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Assessment of Maternal Delivery Choices among Pregnant Women in Ethiope West Local Government Area of Delta State

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Abstract: *This study assessed maternal delivery choices among women in Ethiope West Local Government Area of Delta State, Nigeria, with a focus on perceptions toward nurses, traditional birth attendants (TBAs), and faith-based providers. Using a descriptive cross-sectional design, data were collected from 200 women of reproductive age across five purposively selected communities. Structured questionnaires, validated and pre-tested, captured socio-demographic characteristics, preferred places of delivery, and perceptions of birth attendants. Results revealed that hospitals and health centres were the most preferred places of delivery, particularly in Ogharefe and Mosogar, while Jesse displayed a higher reliance on TBAs. Respondents associated nurses with professional competence, positive past experiences, and availability, though they rated them poorly on interpersonal qualities such as kindness and respect. TBAs were valued for perceived competence, respectful treatment, and accessibility, but not for cultural knowledge or affordability. Faith-based providers, including pastors and spiritual women, were primarily sought for prayers, protection against spiritual harm, and free services. These findings highlight that maternal delivery choices are influenced not only by biomedical trust in skilled care but also by interpersonal relationships, cultural perceptions, and spiritual considerations. The study concludes that improving maternal health outcomes requires an integrated strategy that enhances the interpersonal skills of healthcare workers, fosters collaboration with TBAs and faith leaders, and promotes accessible, culturally sensitive maternal health services across communities.*

Keywords: maternal delivery choices, skilled birth attendants, traditional birth attendants, faith-based providers, interpersonal care

INTRODUCTION

Maternal health remains a cornerstone of global public health, as the outcomes of pregnancy and childbirth are critical indicators of the quality of healthcare systems and overall societal development. Despite remarkable progress in maternal healthcare worldwide, maternal mortality continues to be a major concern in many low- and middle-income countries (LMICs), particularly in Sub-Saharan Africa. The World Health Organization (WHO) estimates that approximately 287,000 women died globally from pregnancy-related causes in 2020, with Sub-Saharan Africa accounting for nearly 70% of these deaths (WHO, 2023). Nigeria, being the most populous country in Africa, contributes significantly to this burden, ranking among the nations with the highest maternal mortality ratios globally. Studies have highlighted that maternal mortality in Nigeria is strongly linked to where and with whom women deliver, underscoring the importance of understanding maternal delivery choices (Adewuyi et al., 2020; Doctor et al., 2019).

The preference for place of delivery and type of birth attendant often determines maternal and neonatal outcomes. Skilled birth attendants, such as nurses, midwives, and doctors, are trained to manage complications and provide safe delivery services. However, in many rural and semi-urban areas of Nigeria, women continue to rely on traditional birth attendants (TBAs), spiritual homes, or unskilled caregivers during childbirth (Umar & Kabir, 2019). This reliance is often shaped by cultural norms, socio-economic status, perceived quality of care, and accessibility of health facilities. In Delta State, particularly in Ethiope West Local Government Area, these dynamics are pronounced, as communities exhibit varied preferences regarding maternal delivery practices, influenced by tradition, religion, and economic realities.

Globally, there has been an increasing recognition of the social determinants of health that influence maternal choices. According to Bohren et al. (2021), the decision of where and how women give birth is not solely a medical one but is also shaped by cultural, emotional, and experiential factors. In many African communities, TBAs are not just considered caregivers but custodians of cultural practices and traditions. Their services are often valued because of their accessibility, familiarity, and flexible payment arrangements compared to formal healthcare providers (Okafor et al., 2018). However, reliance on TBAs and faith-based providers has been associated with poor maternal outcomes due to the absence of professional skills to handle emergencies such as obstructed labour, haemorrhage, or eclampsia (Izugbaa & Wekesah, 2018).

In Nigeria, the determinants of maternal delivery choices have been extensively studied, but findings consistently show that socio-demographic factors play a pivotal role. Age, parity, marital status, education, and occupation strongly correlate with the decision to seek skilled birth attendance (Eze et al., 2020). For instance, women with higher levels of education are more likely to deliver in hospitals and under the supervision of skilled personnel (Ononokpono & Odimegwu, 2019). Similarly, economic empowerment through income-generating occupations enables women to afford hospital delivery and related costs. Conversely, rural and less-educated women are more likely to rely on TBAs, given the financial and geographic barriers to healthcare access (Adewuyi et al., 2020).

