Research Article

Received: 30 July 2026
Accepted: 01 November 2026
Published: 03 November 2026

Factors Determining the Choice of Place of Birth among Pregnant Women: A Cross-Sectional Study

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Cite this article:

A. S. Qasim et al. (2026). Factors Determining the Choice of Place of Birth among Pregnant Women: A Cross-Sectional Study. Revista Cultura Científica, (24), pp. 2247–2256. https://doi.org/10.70517/revcc2624183

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Abstract

The choice of childbirth setting involves access to care, previous birth experiences, family preferences, and expectations concerning the quality of maternity services. Understanding these considerations may support more responsive service planning, although women's reported reasons should be distinguished from statistically established determinants. This study aimed to describe factors reported as influencing the choice of birth location among women attending maternity services in Basrah, Iraq, and to summarize their demographic and obstetric characteristics. A descriptive cross-sectional study included 100 women recruited from public and private hospitals and other maternity settings between January 18, 2024, and March 12, 2025. The questionnaire comprised a demographic and obstetric section and 25 yes/no items concerning the choice of delivery setting. The manuscript reports review by ten experts and pilot testing with 20 mothers, with a Cronbach's alpha coefficient of 0.71. Responses were summarized using frequencies and the reported item means, with yes coded as 2 and no as 1. The largest reported age group was 20–25 years, accounting for 34% of participants; the reported mean age was 29.64 ± 7.56 years. Secondary education was reported for 33% of women and 34% of husbands. Two and three previous children were each reported by 27% of respondents. Housewives accounted for 49%, and 51% reported that their husbands did not work. A history of obstetric difficulties was reported by 67%; 66% lived in rural areas, 79% were classified as having normal body mass index, 74% reported at least four antenatal visits, and 75% reported completed vaccination. Choosing one's own doctor was endorsed by 77%, being at the location by chance by 71%, family or maternal choice by 68%, and complications in a previous pregnancy by 58%. Eight items met the manuscript's descriptive mean-score threshold of 1.50. However, the age frequencies sum to 99 rather than 100, the proximity item contains 110 responses, and some means and obstetric-history responses require verification. The reported delivery-location percentages also lack a consistent denominator and cannot establish a reliable distribution of birth settings. Consequently, the findings should be interpreted as provisional descriptive patterns. They suggest that provider preference, family involvement, previous experience, and practical circumstances merit further investigation; they do not identify independent predictors or demonstrate relationships between demographic characteristics and delivery location. Verification of the source records and clearer reporting of recruitment, measurement, and analysis are required before firm conclusions can be drawn.

Keywords: Birthplace choice; maternity services; antenatal care; maternal preferences; cross-sectional study; Basrah

1. INTRODUCTION

Maternal and newborn health depends on timely access to appropriate care during pregnancy, childbirth, and the postnatal period. The 2025 interagency report on maternal mortality estimated approximately 260,000 maternal deaths worldwide in 2023 and emphasized persistent inequalities between countries and population groups [1]. These estimates provide an appropriate contemporary context for research on maternity service use. They also highlight why birth planning should address access to skilled care, recognition of complications, and pathways for emergency referral rather than treating the choice of delivery location as an isolated personal decision.

The location of childbirth and the qualifications of the attending professional are related but distinct characteristics. Public and private hospitals are both institutional settings; private ownership does not make a hospital delivery non-institutional. Similarly, the location of care alone does not establish whether appropriate personnel, equipment, or referral arrangements are available. The World Health Organization's standards for maternal and newborn care emphasize both the provision of care and women's experience of that care [2]. A meaningful assessment of birth settings must therefore consider clinical readiness, communication, dignity, emotional support, and service organization alongside whether a facility is publicly or privately operated.

Antenatal care offers opportunities to discuss preferences, prepare for birth, and identify practical barriers to reaching an appropriate service. WHO guidance on antenatal care places these activities within a broader approach to a positive pregnancy experience [3]. Its recommendations for intrapartum care similarly emphasize woman-centred care and the importance of a positive childbirth experience [4]. These perspectives support shared planning that respects women's preferences while ensuring access to appropriate care. They do not imply that women alone are responsible for difficulties arising from transport limitations, service costs, inadequate staffing, or other health-system constraints.

