 4.1d: Educational Qualification of Respondents

		Frequency	Percent	Cumulative Percent
Valid	Bachelor's degree	168	43.9	43.9
	Master's degree	31	8.1	52.0
	Primary 6 certificate	19	5.0	56.9
	Secondary school certificate	165	43.1	100.0
	Total	383	100.0	

Source: Survey field 2025

Table 4.1d reveals the education level of the respondents in which 165 (43.1%) has only secondary education. tertiary (B.Sc.) 168(43.9%), while masters 31(8.1%), primary education constitutes 19 (5.0%) and no formal education represents.

This pattern demonstrates that a large majority, over 70% of the respondents possess at least a secondary-school education. Literacy is a critical determinant of maternal-health behavior because it enhances comprehension of antenatal information and confidence in modern medical systems. The equal share between secondary and tertiary graduates indicates broad access to formal education among women of reproductive age in Ado LGA. However, the small group with only primary or no education may still face informational barriers, reinforcing the need for simplified and community-based health campaigns. Overall, the findings suggest that education significantly promotes awareness, informed decision-making, and preference for skilled facility delivery, thereby contributing to safer childbirth outcomes in the study area.

Table 4.1e: Gestational Age at First Antenatal Registration

		Frequency	Percent	Cumulative Percent
Valid	14-28	201	52.5	52.5
	30-35	124	32.4	84.9
	35 Weeks and above	58	15.1	100.0
	Total	383	100.0	

Source: Survey Field 2025

The table reveals that 201 respondents (52.5%) registered for antenatal care during the first trimester, and 124 (32.4.%) during the second trimester. The predominance of first-trimester registration reflects increasing awareness of the importance of early antenatal booking among pregnant women in Ado LGA. Early initiation enables timely health screening, monitoring, and education on delivery preparedness, which improves maternal and neonatal outcomes. However, the 58(15.1%) who registered late highlight persistent challenges such as financial limitation, cultural delay, or misconceptions about pregnancy safety. Late initiation reduces preventive-care opportunities and can expose mothers to unmanaged risks.

Table 4.1f: Parity Distribution of Respondents (Number of Children)

		Frequency	Percent	Cumulative Percent
Valid	0	104	27.2	27.2
	1	98	25.6	52.7
	2	104	27.2	79.9
	3	63	16.4	96.3
	4	14	3.7	100.0
	Total	383	100.0	

Source: Survey field 2025

The table shows that 104 respondents (27.2%) have no children birthed previously (first-time mothers), 98 respondents (25.6%) had one child, 104 respondents (27.2%) had two children, and 63 respondents (16.4%) had three children previously .14 (3.7%) had over 4 children. This pattern reveals that the majority of women in the study area are multiparous, meaning they have had at least one previous delivery experience. Such women are generally familiar with antenatal procedures and facility delivery but may sometimes become complacent or rely on traditional methods due to past successful outcomes. Conversely, first-time mothers tend to be more cautious and are likely to utilize health facilities to ensure safe childbirth.

Table 4.1g: Occupations of Respondents

		Frequency	Percent	Cumulative percent
Valid	Artisan	5	1.3	1.3
	Civil servant	84	21.9	23.2
	Pastor	1	.3	23.5
	Public servant	13	3.4	26.9
	Self employed	227	59.3	86.2
	Student	36	9.4	95.6
	Unemployed	17	4.4	100.0
	Total	383	100.0	

Source: Survey field 2025

The table above shows that some respondents are artisan that is 5 respondents;(1.3%), followed by students 36 (9.4%). 227 of the respondents (59.3%) are self-employed which includes the category of traders, business women, farmers, hair dressers, etc. Others include; house wife (unemployed) 17; (4.4%), civil servants 84 (21.9%), public servants 13 (3.4%), and pastor (1; 0.3%). The predominance of self-employed and students indicates that many women in Ado LGA are economically or academically active. Financial independence and exposure to formal settings often enhance awareness and accessibility to healthcare services. However, a minority group engaged in low-income informal work may face affordability barriers that can hinder consistent use of facility delivery. The result highlights the need for economic empowerment initiatives such as small-business grants and health insurance coverage to ensure that all

occupational groups, especially self-employed women, can afford safe and professional delivery services within health facilities.

Table 4.1h: Monthly income of Respondents

		Frequency	Percent	Cumulative Percent
Valid	0-5,000	30	7.8	7.8
	5,001-50,000	170	44.4	52.2
	50,001-150,000	165	43.1	95.3
	150,001-250,000	13	3.4	98.7
	250,001-500,000	5	1.3	100.0
	Total	383	100.0	

Source: Survey field 2025

The table shows that **170 respondents (44.4%)** earn between ~~₦5,001–₦50,000~~, while **165 respondents (43.1%)** earn ~~₦50,001–₦150,000~~, indicating that the majority fall within low- to middle-income categories. Additionally, **30 respondents (7.8%)** earn ~~₦0–₦5,000~~, reflecting a small group with very limited financial capacity. Only **13 respondents (3.4%)** earn ~~₦150,001–₦250,000~~, and **5 respondents (1.3%)** earn ~~₦250,001–₦500,000~~, showing that high earners make up a very small proportion of the sample. This distribution implies that most pregnant women in Ado LGA operate within modest income brackets, which can influence their ability to afford transportation, antenatal care, and delivery-related expenses. Low income often contributes to delays in seeking care or preference for cheaper alternatives, such as Traditional Birth Attendants. The results highlight the need for cost-reducing policies, subsidized maternal

services, and community health insurance schemes to improve equitable access to facility delivery among financially vulnerable women.

4.2.1 Analysis of Research Questions

Research Question One: What is the level of knowledge of pregnant women regarding the benefits and importance of facility delivery in Ado Local Government Area?

Table 4.2a: Do you know the benefits of delivering in a health facility?

		Frequency	Percent	Cumulative Percent
Valid	MAYBE	4	1.0	1.0
	NO	6	1.6	2.6
	YES	373	97.4	100.0
	Total	383	100.0	

Source: Survey Field 2025

Mean= 2.96. Standard Deviation= 0.27

Out of 383 respondents, 373 (97.4%) affirmed that there are benefits associated with delivering in a health facility, 6 (1.6%) disagreed, and 4 (1.0%) were uncertain. This overwhelming positive response demonstrates strong awareness of the importance of institutional delivery. It implies that most women understand that facility delivery ensures skilled attendance and reduces the risks of complications. The few dissenters may still be influenced by cultural norms or prior

negative experiences. This finding indicates that awareness is high but must translate into consistent utilization through improved access and affordability.