Religious and cultural beliefs further influence delivery practices. In many Nigerian communities, spiritual and faith-based institutions provide maternity services, with women often perceiving them as safer alternatives that offer both physical and spiritual protection during childbirth (Chigbu et al., 2021). While these services may provide psychological comfort, they frequently lack the biomedical expertise and emergency care capacity necessary to prevent maternal deaths. For example, a study by Doctor et al. (2019) found that reliance on prayer houses and churches for childbirth in southern Nigeria contributed significantly to delays in accessing life-saving obstetric care.

Another critical determinant of maternal delivery choice is the perceived quality of care within healthcare facilities. Negative experiences such as disrespect, verbal abuse, long waiting times, and poor interpersonal relations with healthcare workers often discourage women from seeking hospital-based delivery (Bohren et al., 2015). In contrast, TBAs and faith-based attendants are often described as more compassionate, approachable, and culturally sensitive, which strengthens women's preference for them despite the associated risks (Umar & Kabir, 2019). This highlights the importance of patient-centred care as a determinant of skilled birth attendance.

In Delta State, structural challenges also shape maternal delivery decisions. Health infrastructure in rural communities is often underdeveloped, with limited facilities, shortage of skilled health workers, and inadequate supplies of drugs and equipment (Ofili & Okojie, 2020). Transportation barriers, especially in riverine areas, further compound the problem, making health facilities physically inaccessible to many women in labour. These infrastructural limitations perpetuate reliance on TBAs and home deliveries, which are more readily available within communities (Ogu et al., 2021). It is equally important to consider the role of parity in maternal delivery decisions. Evidence suggests that women with higher parity tend to opt for home or TBA-assisted deliveries, perceiving childbirth as a routine event that does not require medical intervention (Ononokpono & Odimegwu, 2019). On the other hand, primigravida women are more likely to deliver under skilled supervision, largely due to fear of complications and family encouragement to seek hospital care (Doctor et al., 2019). Understanding these dynamics is essential for developing targeted interventions that promote safe delivery practices across different socio-demographic groups.

Maternal decision-making is also influenced by community and family structures. In many Nigerian households, husbands and elder relatives play a decisive role in determining where women deliver (Eze et al., 2020). Male partners often control financial resources, and their perceptions about TBAs, faith-based delivery, or hospitals significantly influence women's choices. Consequently, interventions aimed at increasing hospital-based deliveries must engage not only women but also their partners and families to ensure community-wide acceptance (Chigbu et al., 2021).

The persistence of preventable maternal deaths in Nigeria highlights the urgent need to address barriers to skilled birth attendance and safe delivery practices. The Sustainable Development Goal (SDG) 3.1 aims to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030, a target that Nigeria is currently not on track to achieve (WHO, 2023). Addressing maternal delivery choices at the local government level, such as in Ethiope West,

provides context-specific evidence that can inform policies and interventions. By understanding the socio-cultural, economic, and infrastructural determinants of maternal delivery preferences in these communities, policymakers and health practitioners can develop strategies to increase the uptake of skilled birth attendants and reduce maternal deaths.
This study is therefore situated within the broader framework of maternal health improvement in Nigeria. It seeks to assess maternal delivery choices among women in Ethiope West Local Government Area, Delta State. The specific objectives of the study were:

1. To determine the preferred places of delivery among pregnant women across selected communities in Ethiope West Local Government Area of Delta State.
2. To assess the perceptions of pregnant women in Ethiope West Local Government Area of Delta State towards nurses, traditional birth attendants, and faith-based providers during childbirth.