The established three-delays model distinguishes delays in deciding to seek care, reaching an appropriate facility, and receiving adequate care after arrival [5]. This distinction helps explain why a stated preference for a particular birthplace may differ from the setting ultimately used. Household decisions, the timing of labour, transport availability, and service readiness can influence that pathway. A systematic review by Moyer and Mustafa [6] identified multiple drivers and deterrents of facility delivery, while Bohren et al. [7] synthesized qualitative evidence on access, family influences, perceived quality, and previous care experiences. These findings suggest that birthplace choice involves interacting personal, interpersonal, and service-related considerations.

Evidence from individual settings further illustrates this complexity. Ayamolowo, Odetola, and Ayamolowo [8] examined childbirth choices in rural southwestern Nigeria and identified educational, geographical, and provider-related considerations. Aremu, Lawoko, and Dalal [9] examined delivery-care utilization in relation to individual wealth and neighbourhood disadvantage in Nigeria. Envuladu et al. [10] investigated delivery-location choices in a Nigerian community, and Egharevba et al. [11] examined the roles of birth planning, parity, transport, and labour timing among women using antenatal and immunization services. These studies are relevant to the dimensions assessed here, but their estimates cannot be transferred directly to women receiving maternity care in Basrah.

Women's experiences of interpersonal care also warrant attention. A systematic review by Bohren et al. [12] documented mistreatment during facility childbirth and distinguished interpersonal experiences from wider service constraints. Research by Baba et al. [13] in Ghana examined variation in delivery-location preferences alongside education, previous delivery experiences, staff attitudes, and antenatal attendance. These sources support including questions about staff behaviour, familiarity, and perceived convenience. However, whether a woman cites an attribute as a reason for choosing a setting is different from an objective assessment of whether that attribute is present or whether the care is clinically adequate.

The present study describes responses from 100 women attending selected maternity settings in Basrah, Iraq. Its primary objective was to summarize the reasons participants reported for choosing a place of birth. A further objective was to describe demographic, socioeconomic, and obstetric characteristics that could inform subsequent investigation. Although the original objectives included examining relationships between these characteristics and delivery-location choice, no cross-tabulations or inferential analyses were supplied. The present report therefore addresses descriptive patterns and does not claim to establish causal determinants, independent predictors, or statistically tested demographic associations.

2. METHODS

2.1. STUDY DESIGN, SETTING, AND PARTICIPANTS

A descriptive cross-sectional design was used. The study period extended from January 18, 2024, to March 12, 2025, and the reported sample comprised 100 women who were willing to participate and able to communicate with the researchers. The manuscript identifies public and private hospitals, maternity clinics, and a private midwifery setting as

recruitment locations in Basrah. The named settings were Basra Women and Children Teaching Hospital, Al Faiha General Teaching Hospital, Saadi National Hospital, Abu Al Khasib General Hospital, Ibn Al-Bitar Private Hospital, Basra General Teaching Hospital, and a private midwifery birth setting. The official facility names, the precise role of each setting, and the number recruited at each site require confirmation.

The abstract described purposive, non-probability sampling, whereas the methods referred to assigning numbers and randomly selecting participants. These descriptions do not establish a consistent sampling procedure. The sample is therefore treated here as a recruited descriptive sample with an incompletely specified selection process. The sampling frame, number approached, exclusions, refusals, and response rate were not reported. The manuscript also refers to pregnant women while including retrospective questions about previous births; participants' pregnancy or postpartum status and the particular birth to which each response referred should be specified.

2.2. QUESTIONNAIRE AND MEASUREMENT

The questionnaire contained two parts. The first recorded demographic and obstetric information (Table 1), including age, education, occupation, previous children, reported obstetric difficulties, residence, body mass index (BMI), antenatal care (ANC) attendance, and vaccination completion. The second contained 25 dichotomous items concerning reported reasons for choosing a delivery setting. The revised wording in Table 2 corrects the English presentation of those items; it does not establish that a newly translated or validated instrument was administered. The original questionnaire language, administration method, time of completion, and any translation procedures were not specified.

