International Journal of Innovative Medicine & Medicinal Plants Research
10(3):20-28, July-Sept., 2022

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Birth Facility Choice For Women And Their Families

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ABSTRACT
The need to improve health service utilization for the reduction of maternal mortality and morbidity has prompted interest in the choices people make in seeking care when it comes to delivery and other maternity choices. This paper focused on the birth facility choice for women and their families. In spite of the state government's initiatives to increase access to essential maternal health services, disseminating key messages on the advantages of facility delivery and pregnancy complications, in addition to the training of health workers on interpersonal communication, home deliveries have persisted and therefore requires a policy solution. The paper was guided by five objectives. Major issues discussed were medical facility, reasons for choice of facility, type of facilities used by women, factors that influence choice of facility by women and solutions to the identified problems. It was concluded that, a number of steps need to be taken in order to increase facility delivery.
Keywords: Birth, Choice, Families, Maternal, Infant health

INTRODUCTION

The need to improve health service utilization for the reduction of maternal mortality and morbidity has prompted interest in the choices people make in seeking care when it comes to delivery and other maternity choices (Ojifinn, et al.,2018). Individuals make decisions in relation to their health after weighing the potential risks and benefits of the environment, their social rootedness and their whole outlook on life generally. Odetola, (2015) opined that, the choice of healthcare facility for any health problem will therefore be determined by a person's current situation with reference to financial status, social standing and previous experiences. Factors affecting choice of reproductive healthcare include; beliefs about pregnancy, labour and delivery, the perceived consequences of choice of care, financial capacity as at the time of pregnancy, and the constraints faced in situations where they decide to seek help but are unable to. Ojifinn, et al. (2018) stated that, the educational and economic status, decision making capacity, as well as control over household income is positively associated with an individual's ability to seek healthcare. Other factors that have been shown to affect choice of facility include cost of care, proximity to the healthcare facility, type of pregnancy (e.g. multiple pregnancy etc.).

Yahya et al. (2019) stated that the use of orthodox health facilities for delivery may also be affected by socio-cultural values and beliefs, where they hold perception that pregnancy and delivery does not need medical intervention will prevent women from seeking care early enough. In addition feelings of shame associated with very early pregnancy and very late pregnancy may prevent the use of health facilities. On the other hand, Ojifinn, et al. (2018) opined that, confidence and friendliness of the healthcare worker, encouraging staff attitude, a sense of privacy and belief in the confidentiality of information provided, may encourage the use of health facilities.

While choices of care for general illness has been assessed in different areas in the country, there is need to highlight and educate women and their families on how to consider choice of facilities for reproductive health in general. A study carried out by Ojifinn, et al. (2018) in Gombe State,

northeastern Nigeria to assess the factors influencing the decision to choose a birth center by pregnant women recorded a high prevalence of home deliveries with very low facility deliveries despite the efforts of government and international non-governmental organizations in supporting maternal health services. The findings showed that religion accounted for (AOR=12.117, 95% CI 1.774–82.741), paid work (AOR=3.633, 95% CI 1.243–10.615) and identification and knowledge of pregnancy complications (AOR=4.281, 95% CI 1.054–17.387) were the factors found to be significantly associated with choice of birth center by pregnant women. Age, education, closeness to a facility and decision by husband or woman were not found to be statistically significant.

According to Yahya, et al. (2019), only about 36 percent of births take place in a health facility while 63 percent of women deliver at home in Nigeria. Recent findings in 2016–2017, by the National Bureau of Statistics and the United Nations International Children's Emergency Fund puts the percentage of women (15–49 years old) that delivered in the health facility in Northeast Nigeria at 25.8 percent while 74 percent delivered at home. Gombe state recorded 68.4 percent home deliveries and 29.3 percent public sector deliveries.

In spite of the state government's initiatives to increase access to essential maternal health services, disseminating key messages on the advantages of facility delivery and pregnancy complications, in addition to the training of health workers on interpersonal communication, home deliveries have persisted and therefore requires a policy solution. Odetola, (2015), opined that a number of barriers have been found to limit pregnant women from utilizing health facilities as birth centers. Costs of services, transportation to the facility, ability to make decisions on the place of birth and religious and cultural practices are some of the factors found to be influencing the choice of place of delivery among women. Others include the region of residence and educational level of the women. In the Nigerian context, Idris *et al*. (2005) found that only 24 percent of women delivered in a health facility among women surveyed in a semi-urban northern Nigerian setting citing lack of pregnancy complications and the negative attitudes of health providers as their reasons.