Table 4.2b: Are you aware of the available health facilities in your area?

		Frequency	Percent	Cumulative Percent
Valid	MAYBE	6	1.6	1.6
	NO	45	11.7	13.3
	YES	331	86.7	100.0
	Total	383	100.0	

Mean= 2.75. Standard Deviation= 0.65

Source: Survey Field 2025

The analysis indicates that 332 respondents (86.7%) were aware of available health facilities, 45 (11.7%) were unaware, and 6 (1.6%) were uncertain. This high awareness rate suggests that most women know where to access maternal health services within Ado LGA. The finding implies that lack of awareness is not a major obstacle to facility delivery. However, the 11.7% who are uninformed may reside in remote or underserved communities with limited communication and outreach efforts. This highlights the need for stronger health education campaigns targeting hard-to-reach populations. Ensuring that information reaches every woman can help bridge remaining knowledge gaps and encourage higher utilization of facility delivery, ultimately contributing to reduced maternal mortality and improved childbirth outcomes in the area.

Table 4.2c: Do you believe facility delivery reduces the risk of maternal complications?

		Frequency	Percent	Cumulative Percent
Valid	MAYBE	11	2.9	2.9
	NO	36	9.4	12.3
	YES	336	87.7	100.0
	Total	383	100.0	

Mean= 2.78. Standard Deviation= 0.60

Source; Survey Field 2025

Table 3 shows that 336 respondents (87.7%) agreed that facility delivery reduces maternal complications, 36 (9.4%) disagreed, and 11 (2.9%) were undecided. This indicates a strong understanding of the protective role of institutional delivery in preventing life-threatening childbirth outcomes. The high percentage of agreement implies that most women in Ado LGA recognize that skilled care during labor minimizes risks of hemorrhage, infection, and prolonged labor. However, the 9.4% who disagreed may have misconceptions about medical interventions or negative past experiences. Overall, the data reveal high health literacy concerning maternal safety, suggesting that public health campaigns are achieving their goal of promoting safe delivery practices.

Table 4.2d: Have you ever received health information about childbirth from health workers?

		Frequency	Percent	Cumulative Percent
Valid	MAYBE	1	.3	.3
	NO	23	6.0	6.3
	YES	359	93.7	100.0
	Total	383	100.0	

Mean= 2.88. Standard Deviation= 0.48

Survey: Field 2025

Table 4 reveals that a total of 359 (93.7%) respondents receive childbirth information from health workers, 23 (6.0%) do not, and 1 (0.3%) is uncertain. This high percentage demonstrates that health professionals play a major role in providing credible information on pregnancy and delivery and in disseminating maternal health information. The few respondents without access to such information may rely on traditional sources or lack regular antenatal visits. The finding implies that antenatal care and facility-based counseling remain key strategies for empowering women to make informed delivery choices.

Table 4.2e: Do you know the recommended age for antenatal care visits?

		Frequency	Percent	Cumulative Percent
Valid	MAYBE	18	4.7	4.7
	NO	100	26.1	30.8
	YES	265	69.2	100.0
	Total	383	100.0	

Mean= 2.43. Standard Deviation= 0.88

Source: Survey field 2025

Out of 383 respondents, 265 (69.2%) knew the recommended age for antenatal care visits, 100 (26.1%) did not, and 18 (4.7%) were uncertain. This shows that most women possess adequate knowledge of when to start antenatal care, reflecting effective maternal health education in the area. Early initiation of antenatal visits increases opportunities for screening, counseling, and promoting facility delivery. However, over one-quarter of respondents still lack this knowledge, suggesting persistent gaps that could delay antenatal registration and increase health risks. The result implies that although awareness is commendable, continuous education is essential to reach all pregnant women, especially those with low educational backgrounds.

Table 4.2f: Are you aware of the dangers of home delivery

		Frequency	Percent	Cumulative Percent
Valid	MAYBE	9	2.3	2.3
	NO	31	8.1	10.4
	YES	343	89.6	100.0
	Total	383	100.0	

Mean= 2.81. Standard Deviation= 0.56

Source: Survey field 2025

The findings show that 343 respondents (89.6%) agreed that home delivery is dangerous, 31 (8.1%) disagreed, and 9 (2.3%) were uncertain. This indicates that a significant majority of the women are aware of the risks associated with home delivery, such as excessive bleeding, infection, or lack of emergency care. The high level of awareness demonstrates effective maternal health education within the community, largely facilitated through antenatal programs. However, the small portion of women who disagreed or were unsure could reflect cultural beliefs, influence from traditional birth attendants, or poor exposure to health information. This implies that while knowledge about delivery risks is high, behavioral adherence may still vary due to external factors like affordability and accessibility.

Research Question Two: What are the perceptions of pregnant women towards facility delivery in selected facilities in Ado Local Government Area, Ekiti State?

Table 4.3a: I trust the quality of care in health facilities.

		Frequency	Percent	Cumulative Percent
Valid	Agree	115	30.0	30.0
	Disagree	2	.5	30.5
	Neutral	3	.8	31.3
	Strongly Agree	262	68.4	99.7
	Strongly Disagree	1	.3	100.0
	Total	383	100.0	

Mean= 4.66. Standard Deviation= 0.55

Source: Survey field 2025

Results reveal that 262 respondents (68.4%) strongly agreed and 115 (30.0%) agreed that quality of care in health facilities is good. Only 6 respondents (1.6%) expressed disagreement or neutrality. This overwhelmingly positive view implies that most women in Ado LGA are satisfied with the quality of maternal services offered. It reflects growing confidence in the health system and the professionalism of healthcare providers. High satisfaction levels can serve as a strong motivator for consistent use of health facilities during childbirth. Nonetheless, a small fraction of women remains doubtful, possibly due to isolated experiences of long waiting time or

inadequate attention. The findings suggest that maintaining and improving service quality through friendly staff attitudes, cleanliness, and responsiveness will enhance women's trust and further promote facility delivery utilization.

Table 4.3b I feel comfortable delivering in health facilities.