MATERIALS AND METHODS

The study adopted a descriptive cross-sectional research design, which was deemed appropriate for examining the determinants of maternal delivery choices among pregnant women within Ethiope West Local Government Area of Delta State. This design enabled the researcher to collect relevant information at a specific point in time from a defined population, thereby providing a snapshot of the respondents' delivery preferences. The population for this study consisted of women of reproductive age who had either recently given birth or were currently pregnant in the selected communities within Ethiope West Local Government Area. A sample size of 200 respondents was determined using a multi-stage sampling technique to ensure representativeness. The first stage involved the purposive selection of five major communities within the local government area, namely Jesse, Mosogar, Ogharefe, Ogharefe I, and Ogharefe II. These communities were chosen due to their varied patterns of healthcare access and delivery preferences. The second stage involved simple random sampling to select eligible respondents within each community, proportionately distributed based on the estimated population size. This sampling approach enhanced the validity of the findings, minimised bias, and ensured that responses captured the diversity of delivery practices across the communities. Data were collected through a structured questionnaire designed by the researcher and validated by experts in maternal and child health. The questionnaire was divided into sections that covered socio-demographic characteristics, preferred places of delivery, and perceptions of birth attendants, including nurses, traditional birth attendants, and faith-based providers. The instrument was pre-tested in a neighbouring community with similar socio-cultural features, which allowed for the refinement of ambiguous items and ensured that the tool was contextually relevant. To facilitate accurate responses, the questionnaire was administered in English and translated into the local language for participants who were not literate in English. Trained research assistants, who were nursing officers familiar with the cultural context of the communities, assisted in data collection. This ensured that respondents felt comfortable, while also reducing the risk of misinterpretation. Ethical considerations were observed by seeking informed consent from each participant, assuring confidentiality, and guaranteeing that participation was voluntary.

Data obtained were analysed using descriptive statistics. Descriptive statistics such as frequencies, percentages, and means were used to summarise respondents' socio-demographic information and their delivery choices. Cross-tabulations were employed to compare the preference of delivery locations across different communities.

RESULTS

Table 1: Demographic data of respondents

Demographic factors	Frequency	Percentage
Age		
< 20	3	1.5
20 – 29	37	18.5
30 – 39	98	49.0
40 and above	62	31.0
Marital status		
Single	11	5.5
Married	137	68.5
Divorced	28	14.0
Widow	24	12.0
Religion		
Christianity	129	64.5
Islam	6	3.0
African traditional	65	32.5
Educational status		
None	7	3.5
Primary	29	14.5
Secondary	103	51.5
Tertiary	61	30.5
Occupation		
Farming	31	15.5
Trading	78	39.0
Seamstress	49	24.5
Government worker	17	8.5
Others	25	12.5
Parity		
1	2	1.0
2	13	6.5
3	65	32.5
4	91	45.5
5	17	8.5
6	12	6.0

The demographic profile of respondents shows that the majority (49.0%) were aged 30–39 years, followed by 31.0% aged 40 years and above, while only 1.5% were below 20 years.

Most participants were married (68.5%), with a smaller proportion being divorced (14.0%) or widowed (12.0%). In terms of religion, Christianity was predominant (64.5%), followed by African traditional religion (32.5%), while only 3.0% practised Islam. Educationally, more than half (51.5%) had secondary education, 30.5% attained tertiary education, while very few (3.5%) had no formal education. Trading (39.0%) and seamstress work (24.5%) were the most common occupations, with fewer respondents engaged in farming (15.5%) and government work (8.5%). Regarding parity, a large proportion (45.5%) had four children, while 32.5% had three, indicating relatively high fertility rates among the respondents.