According to Yahya et al. (2019), the sudden onset of labor late at night, the absence of transportation and limited options for birth positions were also factors found to promote the high prevalence of home births. A recent qualitative study found factors that discouraged women from giving birth at facilities to include knowledge, attitudes of the women and awareness of labor outcomes, community beliefs and previous birth experience. Decisions taken jointly between the husband and wife were found to significantly favor delivery in a health facility compared to women taking decisions independently. It is therefore imperative, to adequately health educate women and their families on the types of available health facilities, and the criteria that will make them make an informed choices of health facility (Yahya, et al.. 2019).

Rationale/Justification

With reference to Adedokun, et al. (2019), health facility delivery has been described as one of the major contributors to improved maternal and child health outcomes. It provides access to appropriate equipment and drugs, skilled attendants and immediate referral to a higher facility. Proportions of health facility delivery vary across continents and regions. While 9 in every 10 births take place in health facility in Europe, Central and East Asia, the Pacific, Latin America and the Caribbean, only 56% of all births occur in health facility in sub-Saharan Africa. This average performance in respect of facility delivery has reflected in the maternal mortality records in the region. According to Adedokun, et al. (2019), as at 2015, maternal mortality rate in sub-Saharan Africa was 546 per 100,000 live births, accounting for 66% of the global maternal deaths. The situation of maternal health in Nigeria aligns with that of sub-Saharan Africa as a whole. The country's maternal mortality ratio of 576 deaths per 100,000 live births calls for concern. In fact, world records indicate that one-third of the global maternal deaths occurred in Nigeria and India. Since complications resulting from pregnancy contribute substantially to these maternal deaths, strategies have been adopted at different times to improve pregnancy and delivery care. One of such strategies is the SURE-P maternal and child health programme which has been designed to ensure not only access to maternal health services but also the quality of maternal health care. When women are properly informed about the objectives of SURE-P, women and families will be able to make an informed decision on choice of facility (Adedokun, et al. 2019).

Objectives

1. To identify the factors that influence choice of facility by women.
2. To determine if the attitude of healthcare workers affect choice of facility by women.
3. To determine if the socio-economic status of women and their families has influence on choice of facility.
4. To ascertain if proximity to health care facility determine where women chose as their facility of care.
5. To ascertain if beliefs, cultural norms and values have an effect on choice of facilities by women and their families.

DISCUSSION

Definition of a Medical facility

Facility according to Oxford Advanced Learner's Dictionary (2000) is a building, service, equipment etc. that is provided for a particular purpose or, a place, amenity, or piece of equipment provided for a particular purpose. 'Medical Facility' therefore means a hospital, maternity home, nursing home, dispensary, clinic, or an institution by whatever name called that offers services requiring diagnosis, treatment or care for illness, injury, deformity, abnormality or pregnancy in any recognized system of medicine established and maintained by any person or body of persons, whether incorporated or not (https://vmc.gov.in/vmcdocs/OMRF/3.%20Definitions.pdf).

According to the National Partnership for Women & Families 2020, it is important for women to make thoughtful decisions about the choice of facility during pregnancy and labour. These major decisions can affect, the care she will receive, the effects of that care, the quality of the woman's relationship with the care provider(s), how much information she will get, the choices and options she will have, particularly during labor and birth and her involvement with decisions about her care. It is critical that the woman and family feel at home about the health care professional that will provide the maternity care within the preferred setting.

Reasons for choice of facility

In a study carried out by Hodnett, et al. (2012), it was noted that it is imperative to resist choosing a place of birth just because of location, a friend's recommendation, or because someone have used that hospital for other health care needs. The full range of maternity care services any facility center offers should be known before deciding whether it is right or not. The following are signs of an excellent choice of birthplace:

i. The health care facility offers care based on the best available research about what is safe and effective.
ii. The environment and practices in the birth setting work to support the body's natural ability to give birth, rather than disrupt it.
iii. Staff are committed and able to provide lots of support, including comfort and information.
iv. The setting offers individualized care based on the individual health needs, the needs of the baby and the woman's personal preferences and values.

Types of facilities used by women

This is divided into three viz:

- Hospital based delivery,
- Out of hospital based delivery
- Home delivery

1. Hospital based delivery: This include obstetrics and gynaecological health care centers, secondary care facilities and tertiary medical institutions (Hodnett et al. 2012).The hospital is the most common site for birth. Maternity care in a hospital is usually led by physicians and often reflects the **medical model of care**.