		Frequency	Percent	Cumulative Percent
Valid	Agree	96	25.1	25.1
	Disagree	4	1.0	26.1
	Neutral	2	.5	26.6
	Strongly Agree	281	73.4	100.0
	Total	383	100.0	

Mean= 4.71. Standard Deviation= 0.53

Source: Survey field 2025

Out of 383 respondents, 281 (73.4%) strongly agreed and 96 (25.1%) agreed that they feel comfortable delivering in health facilities, while only 6 (1.5%) disagreed or remained neutral. This finding indicates a very high level of comfort and emotional security associated with facility delivery. The results imply that health centers in Ado LGA provide a welcoming and supportive environment that encourages women to deliver under professional care. Comfort is an important determinant of healthcare utilization, as it influences women's perception of safety and trust in health providers. The minimal number of negative responses may stem from previous unpleasant experiences or fear of medical interventions. Overall, the finding reinforces that the majority of

women view institutional delivery positively, highlighting the progress achieved through improved patient care and infrastructural development.

Table 4.3c Facility Delivery is a Good Option

		Frequency	Percent	Cumulative Percent
Valid	Agree	111	29.0	29.0
	Disagree	16	4.2	33.2
	Strongly Agree	255	66.6	99.7
	Strongly Disagree	1	.3	100.0
	Total	383	100.0	

Source: Survey field 2025

The analysis shows that 255 respondents (66.6%) strongly agreed and 111 (29.0%) agreed that facility delivery is a good option for them, while 17 respondents (4.5%) expressed disagreement. This indicates that nearly all participants personally favor institutional childbirth, showing high acceptance and positive perception of healthcare facilities. The result underscores successful awareness campaigns emphasizing the safety and advantages of professional delivery assistance. Women's confidence in facility delivery also suggests that prior experiences were generally positive. However, the few who disagreed may have encountered challenges such as high cost, distance, or negative staff attitude. This finding implies that preference for facility delivery is largely influenced by perceived benefits and service quality

Table 4.3d I would recommend facility delivery to others.

		Frequency	Percent	Cumulative Percent
Valid	Agree	130	33.9	33.9
	Disagree	25	6.5	40.5
	Neutral	4	1.0	41.5
	Strongly Agree	224	58.5	100.0
	Total	383	100.0	

Source: Survey field 2025

Findings show that 224 respondents (58.5%) strongly agreed and 130 (33.9%) agreed that they would recommend facility delivery to others. Only 29 respondents (7.5%) disagreed or were neutral. This reveals a high level of satisfaction and advocacy among women who have experienced or intend to use institutional delivery services. When clients willingly recommend a service, it reflects strong trust and positive perception, which are essential for peer influence in public health. The data imply that women in Ado LGA not only appreciate the benefits of facility delivery but also act as change agents promoting safer childbirth within their communities. The small minority who would not recommend it may have encountered service dissatisfaction or financial constraints.

Table 4.3e Believe Traditional Birth Attendants provide Equally good care

		Frequency	Percent	Cumulative Percent
Valid	Agree	79	20.6	20
	Disagree	186	48.6	69.2
	Neutral	4	1.0	70.2
	Strongly Agree	56	14.6	84.9
	Strongly Disagree	58	15.1	100.0
	Total	383	100.0	

Source: Survey field 2025

Mean= 4.57. Standard Deviation= 0.73

The findings show that 186 respondents (48.6%) disagreed that traditional birth attendants (TBAs) provide care equal to that of health professionals, while 79 (20.6%) agreed, 56 (14.6%) strongly agreed, and 58 (15.1%) strongly disagreed. This distribution indicates that nearly two-thirds of respondents reject the belief that TBAs offer comparable quality care, reflecting growing trust in modern health services. However, the combined 35.2% who agreed or strongly agreed suggests that a significant portion of women still hold traditional views, possibly influenced by cultural beliefs or affordability concerns. The result implies that although medical facilities are increasingly preferred, TBAs remain relevant within community childbirth practices. Persistent reliance on TBAs could hinder full utilization of skilled delivery.

Table 4.3f: I Feel Respected and Well-Treated by Health Workers During Delivery.

		Frequency	Percent	Cumulative Percent
Valid	Agree	159	41.5	41.5
	Disagree	14	3.7	45.2
	Strongly Agree	210	54.8	100.0
	Total	383	100.0	

Source: Survey field 2025

Mean= 4.48. Standard Deviation= 0.69

Out of 383 respondents, 210 (54.8%) strongly agreed and 159 (41.5%) agreed that they felt respected and well-treated by health workers, while only 14 (3.7%) disagreed. This overwhelmingly positive response suggests that the majority of women perceive healthcare providers in Ado LGA as compassionate, professional, and respectful. Such interpersonal experience is crucial in shaping attitudes toward health facility delivery and influences women's future health-seeking behavior. Respectful maternity care fosters trust and encourages women to return to facilities for subsequent deliveries, while negative interactions can discourage utilization.

Table 4.3g Facility Delivery are Unnecessary if There Are no Complications

		Frequency	Percent	Cumulative Percent
Valid	Agree	65	17.0	17.0
	Disagree	175	45.7	62.7
	Neutral	6	1.6	64.2
	Strongly Agree	78	20.4	84.6
	Strongly Disagree	59	15.4	100.0
	Total	383	100.0	

Mean= 2.81. Standard Deviation= 1.42

Source: Survey field 2025

The results reveal that 175 respondents (45.7%) disagreed, 59 (15.4%) strongly disagreed, while 65 (17.0%) agreed, and 78 (20.4%) strongly agreed that facility deliveries are unnecessary if there are no complications. This mixed response pattern indicates that a majority (61.1%) recognize that all deliveries require professional supervision, but a notable 37.4% still believe that home births are acceptable in the absence of visible problems. This misconception reflects a persistent knowledge gap about the unpredictable nature of childbirth complications. The implication is that despite awareness of health facility benefits, some women still underestimate risks associated with home delivery. Addressing this perception requires targeted health education that emphasizes prevention rather than crisis response.

Research Question Three: What socio cultural, economic, and institutional barriers hinder pregnant women from utilizing facility delivery in the study area?