The manuscript reports that ten experts from different specialties reviewed the instrument and that it was pilot-tested with 20 mothers at Basra Women and Children Teaching Hospital. A Cronbach's alpha coefficient of 0.71 was reported. This coefficient describes internal consistency under the conditions in which it was calculated; it does not establish validity of every item or show that the 25 distinct reasons form a single construct. The authors should confirm whether the coefficient refers to the pilot or main sample, whether pilot participants were included in the final sample, and which items were included in the reliability calculation. BMI thresholds, the timing of weight measurement, the definition of obstetric difficulties, and the vaccine or schedule assessed were also not supplied.

2.3. DATA ANALYSIS

Responses were summarized descriptively. For the choice items, yes was coded as 2 and no as 1. With 100 valid responses to an item, its mean would therefore equal $1 + n_{\text{yes}}/100$. The manuscript used 1.50 as a descriptive threshold, originally labelled "pass" or "fail." Here, those labels are presented as "at/above" or "below" the threshold to avoid implying a clinical standard or a statistical significance test. The source does not provide a validation or substantive justification for the threshold, and the item-level frequencies remain the primary descriptive information.

The abstract named SPSS version 23, whereas the methods named version 25.0. Analysis is therefore described as conducted using IBM SPSS Statistics, with the exact version requiring author confirmation. No hypothesis-test results, regression models, confidence intervals, or effect-size estimates were supplied. Item means and classifications are retained as reported where they conflict with response counts, and the discrepancies are identified explicitly rather than resolved by assuming which entry is correct. Percentages are interpreted using the stated sample size of 100 unless the supplied information indicates an unresolved denominator.

2.4. ETHICAL CONSIDERATIONS

The manuscript reports permission from the Basra Health Directorate and participating administrations, participant consent, and the use of anonymous questionnaires without names. It also mentions an ethical review committee without identifying the committee, approval number, or approval date. Those details, together with whether consent was written or oral and how participation was kept voluntary, require confirmation. Administrative permission and participant consent are reported separately from formal research ethics approval, which cannot be inferred from the information provided.

3. RESULTS

3.1. PARTICIPANT CHARACTERISTICS

Table 1 presents the reported demographic and obstetric characteristics. The largest listed age group was 20–25 years, accounting for 34% of the sample; this was a plurality rather than a majority. The reported mean age was 29.64 ± 7.56 years. The age frequencies sum to 99, and the final age category was printed as ≥ 4 without an interpretable age boundary. Consequently, neither the complete age distribution nor its agreement with the reported mean can be verified from the table alone.

Table 1. *Reported Demographic And Obstetric Characteristics Of Participants ($N = 100$)*

Characteristic	Category	Reported value
Age (years)	20–25	34
	26–30	30
	31–35	13
	36–40	13
	Unclear final age category[a]	9
	Sum of listed age frequencies	99
	Total stated in the source	100
	Reported mean ± SD (years)	29.64 ± 7.56
Women's education	Primary	29
	Intermediate	25
	Secondary	33
	Institute level or above	13
Husbands' education	Primary	33
	Intermediate	22
	Secondary	34
	Institute level or above	11
Previous children	1	21
	2	27
	3	27
	4	13
	Unclear final category[b]	12
	Total	100
Women's occupation	Government employee	8
	Self-employed/private business	43
	Housewife	49
	Total	100
Husbands' occupation	Government employee	26
	Self-employed/private business	23
	Not working	51
	Total	100
History of obstetric difficulties	Yes	67
	No	33
	Total	100
Residence	Rural	66
	Urban	34
	Correct arithmetic total[c]	100
Reported BMI category	Underweight	9
	Normal	79
	Overweight/obese	12
	Total	100
Number of ANC visits	None	19
	1–3	7
	≥ 4	74
	Total	100
Reported vaccination completion	Yes	75
	No	25
	Total	100

Notes. The source combined frequencies and percentages in one column labelled "F %." With $N = 100$, a valid category frequency has the same numerical value as its percentage; the listed values are retained. SD = standard deviation; BMI = body mass index; ANC = antenatal care. [a]The final age category was printed as ≥ 4 and cannot be reconstructed reliably; the age frequencies sum to 99. [b]The source printed "5 >"; whether this means five or more, more than five, or another category requires confirmation. [c]The original residence total was printed as 66, although $66 + 34 = 100$; only this unambiguous arithmetic total has been corrected.