Advantages Of Hospital Delivery

i. Although most childbearing women and newborns are well and healthy, a hospital is best equipped to diagnose and treat those with serious complications or high risk of developing such complications.
ii. There would be no need to transfer to another facility before, during or after labor (apart from the rare situation of needing highly specialized care that may not be available in that hospital).

iii. In the rare case of an emergency requiring hospital care, the woman is already in the facility and the needed personnel may be immediately available.
iv. The woman can access some interventions she may want, such as epidural pain relief, which is not available in non-hospital settings.

Disadvantages Of Hospital Delivery

1. Emphasize standardized care rather than individualized care.
2. Use some health interventions whether or not birthing women need them (e.g., electronic fetal monitoring, breaking membranes, and cesarean birth).
3. Rely more on the facility's technology than the woman’s body’s physiology.
4. Not have staff available to provide continuous physical, emotional and informational support during labor and delivery. (Many women may be in labor at the same time, and the staff might be focused on managing technology.)

Outcomes Of In-Hospital Birth Centers

i. Admission of baby in newborn intensive care unit.
ii. Early separation of baby from mother
iii. Perinatal death.
iv. Medicalized birth

2. Out of hospital based delivery: This include Primary health care centers and Maternity homes (Alliman, et al. 2016). Demand for out of hospital birth centers/Primary Health Care centers is growing and many new ones are being set up. However, they are not yet available in all parts of the country. This type of care can be a good choice for women who want more personalized care than in hospitals and those who want to limit the use of interventions, but don’t feel comfortable with home birth.In contrast to the institutional environment in hospitals, most out of hospital birth centers have a home-like environment, and many are, in fact, located in converted homes. Care in this birth centers is often provided by midwives and often reflects the **midwifery model of care**. This means that birth center care may:

i. Emphasize individualized rather than standardized care.
ii. Provide care based on what the woman needs and prefers, and avoid the routine use of interventions.
iii. Rely more on the body's own healthy processes than the facility's technology. (this means many types of interventions are less common in this birth centers.)
iv. Have staff available to give continuous physical, emotional and informational support during labor and delivery, and to support companions as well. (The woman may be the only one there in labor, and the staff are less likely to be focused on managing technology than in hospitals.)

Advantages Of Out Of Hospital Based Delivery

Alliman, et al. (2016) stated that the following outcomes are better for women and babies using birth center care than for women using hospital care:-

i. Less use of overall pain medication and epidural analgesia in particular.
ii. Less use of drugs to accelerate labor (synthetic oxytocin or “Pitocin”).
iii. Less use of episiotomy.
iv. More experience of intact perineum with vaginal birth (no tear or episiotomy).
v. Less use of vacuum extraction or forceps.
vi. More experience of vaginal birth with neither vacuum extraction nor forceps.
vii. Less use of cesarean birth.
viii. Greater satisfaction with care.

Drawbacks Of Birth In Out-Of-Hospital Birth Centers

There are several drawbacks of birth in out-of-hospital birth centers:

- Although most women accepted for birth center care do give birth in this setting, some switch to hospital care before, during or after labor. This switch could occur as a precaution, or due to complications.
- Although delivery in this birth centers have established emergency care plans, in the rare instance of an emergency requiring hospital care, the hospital facility and personnel are not

immediately available. The woman and/or baby would need to relocate or be transferred to a hospital.

- Epidural pain relief which the woman may want to have may not be available in this centers. This is because this centers offer many "low-tech" forms of care.

However, women giving birth in birth centers experienced longer labors in comparison with women in hospitals. The chance of having a serious tear going into or through the anus during labor does not differ between women giving birth in hospitals and those giving birth in birth centers.

Rates of transfer of women from birth center care to hospital care are as follows:

- During pregnancy for medical reasons: from 13 percent to 27 percent
- During labor: from 12 percent to 37 percent. (transport was "at least five times higher" for first-time mothers than for women who had already given birth)
- After birth: 1 percent to 5 percent

The most common reasons for transport were slow or prolonged labor and rupture of membranes without labor. (Wax, et. al 2010)

3. Home delivery: This include delivery at home and with traditional birth attendants. Home birth shares many qualities of birth with out of hospital/Primary Health Care centers. In addition, it is the woman's own familiar and private space and she do not have to relocate during labor or after giving birth. Most home birth care providers are midwives offering what has been called the midwifery model of care. This means that birth in one's own home may:

i. Be highly tailored to the woman's needs and preferences.
ii. Avoid the routine use of interventions and their side effects.
iii. Rely more on the body's own healthy processes than technology.
iv. Enables the woman receive continuous physical, emotional and informational support during labor and delivery, and offer important support to loved ones who are around.