Table 4.4a

		Frequency	Percent	Cumulative Percent
Valid	Agree	81	21.1	21.1
	Disagree	116	30.3	51.4
	Neutral	9	2.3	53.8
	Strongly Agree	128	33.4	87.2
	Strongly Disagree	49	12.8	100.0
	Total	383	100.0	

Mean= 3.32. Standard Deviation

Source: Survey field 2025

Findings show that 128 respondents (33.4%) strongly agreed, 81 (21.1%) agreed, 116 (30.3%) disagreed, while 49 (12.8%) strongly disagreed, and 9 (2.3%) were neutral. This indicates that more than half of the respondents (54.5%) acknowledge experiencing or anticipating barriers like cost, distance, or poor transportation when seeking facility delivery. These constraints are critical determinants of healthcare utilization, particularly in semi-urban or rural areas. The result implies that despite positive perceptions toward facility delivery, socioeconomic and infrastructural challenges still hinder actual practice. Financial limitations, poor road networks, and limited access to vehicles may discourage timely attendance during labor. The finding

underscores the need for government and policymakers to strengthen maternal health support systems such as community ambulances, free maternity services, and rural road maintenance. Reducing these barriers can translate high awareness levels into actual utilization, thereby improving maternal and neonatal outcomes in Ado LGA.

Table 4.4bDistance to Health Facility is a challenge

		Frequency	Percent	Cumulative Percent
Valid	Agree	125	32.6	32.6
	Disagree	94	24.5	57.2
	Neutral	2	.5	57.7
	Strongly Agree	103	26.9	84.6
	Strongly Disagree	59	15.4	100.0
	Total	383	100.0	

Mean= 3.31. Standard Deviation= 1.47

Source: Survey field 2025

The table shows that 125 respondents (32.6%) agreed, 103 (26.9%) strongly agreed, 94 (24.5%) disagreed, and 59 (15.4%) strongly disagreed that distance poses a challenge. This distribution reveals that 59.5% of respondents perceive distance as a barrier to accessing facility delivery. It highlights how geographical accessibility remains a critical factor influencing maternal healthcare utilization. Women living far from facilities may face delays during labor or resort to

home deliveries, especially where transportation is poor. The 39.9% who disagreed likely live closer to urban centers with better road connections. The findings imply that even with good awareness, physical distance can significantly reduce facility use rates. Improving spatial access through community health posts, maternity outreach centers, and improved transportation services would mitigate this limitation.

Table 4.4c Lack of Transportation is a Problem

		Frequency	Percent	Cumulative Percent
Valid	Agree	91	23.8	23.8
	Disagree	90	23.5	47.3
	Neutral	7	1.8	49.1
	Strongly Agree	136	35.5	84.6
	Strongly Disagree	59	15.4	100.0
	Total	383	100.0	

Mean= 3.40. Standard Deviation= 1.53

Source: Survey Field 2025

The findings reveal that 136 respondents (35.5%) strongly agreed and 91 (23.8%) agreed that lack of transportation is a problem, while 90 (23.5%) disagreed, 59 (15.4%) strongly disagreed, and 7 (1.8%) were neutral. This means that 59.3% of women consider inadequate transportation as a major barrier to accessing health facilities for delivery. The result indicates that even though

awareness and willingness to use health facilities are high, physical and infrastructural constraints remain substantial. Poor road conditions, high transport costs, and unavailability of vehicles during labor often delay or prevent timely access to care. The 38.9% who disagreed may reside in urban or well-connected areas of Ado LGA. Overall, the result highlights transportation as a key social determinant of maternal health.

Table 4.4d Quality of Care Affects My Decision to Deliver in a Health Facility

		Frequency	Percent	Cumulative Percent
Valid	Agree	104	27.2	27.2
	Disagree	96	25.1	52.2
	Neutral	7	1.8	54.0
	Strongly Agree	92	24.0	78.1
	Strongly Disagree	84	21.9	100.0
	Total	383	100.0	

Mean= 3.06. Standard Deviation= 1.54

Source: Survey Fied 2025

The table shows that 104 respondents (27.2%) agreed, 92 (24.0%) strongly agreed, 96 (25.1%) disagreed, 84 (21.9%) strongly disagreed, and 7 (1.8%) were neutral. This suggests a divided perception among women concerning the quality of care in health facilities. About 51.2% believe

poor service quality influences their decision to avoid facility delivery, while 47% disagree. This mixed perception implies variability in healthcare experiences some women may have encountered overcrowded facilities, delays, or poor staff attitudes. On the other hand, others might have received satisfactory care, shaping more positive perceptions.

Table 4.4e Cultural or Traditional Reason Influence My Choice Of Delivery Location

		Frequency	Percent	Cumulative Percent
Valid	Agree	73	19.1	19.1
	Disagree	127	33.2	52.2
	Neutral	8	2.1	54.3
	Strongly Agree	76	19.8	74.2
	Strongly Disagree	99	25.8	100.0
	Total	383	100.0	

Mean= 3.32. Standard Deviation= 1.51

Results show that 76 respondents (19.8%) strongly agreed and 73 (19.1%) agreed that cultural or traditional beliefs affect their delivery location. In contrast, 127 (33.2%) disagreed and 99 (25.8%) strongly disagreed, while 8 (2.1%) were neutral. This means that about 38.9% of respondents acknowledge cultural influence, whereas 59% reject it. The findings indicate that while modern healthcare awareness is dominant, traditional and cultural norms still influence a considerable traditional birth attendants remain relevant in some communities.

Table 4.4f Negative Attitude of Health Workers Discourages Women

		Frequency	Percent	Cumulative Percent
Valid	Agree	123	32.1	32.1
	Disagree	80	20.9	53.0
	Neutral	14	3.7	56.7
	Strongly Agree	89	23.2	79.9
	Strongly Disagree	77	20.1	100.0
	Total	383	100.0	

Mean= 3.17. Standard Deviation= 1.50

The findings reveal that 123 respondents (32.1%) agreed, 89 (23.2%) strongly agreed, 80 (20.9%) disagreed, 77 (20.1%) strongly disagreed, and 14 (3.7%) were neutral. This indicates that 55.3%. This perception highlights the importance of interpersonal relations in maternal healthcare. Even when women are aware of the benefits of institutional delivery, unpleasant interactions such as rudeness or neglect can discourage repeat utilization. The 41% who disagreed may have had positive experiences with respectful and supportive staff. Establishing patient feedback mechanisms and enforcing respectful maternity care standards could enhance satisfaction and trust. Addressing this factor would not only improve utilization rates but also foster positive word-of-mouth advocacy for facility delivery in Ado LGA.