Secondary education was the most frequently reported category among women (33%) and husbands (34%). The latter value corrects the conflicting statement of 27% in the original prose by following the supplied table. Two previous children and three previous children were each reported by 27% of respondents. Housewives accounted for 49% of the women, while 43% were described as self-employed or engaged in private business and 8% as government employees. For husbands, 51% were reported as not working, 23% as self-employed or engaged in private business, and 26% as

government employees.

A history of obstetric difficulties was reported by 67%, so the supplied results do not support the original conclusion that most women had experienced no difficulties. Rural residence was reported by 66% and urban residence by 34%. Their arithmetic total is 100%; the printed residence total of 66 in the original table was an erroneous subtotal. Normal BMI was reported for 79%, at least four ANC visits for 74%, and vaccination completion for 75%. These descriptions follow the supplied categories and should not be interpreted as independently verified measures of appropriate care or nutritional status.

3.2. REPORTED REASONS FOR CHOOSING A BIRTH SETTING

Table 2 presents all 25 questionnaire items and their supplied response counts, means, and threshold classifications. Choosing one's own doctor had the highest reported endorsement (77%), followed by the statement concerning a first baby (72%), finding oneself at the location by chance (71%), family or maternal choice (68%), previous pregnancy complications (58%), the husband's preference (55%), and having delivered at the same place previously (54%). These are item-level responses rather than mutually exclusive reasons; respondents could endorse several items. The first-baby response requires particular caution because it conflicts with the previous-children categories in Table 1, all of which begin at one child.

Eight items had reported means at or above 1.50: items 1, 4, 15, 16, 17, 18, 19, and 20. However, item 4 records 49 yes and 61 no responses, giving 110 responses, while its reported mean is 1.59. Neither its frequency distribution nor its threshold classification can therefore be validated. Item 17 records 55 yes and 45 no responses but a mean of 1.51; under the stated coding, those counts would imply 1.55. Both reported entries are retained pending examination of the original data. These discrepancies prevent a definitive ranking based on all the reported means.

Table 2. *Reported Reasons For Choosing A Delivery Setting And Supplied Item Scores*

No.	Questionnaire item	Yes	No	Mean	Threshold
1	I found myself at this location by chance.	71	29	1.71	At/above
2	The cost was fair and affordable.	28	72	1.28	Below
3	The setting had appropriate equipment and medicines.	20	80	1.20	Below
4	The setting was close to my home.[a]	49	61	1.59	At/above
5	The staff were polite and friendly.	25	75	1.25	Below
6	Services were consistently available.	19	81	1.19	Below
7	Labour began suddenly at night, and this setting provided 24-hour services.	24	76	1.24	Below
8	The staff could assess my health needs.	9	91	1.09	Below
9	The setting provided appropriate hygiene for my baby and me.	25	75	1.25	Below
10	The services were convenient.	24	76	1.24	Below
11	The staff provided advice and information.	35	65	1.35	Below
12	My previous birth was very difficult.	47	53	1.47	Below
13	I was afraid of childbirth complications.	14	86	1.14	Below
14	The staff were qualified and had the required experience.	9	91	1.09	Below
15	I could choose my own doctor.	77	23	1.77	At/above
16	The location was chosen by my family or mother.	68	32	1.68	At/above
17	The location was my husband's choice.[b]	55	45	1.51	At/above
18	This was my first baby, and I was happy about it.[c]	72	28	1.72	At/above
19	I had given birth at this location previously.	54	46	1.54	At/above
20	I had experienced complications in a previous pregnancy.	58	42	1.58	At/above
21	My mother or sister was allowed to accompany me.	22	78	1.22	Below
22	The setting provided comprehensive newborn care.	12	88	1.12	Below
23	Birth documents could be obtained easily.	14	86	1.14	Below
24	The birth attendant was well known to my family.	16	84	1.16	Below
25	I knew the person attending my birth from my previous delivery.	37	63	1.37	Below