Drawbacks of home birth:
There are several drawbacks of home birth:

- Some women planning home birth switch to hospital care before, during or after labor as a precaution if concerns arise, or due to complications.
- In case of any unexpected emergencies, the facility and personnel are not immediately available.
- Pain relief which the woman may want to have may not be available in this centers.

Wax, J.R., et. al (2010) stated that the outcome in home births include

i. More "post-term" births at or beyond 42 weeks.
ii. More neonatal deaths.
iii. Cord prolapse, a serious complication.
iv. Newborn large for gestational age.
v. Newborn requiring ventilation.
vi. Perinatal death (stillbirth from 20 or more weeks).

Factors that influence choice of facility by women.

In Nigeria, there is a 1 in 13 chance of a woman dying during pregnancy. Maternal deaths mainly occur during labor, delivery, or within the first 24 hours after birth. In most cases, they are largely due to preventable causes such as hemorrhage, infections, unsafe abortions, eclampsia, and obstructed labor. Availability of skilled health professionals at the point of delivery is the single most important factor in the prevention of maternal deaths. In Nigeria, only 35% (25% in rural and 60% in urban areas) of pregnant women use delivery services at healthcare facilities (Egharevba, et. al 2017). A study by Idris, Sambo reported that while 98% of new mothers in Northern Nigeria attended ANC services at a health facility, only 24% of them actually delivered at a healthcare facility. The main barriers to healthcare facility delivery identified in their study were no previous complications with delivery (57%) at home and negative attitudes of providers (24%), nearness to health facility, the ability to get transportation; labor occurring at night and allowing time to get to the health facility;

having a person to accompany the woman to the healthcare facility; problems during labor; and previous home delivery. Egharevba, et. al (2017).

Attitude of healthcare workers affect choice of facility by women.

According to (Bohren, et al. 2017), women in Nigeria report that poor provider attitudes influence their use of maternal health services. In Nigeria, women may expect to receive poor quality of care at health facilities during pregnancy and childbirth, which may mean that they will not use these potentially life-saving services. Bohren, et. al (2017) stated that women and providers reported experiencing or witnessing physical abuse including slapping, physical restraint to a delivery bed, detainment in the hospital and verbal abuse, such as shouting and threatening women with physical abuse. Women sometimes overcame tremendous barriers to reach a hospital, only to give birth on the floor, unattended by a provider. A study from Bohren, et. al (2017) in northwestern Nigeria concluded that 23.7% of women who did not give birth in a health facility cited negative provider attitudes as the primary reason for not using delivery services, and 52.0% of women suggested that improvements in provider attitudes are necessary to increase demand for facility-based childbirth

Influence of socio-economic status and proximity on choice of facility by women and their families

As skilled antenatal care and birth attendance is crucial intervention to reduce maternal mortality, some factors have been identified to inhibit skilled care. These factors as opined by Odetola, (2015) include: cost of services, socio-demographic and educational level of the client, women's level of autonomy in making health care decisions and physical accessibility to health care services. Maternal deaths could be prevented if women were able to access and utilize good quality services, especially when complications arise. However, in reality, most women experience serious barriers to accessing services due to distance and their social economic status. Odetola, (2015)

Beliefs, cultural norms and values and it's effect on choice of facilities by women and their families.

The influence of socio-cultural factors on institutional birth is not sufficiently documented. Thus, a study was carried out to explore socio-cultural beliefs and practices during childbirth and how it influences the utilization of institutional delivery services (Ababor,et al. 2019).

Their study identified socio-cultural factors influencing institutional birth in the study communities. There is high preference for traditional birth attendants (TBAs) and home delivery, as it is an intergenerational culture and it is equally suitable for privacy. Similarly, culturally unacceptable birth practices at health facilities (such as birth position, physical assessment, delivery coach) and inconvenience of health facility setting to practice traditional birth rituals such as newborn welcoming ceremony made women avoid health facility birth. On the other hand, misperceptions and worries on medical interventions such as episiotomy, combined with mistreatment from health workers, and lack of parent engagement in delivery process discouraged women from seeking institutional birth. The provision of delivery service by male health workers was cited as a social taboo and it is against the communities' belief system. This prohibited women from giving birth at a health facility.