Table 4.g I fear Unnecessary Intervention Like Caesarian Section

		Frequency	Percent	Cumulative Percent
Valid	Agree	106	27.7	27.7
	Disagree	51	13.3	41.0
	Neutral	10	2.6	43.6
	Strongly Agree	161	42.0	85.6
	Strongly Disagree	55	14.4	100.0
	Total	383	100.0	

Mean= 3.70. Standard Deviation= 1.48

Out of 383 respondents, 161 (42.0%) strongly agreed and 106 (27.7%) agreed that they fear unnecessary medical interventions, while 51 (13.3%) disagreed, 55 (14.4%) strongly disagreed, and 10 (2.6%) were neutral. This means that 69.7% of women harbor fears concerning medical procedures, particularly caesarean sections. This perception poses a psychological barrier to facility delivery, as fear of surgical intervention can drive women toward home births. The finding suggests that misinformation and past negative stories about caesarean deliveries persist in the community. Addressing these fears requires intensive education on the life-saving importance of surgical intervention when medically necessary. Health workers should explain procedures clearly during antenatal sessions to build confidence and trust. Reducing fear-based

resistance will enhance positive perceptions of hospital delivery and increase women's willingness to deliver under skilled supervision across Ado LGA.

Table 4.4h My Husband and Family Prefers Home Delivery

		Frequency	Percent	Cumulative Percent
Valid	Agree	30	7.8	7.8
	Disagree	119	31.1	38.9
	Neutral	10	2.6	41.5
	Strongly Agree	44	11.5	53.0
	Strongly Disagree	180	47.0	100.0
	Total	383	100.0	

Mean= 2.06. Standard Deviation= 1.36

The results show that 180 respondents (47.0%) strongly disagreed and 119 (31.1%) disagreed that their husband and family prefer home delivery, while 44 (11.5%) strongly agreed, 30 (7.8%) agreed, and 10 (2.6%) were neutral. This distribution indicates that 78.1% of respondents do not experience family pressure toward home delivery, whereas 19.3% still face familial influence. The findings imply that spousal and family support for health facility delivery is strong among most participants in Ado LGA. However, the presence of nearly one-fifth under family pressure underscores the continuing role of male decision-making and extended family traditions in childbirth choices. Strengthening family-oriented maternal health interventions will enhance, thereby increasing the consistency of facility delivery practices across households in Ado LGA

Research Question Four: What are the **Factors** affecting facility delivery.

Table 4.5a I Prefer Delivering at Home Because I Feel Comfortable and Relax

		Frequency	Percent	Cumulative Percent
Valid	Agree	23	6.0	6.0
	Disagree	102	26.6	32.6
	Neutral	20	5.2	37.9
	Strongly Agree	34	8.9	46.7
	Strongly Disagree	204	53.3	100.0
	Total	383	100.0	

Mean= 1.91. Standard Deviation= 1.27

Out of 383 respondents, 204 (53.3%) strongly disagreed and 102 (26.6%) disagreed that they prefer home delivery, while 34 (8.9%) strongly agreed, 23 (6.0%) agreed, and 20 (5.2%) were neutral. This reveals that 79.9% of respondents reject home delivery preference, while 14.9% still view it as more comfortable. The high rate of disagreement indicates that most women in Ado LGA now associate comfort with safety and trust in professional healthcare rather than with traditional home settings. Those still preferring home delivery may be influenced by fear of medical procedures or cultural norms emphasizing privacy. The finding demonstrates a positive behavioral shift toward facility delivery, likely due to improved service quality and community sensitization.

Table 4.5b I lack Information About the Benefits of Facility Delivery

		Frequency	Percent	Cumulative Percent
Valid	Agree	56	14.6	14.6
	Disagree	100	26.1	40.7
	Neutral	15	3.9	44.6
	Strongly Agree	44	11.5	56.1
	Strongly Disagree	168	43.9	100.0
	Total	383	100.0	

Mean= 2.24. Standard Deviation= 1.43

The findings show that 168 respondents (43.9%) strongly disagreed and 100 (26.1%) disagreed with lacking information, while 44 (11.5%) strongly agreed, 56 (14.6%) agreed, and 15 (3.9%) were neutral. This means that 70% of respondents feel adequately informed about facility delivery benefits, while 26.1% still experience information gaps. The result implies that most women in Ado LGA have received sufficient health education through antenatal sessions, community campaigns, or local media. However, a significant minority remain uninformed, potentially limiting their confidence and decision-making. This highlights the need for continuous and inclusive maternal health communication targeting less literate or rural

populations. Strengthening interpersonal communication between health workers and expectant mothers will ensure that all women understand the benefits of skilled birth attendance.

Table 4.5c Facility Delivery Provides Better Postpartum Care

		Frequency	Percent	Cumulative Percent
Valid	Agree	156	40.7	40.7
	Disagree	4	1.0	41.8
	Neutral	14	3.7	45.4
	Strongly Agree	163	42.6	88.0
	Strongly Disagree	46	12.0	100.0
	Total	383	100.0	

Mean= 4.01. Standard Deviation= 1.26

Results reveal that 163 respondents (42.6%) strongly agreed and 156 (40.7%) agreed that facility delivery provides better postpartum care, while 46 (12.0%) strongly disagreed, 4 (1.0%) disagreed, and 14 (3.7%) were neutral. This shows that 83.3% of respondents acknowledge the superiority of facility-based postpartum care. The finding suggests strong confidence in the ability of health professionals to manage postnatal recovery and infant care. It reflects that women recognize the advantages of professional follow-up, immunization, and post-delivery monitoring services available in health centers. The small minority who disagreed may have encountered negative experiences or hold misconceptions about postpartum practices. Overall,

this result reinforces that quality postpartum services contribute significantly to women's preference for institutional delivery.

Table 4.5d I plan to deliver in a Health Facility for my Next Pregnancy

		Frequency	Percent	Cumulative Percent
Valid	Agree	123	32.1	32.1
	Disagree	6	1.6	33.7
	Neutral	13	3.4	37.1
	Strongly Agree	227	59.3	96.3
	Strongly Disagree	14	3.7	100.0
	Total	383	100.0	

Mean= 4.42. Standard Deviation= 0.92

The analysis indicates that 227 respondents (59.3%) strongly agreed and 123 (32.1%) agreed to plan for facility delivery in future pregnancies, while 6 (1.6%) disagreed, 14 (3.7%) strongly disagreed, and 13 (3.4%) were neutral. This overwhelming 91.4% positive response demonstrates a strong commitment among women toward institutional delivery. It implies that awareness campaigns, antenatal education, and improved service experiences have effectively shaped women's intentions toward safe childbirth practices. The small percentage of dissenters may represent women constrained by socio-economic or logistical challenges. This finding signifies a behavioral shift from traditional to modern healthcare approaches and predicts

sustained utilization of skilled delivery services in Ado LGA. Maintaining this momentum requires continuous health education, improved facility accessibility, and ongoing quality improvement

4.2.2 Hypotheses Testing

H₀₁: There is no significant relationship between Knowledge and the utilisation of facility delivery among pregnant women in selected facilities in Ado Local Government Area

Facility delivery is a good option for me * I have experienced or anticipate challenges/barriers in accessing facility delivery, such as cost, distance, or transportation issues.