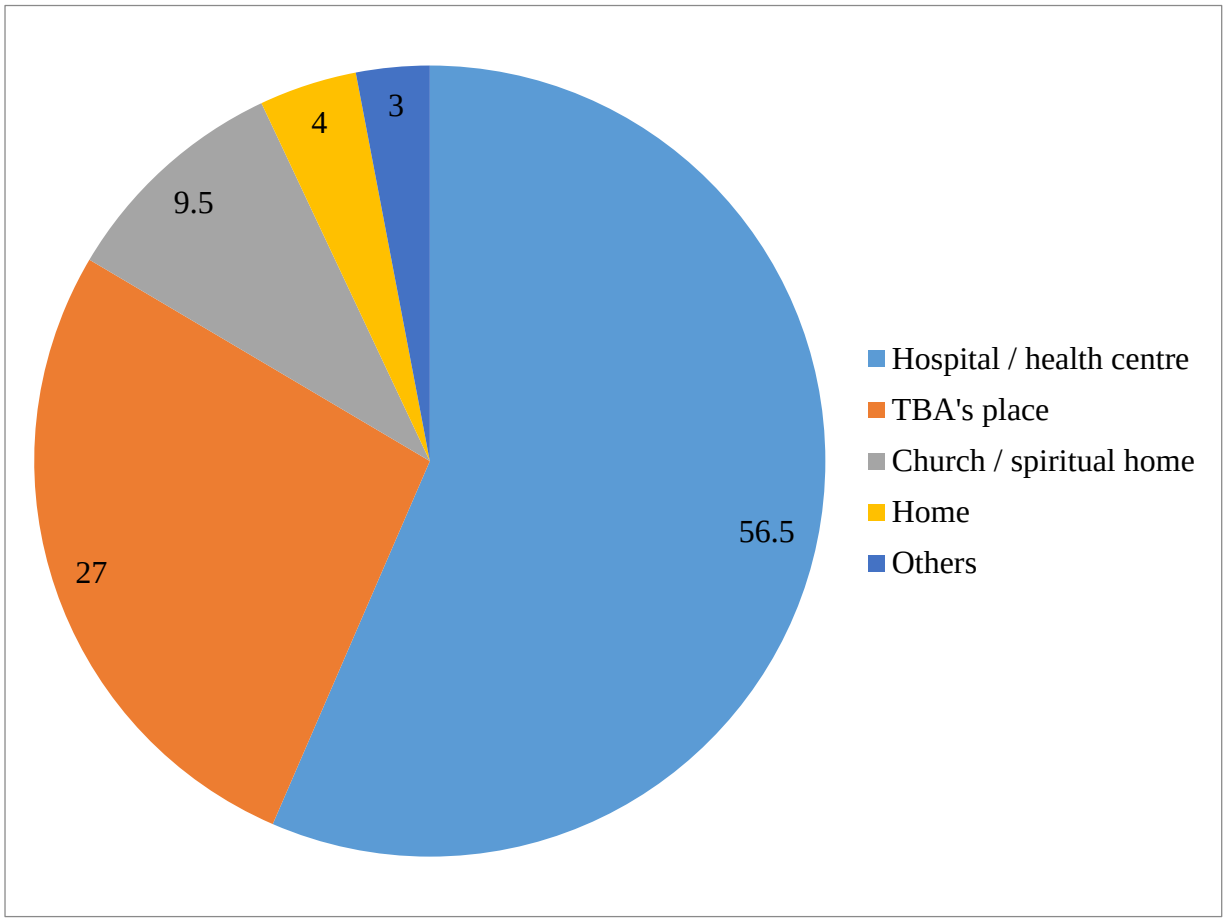

Figure 1: Response to skilled birth attendants

Figure 1 showed a pie chart representation of responses according to places that offer SBA. 56.5%, which signifies a large portion of hospital and healthcare provided by the SBA for pregnancy mothers, 27% were TBA, 9.5% showed Church/Spiritual home, while 4% indicates home and 3% indicates others. This indicates that skill birth attendants are provided in hospitals/health centre due to their standard of healthcare.

Table 2 Preference of place of delivery across the locations studied

Location	Birth Place	Frequency
Jesse	Hospital	12
	TBA	21
	Church	5
	Home	2
	Others	0
	Total	40
Mosogar	Hospital	28
	TBA	9
	Church	2
	Home	0
	Other	1
	Total	40
Ogharefe	Hospital	39
	TBA	0
	Church	1
	Home	0
	Other	0
	Total	40
Ogharefe I	Hospital	26
	TBA	6
	Church	3
	Home	5
	Other	0
	Total	40
Ogharefe II	Hospital	30
	TBA	9
	Church	0
	Home	1
	Other	0
	Total	40

The data on delivery preferences across the studied locations reveals significant variation in birth place choices. In Jesse, most respondents delivered with traditional birth attendants (21), while only 12 chose hospitals and smaller numbers opted for churches (5) or home deliveries (2). In contrast, Mosogar showed a stronger preference for hospitals (28), with fewer using TBAs (9), churches (2), or others (1). Ogharefe demonstrated the highest hospital preference, with 39 out of 40 respondents delivering in hospitals and just one in a church. Similarly, in Ogharefe I, hospitals were dominant (26), though a notable number still delivered with TBAs (6), at home (5), or in churches (3). Ogharefe II also reflected a strong hospital preference (30), with 9 deliveries by TBAs and only one at home. Overall, while hospitals were the most preferred place of delivery across most locations, Jesse stood out with a higher reliance on TBAs, highlighting location-specific variations in maternal health-seeking behaviours.