DISCUSSION

Egharevba, et al. (2017), stated that labor occurring during the night was a strong predictor of home/TBA delivery. Though sometimes labor can be sudden, in most cases it is not. Women who deliver at home many times attribute their actions to the sudden nature of their labor. Having more children is associated with a decreased likelihood of healthcare facility delivery. This may be associated with more experience and confidence with childbirth. Women and families with more children may also be less likely to be able to afford healthcare facility delivery due to other financial commitment of their large families. Participants who had planned to deliver at a hospital were 30 times more likely to deliver at a health facility. Increased maternal and paternal education were significantly associated with healthcare facility delivery, because education helps people to understand and appreciate the importance of healthcare facility delivery. Education can also influence hospital delivery through its effect on socioeconomic status, as the more educated respondents are also more likely to be able to afford transportation to a healthcare facility during labor. (Egharevba, et al. 2017).

Bohren, et al. (2017), noted that slapping a woman during childbirth was viewed as a means by which to ensure a positive outcome, and that women provoked healthcare providers when their disobedience

endangered her baby. Systemic physical resource and staffing constraints contribute to a disabling work environment and propagate provider stress, and when providers cannot cope with this stress, they may transfer their aggression onto the woman herself. In this study, both women and providers blamed mistreatment during childbirth on a disempowering health system where providers are overworked and facilities are understaffed and overcrowded. Both women and healthcare providers considered physical and verbal abuse as acceptable and appropriate measures to gain compliance from the woman and ensure a good outcome for the baby.

Odetola, (2015) noted that proximity as a very strong determinant of choice of health institution to the child bearing woman cannot be over emphasized; this implies that hospitals especially primary health centers, when sited 5km from place of residence/work, is likely to receive high turnout of clients. According to Babar et al. (2007, the effect of distance on service use becomes stronger when combined with the dearth of transportation and with poor roads which contribute towards increase costs of visits. When services are rendered within the economic power of the consumers of health services, people will be able to access the services adequately.

Multiple socio-cultural factors and perceptions generally affected utilization of institutional birth in study communities. Hence, culturally competent interventions through education, re-orientation, and adaptation of beneficial norms combined with women friendly care are essential to promote health facility birth (Ababor, et. al 2019)).

Solutions to the problems and means of circumventing

In order to improve health facility delivery, Egharevba, et al. (2017) noted that early commencement of ante natal care by pregnant women should be encouraged at the community level. During ante natal care, pregnant women should be counseled on how to detect labor signs early and to seek care early in labor. There should be intensified counseling for women with more children and those with history of previous home deliveries to emphasize the benefit of facility delivery. Ante natal care attendees should be encouraged to prepare for childbirth financially and psychologically. Increased social support is needed throughout pregnancy and it should be intensified near delivery. Such social support should also include financial provisions for the women during the third trimester of pregnancy to help facilitate their transportation to the healthcare facility when labor ensues.