Table 4.2.2a

Count						
		I have experienced or anticipate challenges/barriers in accessing facility delivery, such as cost, distance, or transportation issues.				
		Agree	Disagree	Neutral	Strongly Agree	Strongly Disagree
Facility delivery is a good option for me	Agree	28	38	2	29	14
	Disagree	3	3	0	9	1
	Strongly Agree	49	75	7	90	34
	Strongly Disagree					
		Total				

Strongly Disagree	1	0	0	0	0	1
Total	81	116	9	128	49	383

Chi-Square Tests

	Value	Df	Asymptotic Significance (2- sided)
Pearson Chi-Square	12.247 ^a	12	.426
Likelihood Ratio	11.895	12	.454
N of Valid Cases	383		

a. 10 cells (50.0%) have expected count less than

5.

b. The minimum expected count is .02.

Interpretation: The relationship between respondents' opinion on facility delivery being a good option and their experience of challenges such as cost, distance, or transportation was examined using the Chi-square test of independence. The result produced a Pearson Chi-square value of

12.247 with 12 degrees of freedom and an Asymptotic Significance (2-sided) of 0.426. Since the p-value is greater than 0.05, the relationship is statistically not significant.

This implies that respondents' perception of facility delivery as a good option does not depend on whether they have experienced or anticipate challenges in accessing it. In other words, agreement or disagreement with facility delivery being a good option occurs independently of difficulties such as cost, distance, or transport. Although 50% of the cells had expected counts less than five (minimum expected count = 0.02), suggesting a possible limitation in the validity of the Chi-square approximation, the general conclusion remains that there is no significant association between both variables.

Ho2 There is no significant relationship between Perception and utilisation of facility delivery among pregnant women in selected facilities in Ado Local Government Area

Facility delivery reduces the risk of maternal complications * I have experienced or anticipate challenges/barriers in accessing facility delivery, such as cost, distance, or transportation issues.

Count						
I have experienced or anticipate challenges/barriers in accessing facility delivery, such as cost, distance, or transportation issues.						Total
		Agree	Disagree	Neutral	Strongly Agree	Strongly Disagree
facility delivery	MAYBE3	2	0	4	2	11

reduces the risk of maternal complications	NO	8	6	0	20	2	36
	YES	70	108	9	104	45	336
Total		81	116	9	128	49	383

Chi-Square Tests

	Value	Df	Asymptotic Significance (2- sided)
Pearson Chi-Square	12.346 ^a	8	.136
Likelihood Ratio	13.441	8	.098
N of Valid Cases	383		

a. 7 cells (46.7%) have expected count less than 5. The minimum expected count is .26.

Interpretation: A Chi-square test was also carried out to determine whether respondents' belief that facility delivery reduces maternal complications is associated with the challenges they face in accessing such delivery. The test yielded a Pearson Chi-square value of 12.346 with 8 degrees of freedom and a p-value of 0.136. Since the p-value exceeds the 0.05 level of significance, the association is statistically not significant.

This indicates that the perception that facility delivery minimizes maternal complications is independent of the barriers respondents experience, such as transportation issues, distance, or cost. Despite a substantial proportion of respondents agreeing that facility delivery helps prevent complications, their responses were not significantly influenced by whether or not they faced challenges. About 46.7% of the cells had expected counts less than five (minimum expected count = 0.26), which should be considered when interpreting the result, but the overall inference remains the same there is no significant association between the two variables.

4.3 Discussion of Findings

Findings from the study revealed that the respondents demonstrated a high level of knowledge about the benefits of facility delivery. The majority (97.4%) agreed that delivery in a health facility reduces maternal complications, while 89.6% acknowledged the dangers of home delivery. Similarly, 93.7% were aware of the availability of health facilities in their community. The overall mean knowledge score ($M = 2.77$, $SD = 0.57$) confirmed that the respondents possessed adequate awareness of safe delivery practices. This finding aligns with the work of Gabrysch and Campbell who reported that increased maternal awareness about institutional delivery correlates with improved utilization of skilled birth attendants. It also agrees with Osubor et al. who found that women's understanding of facility-based care significantly contributes to maternal health-seeking behavior. The implication is that health education interventions and antenatal counseling in Ado LGA have effectively promoted awareness of the importance of facility delivery. However, despite the high level of knowledge, a minority of respondents still held misconceptions about the necessity of institutional delivery when there are no visible complications. This suggests that continuous health education is needed to strengthen

understanding that all deliveries, regardless of risk perception, should occur under skilled supervision.

The perception of respondents toward facility delivery was generally positive. The mean perception scores ranged from 4.01 to 4.71, indicating strong agreement with statements such as “health facilities provide quality care,” “women feel comfortable delivering in a health center,” and “health workers treat patients with respect.” These findings are consistent with Adewemimo et al.² who reported that women’s attitudes toward skilled birth attendants have improved due to increased trust in facility-based services. Nevertheless, mixed opinions were recorded on issues relating to the attitude of health workers, cost of care, and fear of medical interventions. For instance, while most respondents agreed that facility delivery is beneficial, some expressed concern about perceived rudeness of staff and expensive delivery fees. This variability, reflected in higher standard deviations ($SD > 1.0$) for some items, suggests that although perception is largely positive, isolated experiences of poor service still influence women’s opinions.

The study also examined socio-economic and logistical factors affecting utilization. Cost, distance, and transportation challenges emerged as the most critical barriers. Over half (54.5%) of the respondents cited cost as a limiting factor, while 59.3% mentioned distance and poor transportation as major obstacles. This aligns with the findings of Doctor et al. and Babalola and Fatusi who identified financial constraints and physical access as persistent barriers to maternal health service utilization in Nigeria. Chi-square analyses revealed no significant association between educational level and experience of barriers ($\chi^2 = 8.389$, $p = 0.754$), or between perception of facility delivery and reported challenges ($\chi^2 = 12.247$, $p = 0.426$). This suggests that while awareness and perception are generally favorable, structural and economic factors still impede full utilization. In other words, knowledge and attitude alone do not guarantee behavioral

change unless systemic barriers are addressed. The implication is that even well-informed women may deliver at home if faced with transportation difficulties or unaffordable medical costs. Therefore, improving accessibility through community-based transport schemes, reduction of delivery fees, and rural health infrastructure expansion remains essential for achieving optimal maternal outcomes.