Table 3: Perception of the attitude of birth attendants

Statements	Strongly agree (5)	Agree (4)	Undecided (3)	Disagree (2)	Strongly disagree (1)	Mean	Remark
Reasons choosing nurse/wife							
She is always available	75(375)	80(320)	-	20(40)	25(25)	3.74	A
She is well qualified to do the job	90(450)	70(280)	20(6)	15(30)	5(5)	4.15	A
She is caring and kind	5(25)	10(40)	40(12)	100(200)	45(45)	1.61	R
She respects people	10(50)	18(72)	-	120(240)	52(52)	2.07	R
She treated me well in the last delivery	80(400)	90(360)	20(60)	10(20)	-	4.2	A
Reasons for choosing TBA							
She knows the job	70(350)	80(360)	30(90)	20(40)	-	4.2	A
She treats people with respect	40(200)	100(400)	20(60)	10(20)	20(20)	3.5	A
She lives near me	10(40)	20(80)	-	60(120)	110(110)	1.75	R
She is always available	86(430)	54(216)	-	20(40)	60(60)	3.73	A
She gives traditional medicine	-	-	-	80(160)	120(120)	1.4	R
She knows our tradition	1(5)	17(68)	22(66)	100(200)	60(60)	1.99	R
She charges low	10(50)	20(80)	-	100(200)	70(70)	2.0	R
Reasons for choosing pastors/spiritual woman							
She prays for me	90(450)	80(360)	-	30(60)	-	4.35	A
She sees vision	40(200)	40(160)	-	100(200)	20(20)	2.9	R
She can prevent an evil attack	50(250)	30(120)	30(90)	60(120)	30(30)	3.05	A
She does not charge me	90(450)	60(240)	20(60)	20(40)	10(10)	4.0	A

Mean Cut-off: 3.00 ***A - Accepted; R - Rejected***

The perception of birth attendants, as reflected in the table, highlights varying reasons why respondents choose nurses, traditional birth attendants (TBAs), or pastors/spiritual women for delivery services. For nurses, respondents strongly associated their choice with professional qualifications (mean = 4.15), past positive experiences (mean = 4.2), and availability (mean = 3.74), all of which were accepted (A). However, attributes such as caring and kindness (mean

= 1.61) and respect (mean = 2.07) were rejected (R), suggesting that while nurses were valued for competence and reliability, their interpersonal relationships were not perceived positively. In the case of TBAs, they were favoured because they were believed to know the job (mean = 4.2), treat people with respect (mean = 3.5), and were generally available (mean = 3.73). However, reasons tied to traditional medicine (mean = 1.4), proximity (mean = 1.75), low charges (mean = 2.0), and cultural knowledge (mean = 1.99) were rejected, indicating that the reliance on TBAs is less about cultural or economic reasons and more about perceived competence and relational respect.

Pastors or spiritual women were preferred largely for their spiritual roles, especially the belief that they can pray for safe delivery (mean = 4.35) and because they often do not charge fees (mean = 4.0). The ability to prevent perceived evil attacks (mean = 3.05) was also accepted, though moderately, while reliance on visions (mean = 2.9) was rejected. These findings imply that respondents' choice of birth attendants is influenced by a complex interplay of professionalism, respect, affordability, availability, and spirituality. The inference drawn is that while nurses are trusted for their technical expertise, TBAs are valued for their interpersonal respect, and spiritual women for faith-based assurances. This demonstrates that maternal care choices in the studied communities are not solely based on medical competence but are significantly shaped by socio-cultural and spiritual considerations, pointing to the need for an integrated maternal health strategy that acknowledges professional, cultural, and spiritual dimensions.

DISCUSSION

The findings of this study reflect the complex interplay of cultural, socio-economic, and structural determinants shaping women's choices of birth attendants in Ethiope West. The predominance of hospitals and health centres across most communities highlights the growing trust in skilled birth attendants (SBAs), consistent with evidence that institutional delivery improves maternal and neonatal outcomes (Chukuezi, 2010; Doctor et al., 2018). This suggests that in areas such as Mosogar and Ogharefe, improved access to quality health facilities, awareness of maternal risks, and positive health-seeking behaviours may be influencing women's choices. The marked preference for hospitals in Ogharefe particularly reflects the impact of accessibility and health infrastructure, aligning with findings that availability of functional facilities and trained personnel strongly determine women's decisions (Adewuyi et al., 2018).