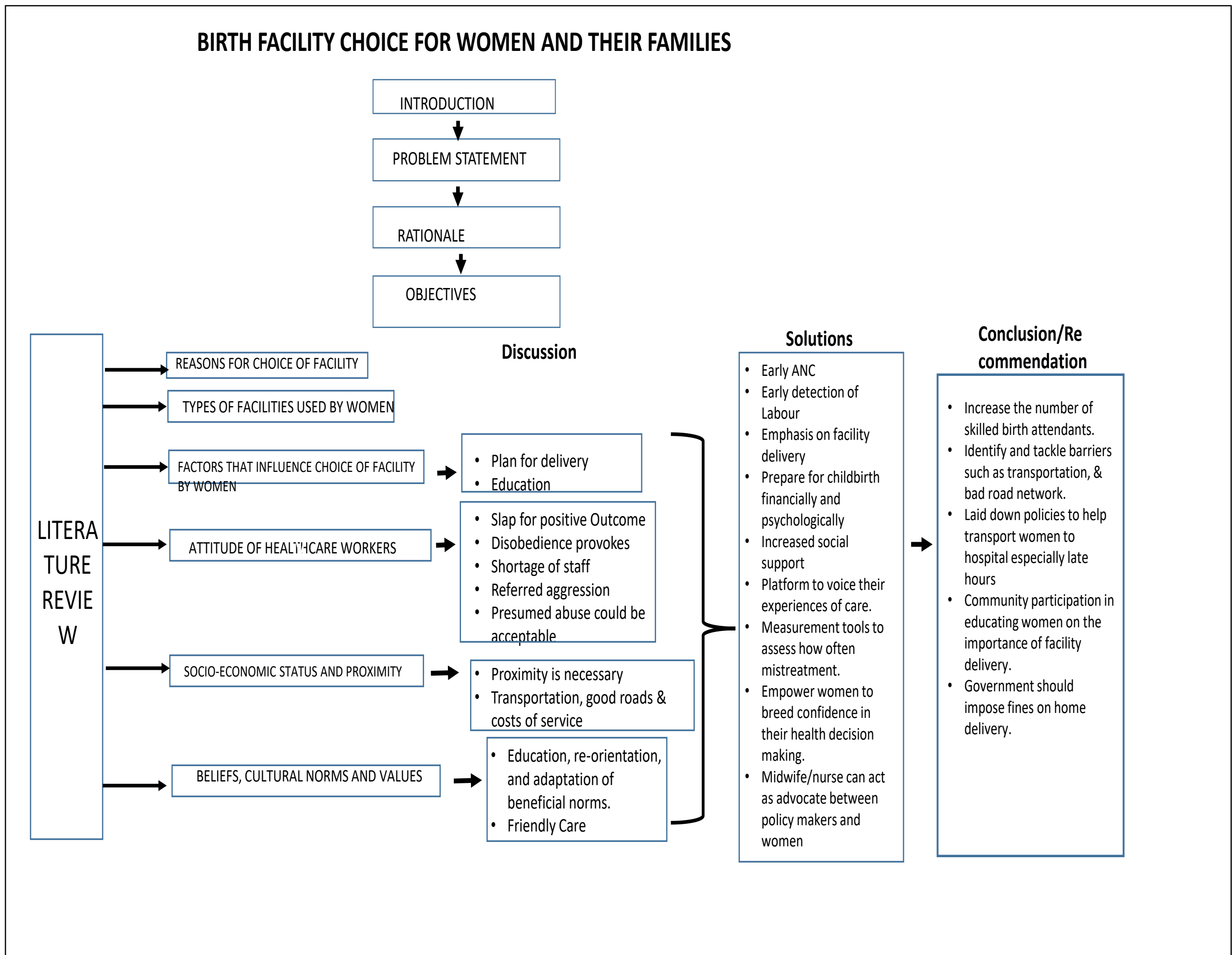
Bohren, et. al (2017) stated that women must be given a platform to voice their experiences of care. There should be a measurement tools to assess how often mistreatment occurs and in what manner. This must be developed for monitoring and evaluation. Finally, global health leaders, researchers, advocacy groups and other key stakeholders must collaborate to develop a global definition of the mistreatment of women during childbirth. Such efforts are necessary to put the mistreatment of women during childbirth on the global agenda.

Odetola, (2015) stated that empowerment of women is critical to choice of health services and safe motherhood because it enables women to: articulate their health needs and concerns; access services with confidence and without delay; seek accountability from service providers programme managers, and act to reduce gender bias in families, communities and markets. Empowering women means; enabling them to overcome social, economic and cultural factors that limit their ability to make informed choices, particularly in ' their reproductive health. Women can be taught mother craft and be encouraged to be involved in business to help them economically even if they are civil servants. The midwife/nurse can act as advocate between the policy makers and our women for provision of good road networking, adequate facilities, and skilled attendants etc in the primary health institution to discourage overcrowding of the secondary and tertiary health care institution.

CONCLUSION AND RECOMMENDATION

1. A number of steps need to be taken in order to increase facility delivery in the region. Such steps include
2. The need to increase the number of skilled birth attendants, both in Primary Health Care Centers, State hospitals and tertiary institutions.
3. Identifying and tackling the barriers which make it difficult for women to reach the health facility such as bad road network.
4. There should be a laid down policies by government that will help women contact government owned transport agencies which will help transport women to hospital during labour, especially when the labour commence in late hours of the day,

5. The community should be engaged to help health workers or participate in sensitizing women on the importance of facility delivery.
6. The need to facilitate change in the norm on home delivery.
7. Government should impose fines on home delivery.



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