Endnotes

1. Sabine Gabrysch and Oona M. R. Campbell, “Still Too Far to Walk: *Literature Review of the Determinants of Delivery Service Use*,” **BMC Pregnancy and Childbirth** 9, no. 34 (2009): 1–13, <https://doi.org/10.1186/1471-2393-9-34>. **Endnote**
2. K. M. Osubor, A. O. Fatusi, and J. C. Chiwuzie, “*Maternal Health-Seeking Behavior and Associated Factors in a Rural Nigerian Community*,” **Maternal and Child Health Journal** 10, no. 2 (March 2006): 159–69, doi:10.1007/s10995-005-0037-z.
3. A. W. Adewemimo, A. Msuya, T. Nyasulu, and E. M. Oladapo, “*Utilisation of Skilled Birth Attendance in Northern Nigeria: A Cross-Sectional Survey*,” **Midwifery** 30, no. 1 (January 2014): e7–e13, <https://doi.org/10.1016/j.midw.2013.10.002>.
4. Maryam Abdulsalam-Anibilowo, “*Health Facility Delivery in Sub-Saharan Africa: Successes, Challenges, and Implications for the 2030 Development Agenda*,” **BMC Public Health** 18, no. 765 (2018): 1–12, <https://doi.org/10.1186/s12889-018-5695-z>.

5. Stella Babalola and Adesegun Fatusi, “*Determinants of Use of Maternal Health Services in Nigeria — Looking Beyond Individual and Household Factors,*” **BMC Pregnancy and Childbirth** 9, no. 43 (2009): 1–13, doi:10.1186/1471-2393-9-43.

Chapter 5

Conclusion

5.1 Summary of Findings

This study examined the knowledge, perception, and factors influencing the utilization of facility delivery among pregnant women in Ado Local Government Area, Ekiti State, Nigeria. The study was anchored on the Health Belief Model and Andersen’s Behavioral Model of Health Service Utilization, both of which explain how individual beliefs, perceived barriers, and access influence health-seeking behavior. A descriptive cross-sectional design was adopted. Data were collected from 383 pregnant women attending selected antenatal clinics using a validated structured questionnaire. The findings revealed that respondents demonstrated high knowledge of the importance and benefits of facility delivery. The overall mean knowledge score was 2.77 (SD = 0.57), showing that the majority were aware of the role of health facilities in reducing maternal complications and preventing delivery-related deaths. The study further found that respondents’ perception of facility delivery was highly positive, with mean scores ranging

between 4.01 and 4.71 for statements relating to quality of care, comfort, and positive experiences with health workers. However, a few respondents expressed dissatisfaction regarding staff attitudes and cost of services. Despite this awareness and positive attitude, barriers such as high cost, long distance, and transportation difficulties remained prominent. Over half of the respondents reported cost and distance as the main challenges preventing consistent use of facility-based delivery. The Chi-square analysis showed no significant relationship between educational level and experience of barriers ($\chi^2 = 8.389$, $p = 0.754$), and between perception of facility delivery and reported challenges ($\chi^2 = 12.247$, $p = 0.426$).

This implies that even though women possess adequate knowledge and favorable attitudes toward facility delivery, systemic and environmental factors continue to limit full utilization. The study highlights that improving physical and financial access is essential for translating awareness into behavioral change.

5.2 Conclusion

The findings of this study show that pregnant women in Ado LGA possess adequate knowledge and favorable perceptions of facility delivery. However, knowledge and perception alone do not guarantee utilization. Structural and cultural barriers such as cost, transportation, and family influence remain significant challenges.

It is therefore concluded that while the awareness of facility delivery is encouraging, more effort is required to address the systemic and socio-cultural obstacles preventing its full adoption. Improving health infrastructure, enhancing accessibility, and fostering active family and community engagement are essential to achieving better maternal health outcomes within Ado LGA.

5.3 Recommendations

Based on the findings of this study, the following recommendations are made:

i Health Education and Awareness:

Continuous community-based health education should be conducted to reinforce knowledge of safe facility delivery and correct misconceptions particularly fears surrounding caesarean sections.

ii Accessibility and Cost Reduction:

Government and stakeholders should make maternal health services more affordable by subsidizing costs and ensuring the availability of community-based ambulance or transport services.

1. Quality of Health Services:

Ongoing capacity building for healthcare personnel is necessary to strengthen professional conduct and guarantee respectful maternity care for every woman

2. Community and Male Involvement:

Intervention programmes should deliberately engage men, families, and local leaders in decision-making about maternal care to promote shared responsibility for safe delivery.

3. Policy and Infrastructure Development:

Local and state governments should invest in upgrading facilities, providing more skilled staff, and ensuring that rural areas have adequate maternal health infrastructure.

5.4 Contribution to Knowledge

This study contributes to knowledge in the following ways:

- This study offers up-to-date empirical insights into women's knowledge, perceptions, and use of facility-based delivery services in Ado LGA, adding to the body of research on maternal health in Nigeria.
- It identifies a clear disparity between awareness and actual service use, indicating that knowledge and positive attitudes alone are insufficient to ensure facility-based delivery, as structural and cultural barriers play a significant role.
- It underscores the influential role that male partners and family members play in determining women's maternal health choices.
- It suggests that **multi-level interventions** covering education, accessibility, healthcare quality, and socio-cultural factors are required to improve maternal health outcomes in low-resource settings.

5.5 Suggested Areas of Further Studies

Further investigations are recommended in the following domains:

1. The perspectives of healthcare workers on barriers to providing maternal health services in Ado LGA.
2. The role of husbands, families, and cultural norms in shaping women's maternal health choices.
3. Comparative studies between urban and rural LGAs in Ekiti State to identify location-specific challenges in maternal health utilization.
4. Longitudinal studies that follow pregnant women from antenatal care through delivery to understand the factors influencing final decisions on delivery location.
5. The impact of government policies and health financing schemes on facility delivery utilization in Nigeria.