However, Jesse presents a contrasting pattern where reliance on traditional birth attendants (TBAs) remains high. This finding resonates with studies in Nigeria and other low-resource settings, which report that TBAs continue to thrive due to affordability, cultural acceptability, and perceived emotional support during labour (Osubor, Fatusi & Chiwuzie, 2006; Adedokun & Uthman, 2019). Despite efforts to discourage TBA use, many rural women still view them as more accessible and trustworthy, particularly when modern health services are perceived as expensive, distant, or insensitive (Ezeh et al., 2014). Similarly, the use of churches and home deliveries, though minimal, demonstrates the influence of spiritual beliefs and traditional norms in childbirth choices, a phenomenon also observed in other African contexts (Moyer & Mustafa, 2013).

The findings from this study underscore the multifaceted nature of maternal delivery choices, where women's preferences are influenced not only by professional competence but also by interpersonal, socio-cultural, and spiritual considerations. The preference for nurses due to their professional qualifications and past positive experiences resonates with findings from Fagbamigbe et al. (2020), who observed that women's confidence in skilled birth attendants often stems from their medical expertise and perceived safety. However, the rejection of attributes such as kindness and respect suggests gaps in interpersonal care, echoing Bohren et al. (2015), who highlighted widespread reports of disrespect and mistreatment of women during facility-based childbirth in Nigeria and other low-resource settings. This indicates that while technical competence is vital, relational aspects of care strongly shape perceptions of maternal health providers.

The reliance on traditional birth attendants (TBAs) highlights the enduring role of community-based providers in maternal care. The positive perceptions of TBAs' competence and respect align with the observations of Adatara et al. (2018), who found that many women in sub-Saharan Africa trust TBAs for their empathetic approach and community embeddedness, even in contexts where formal healthcare is available. The rejection of cultural knowledge and affordability as significant reasons for their use in this study, however, suggests a shift from purely cultural or economic motivations towards a preference for respectful treatment and accessibility, reinforcing the need to integrate respectful maternity care into formal systems (Shiferaw et al., 2020).

For pastors and spiritual women, the appeal lies primarily in their provision of spiritual reassurance and perceived protection from harm, which corresponds with findings by Chukwuma et al. (2017), who noted that spirituality plays a critical role in shaping maternal care choices in Nigeria. The preference for prayer and free services reflects the socio-religious fabric of many Nigerian communities where faith is interwoven with health-seeking behaviour (Darteh et al., 2020). This implies that spiritual providers are not necessarily chosen as alternatives to medical care but as complementary actors addressing women's psychosocial and spiritual needs during childbirth.

CONCLUSION

The findings from this study reveal that the majority of respondents were women in their reproductive age, predominantly married, with secondary-level education, and engaged largely in trading and seamstress work. A significant proportion of respondents had three to four children, suggesting relatively high fertility rates. When it came to maternal health service utilisation, hospitals were the most preferred places of delivery across most locations, particularly in Ogharefe and Mosogar, while Jesse stood out with higher reliance on traditional birth attendants (TBAs). The perception of birth attendants further highlights a complex interplay of factors shaping delivery choices: nurses were preferred for their professional competence and past treatment experiences but scored poorly on interpersonal qualities like respect and kindness. TBAs, on the other hand, were chosen largely because of perceived job competence, respect, and availability, while pastors or spiritual women were valued primarily for prayers, prevention of perceived spiritual attacks, and the fact that their services were often free.

The overall conclusion is that maternal health-seeking behaviours in the studied communities are driven not only by biomedical competence but also by interpersonal relations, cultural beliefs, and spirituality. While hospitals and skilled birth attendants dominate in terms of technical trust, TBAs remain relevant due to their relational approach and accessibility, whereas pastors or spiritual women play a complementary role in meeting faith-based and spiritual needs. This suggests that an effective maternal health strategy must integrate medical, socio-cultural, and spiritual dimensions to increase skilled birth attendance, reduce maternal risks, and encourage community-wide acceptance of hospital-based delivery services.

Recommendations

1. Healthcare workers, particularly nurses, should be trained and sensitised on improving interpersonal relationships, respect, and empathy to build trust and encourage more women to use skilled birth attendants.
2. Government and policymakers should strengthen community health education to address myths and misconceptions around childbirth while promoting the importance of skilled care during delivery.
3. Collaboration between hospitals, TBAs, and faith-based leaders should be fostered, ensuring referral systems that allow TBAs and spiritual women to direct complicated cases to skilled health facilities promptly.
4. Maternal health programmes should be decentralised and made more accessible in rural communities, reducing the dependence on TBAs and faith-based providers while still respecting cultural and spiritual contexts.

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