Appendix

Lead City University

Questionnaire

**Knowledge Perception And Factors Influencing The Utilization Of Facility Delivery
Among Pregnant Women In Ado Local Government Area, Ekiti State.**

Dear Respondent,

I am a master's student of Lead city university, carrying out a research study on the above topic in partial fulfillment for the award of Master's degree in Lead City University. Please, your sincere response to this questionnaire is needed as the information given is purely for academic purpose and it will be treated with absolute confidentiality.

Thank You.

Yours Faithfully,

Asonibare Omolara

Researcher

Section A

Socio-demographic characteristics of respondents.

Instruction: Please tick the correct answers in the box(es) below:

1. Age: _____
2. Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐
3. Religion: Christianity ☐ Islam ☐ Traditional Religion ☐
4. Tribe: Yoruba ☐ Hausa ☐ Igbo ☐ Others ☐
5. Gestational Age: 14-28 weeks ☐ 30-35 weeks ☐ 35 weeks and above ☐
6. Level of Education: Primary Certificate ☐ Secondary Certificate ☐ Bachelor's Degree ☐ Master's Degree ☐
7. Occupation: _____
8. Parity (No of Previous birth): _____
9. Monthly Income: _____

Section B

Test For Knowledge

Instruction: Please answer the following questions based on your knowledge. Choose YES if you think the statement is true, NO if you think it's false, and MAYBE if you're unsure.

S/N	Question	Yes	No	Maybe
	Knowledge About Facility Delivery			
1	Do you know the benefits of delivering in a health facility?			
2	Are you aware of the available health facilities in your area?			
3	Do you believe facility delivery reduces the risk of maternal complications?			
4	Have you ever received health information about childbirth from health workers?			
5	Do you know the recommended age for antenatal care visits?			
6	Are you aware of the dangers of home delivery?			

Perception Of Facility Delivery

Instruction: For the following statements, please indicate your level of agreement by selecting:

SA (Strongly Agree) if you strongly agree with the statement

A (Agree) if you agree with the statement

U (Undecided) if you are neutral or unsure

D (Disagree) if you disagree with the statement

SD (Strongly Disagree) if you strongly disagree with the statement

	Perception Of Facility Delivery	SA	A	D	SD	U
1	I trust the quality of care in health facilities.					
2	I feel comfortable delivering in health facilities.					
3	Facility delivery is a good option for me.					
4	I would recommend facility delivery to others.					
5	I believe traditional birth attendants provide equally good care.					

6	I feel respected and well-treated by health workers during delivery.					
7	Facilities deliveries are unnecessary if there are no complications.					

Factors Influencing Utilization Of Facility Delivery.

Instruction: For the following statements, please indicate your level of agreement by selecting:

SA (Strongly Agree) if you strongly agree with the statement

A (Agree) if you agree with the statement

U (Undecided) if you are neutral or unsure

D (Disagree) if you disagree with the statement

SD (Strongly Disagree) if you strongly disagree with the statement

	Factors Influencing Utilization Of Delivery.	SA	A	SD	D	U
1	I have experienced or anticipate challenges/barriers in accessing facility delivery, such as cost, distance, or transportation issues.					
2	Distance to health facility is a challenge.					
3	Lack of transportation is a problem.					
4	Poor quality of care is a concern that affects my					

	decision to deliver in a health facility.					
5	Cultural or traditional reasons influence my choice of delivery location.					
6	Negative attitude of health workers discourages women.					
7	I fear unnecessary medical intervention like caesarian section.					
8	My husband and family prefer home delivery.					

Factors Affecting Facility - Delivery

Instruction: For the following statements, please indicate your level of agreement by selecting:

SA (Strongly Agree) if you strongly agree with the statement

A (Agree) if you agree with the statement

U (Undecided) if you are neutral or unsure

D (Disagree) if you disagree with the statement

SD (Strongly Disagree) if you strongly disagree with the statement

	Factors Affecting Facility – Delivery	SA	A	SD	D	N
--	--	----	---	----	---	---

1	I prefer delivering at home because I feel comfortable and relaxed.					
2	I lack information about the benefits of facility-based delivery.					
3	Facility delivery provides better postpartum care					
4	I plan to deliver in a health facility for my next pregnancy					

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Lead City University (LCU)

Motto: Knowledge for Self-reliance

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**Department of Nursing Science
Faculty of Basic Medical and Health Sciences**

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7th October, 2025

Lead City University, Ibadan,
Faculty of Basic Medical & Health Sciences
Department of Nursing Science,

To:

The Permanent Secretary
Ekiti State Ministry of Health,
Ado Ekiti

Through:

The Director Planning Research and Statistics
Ekiti State Ministry of Health,
Ado Ekiti

Dear Sir,

**LETTER OF INTRODUCTION: ETHICAL APPROVAL
ASONIBARE OMOLARA IBIYEMI – MATRIC NO. LCU/PG/006617**

I write to confirm that Asonibare Omolara Ibiyemi is an MSc student in the Department of Nursing Science, Faculty of Basic Medical and Health Sciences, Lead City University, Ibadan.

She is seeking ethical approval to enable her carry out a research work TITLED " KNOWLEDGE PERCEPTION AND FACTORS INFLUENCING THE UTILIZATION OF FACILITY DELIVERY AMONG PREGNANT WOMEN IN SELECTED FACILITIES IN ADO LOCAL GOVERNMENT AREA, EKITI STATE"

I hereby request your kind assistance and approval.

Thank-you very much

Yours faithfully

Dr. T. A. Otufale
Head of Department

Lead City University
Department of Nursing Science

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Lead City University Ibadan DO NOT COPY



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MINISTRY OF HEALTH AND HUMAN SERVICES

Peju Babafemi Building, State Secretariat Complex, Ado-Ekiti, Ekiti State, Nigeria.
Email: ekmhhs@ekitistate.gov.ng

*All communications should be addressed
to the permanent secretary quoting:*

Date: 27th October, 2025.

Our Ref. No: MOH/PRS/040
Asonibare Omolara Ibilyemi
Department of Nursing Science,
Lead City University,
Ibadan, Oyo State.

Dear Sir,

RE: APPLICATION FOR ETHICAL APPROVAL

Your application for ethical approval on the topic 'Knowledge, Perception and Factors Influencing the Utilization in Selected Facilities in Ado Local Government Area, Ekiti State' is approved.

Your approval number is MOH/EKHREC/EA/P/146 and can be quoted in future correspondence.

You are strongly implored to abide by the basic health research principles of respect of persons, beneficence and justice, and also protecting all data obtained from the study participants.

I wish you success in your investigation.

Dr. Sunday Omoya
For: Permanent Secretary

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