Notes. Yes = 2; no = 1. "At/above" means a reported mean ≥ 1.50; "below" means a reported mean < 1.50. These descriptive classifications replace the original "pass/fail" labels and do not indicate statistical significance. All response counts and means are retained as supplied. [a]Item 4 totals 110 responses and has an incompatible reported mean; counts, denominator, and score require correction from source records. [b]Item 17 has a reported mean of 1.51, whereas the listed counts imply 1.55 under the stated coding. [c]Item 18 conflicts with the absence of a zero-previous-children category in Table 1; its reference pregnancy and interpretation require clarification.

3.3. DISTRIBUTION OF DELIVERY LOCATIONS

The original narrative reported 75% for private wards within government hospitals, 7% for general wards, and 25% for private hospitals. These values sum to 107%, and the source does not clarify whether the categories overlap or use different denominators. The abstract separately reported 36% for a maternity and children's hospital without a supporting frequency table. These figures are recorded here as unresolved source discrepancies, not as a validated distribution. Consequently, the available results cannot establish which facility category was most frequently chosen, compare public and private delivery rates, or assess whether any distribution corresponds to household income.

4. DISCUSSION

The reported responses suggest that provider preference, family involvement, previous maternity experiences, and practical circumstances may be relevant to birthplace choice in this recruited sample. Choosing one's own doctor was endorsed more frequently than most other listed reasons, and family or maternal preference was also commonly reported. These observations concern what women said influenced their decisions; they do not establish which reasons independently predicted the setting used. The absence of an internally consistent delivery-location distribution further limits comparison between the reported motivations and actual use of particular services.

The demographic findings should be interpreted as sample characteristics rather than evidence of determinants. For example, secondary education was the most frequently reported category among women and husbands, but this alone does not demonstrate an association between education and birth setting. Aremu et al. [9] examined socioeconomic patterns of delivery-care utilization using an analytical design that differs from the descriptive summaries available here. Likewise, Rahman et al. [14] analyzed delivery location in Bangladesh, Nepal, and Pakistan in relation to education, household economic circumstances, and ANC attendance. Their findings identify variables that merit study in Basrah, but they cannot establish corresponding relationships in the present sample. Comparing the proportion of educated respondents across studies is also insufficient to demonstrate agreement or disagreement about an education effect.

The distribution of previous children similarly does not show whether parity influenced childbirth location. Bekuma et al. [15] investigated delivery-place choice in western Ethiopia and examined obstetric history, education, ANC attendance, and transport access. Their community-based study provides a relevant comparison of possible explanatory domains. However, differences in the composition of samples do not establish that the underlying relationships are the same. The inconsistency between the first-baby item and the previous-children categories in the current report needs resolution before parity-related interpretations can be made. It is especially important to distinguish previous live births, living children, previous pregnancies, and the current or most recent birth, because these measures are not interchangeable.

Housewives represented 49% of participants, and 51% reported that their husbands did not work. These categories do not directly measure household income, wealth, financial support, or ability to pay for childbirth care. The study therefore cannot conclude that participants had a particular income level or that cost determined their distribution across private and public services. Envuladu et al. [10] examined factors influencing delivery-location choice in another setting, while the broader review by Moyer and Mustafa [6] emphasizes the range of economic and access-related influences. Together, these sources support collecting direct information on fees, transport expenditure, household resources, and financial decision-making in future research.

Rural residence was common in the reported sample, but the table provides no comparison of rural and urban women by delivery setting. Proximity and transport deserve further study, especially because the current proximity item contains incompatible counts and scores. Egharevba et al. [11] examined birth planning, the timing of labour, and time available for transport in relation to delivery location. This evidence supports separating an intended birthplace from the setting reached when labour begins. In the present report, the high endorsement of arriving at a setting by chance may reflect several possible circumstances, but the questionnaire does not identify which explanation applies. Referral, emergency presentation, transport constraints, and changes in preference should therefore be investigated rather than assumed.

Family involvement is another important domain. Okwuikpo, Komolafe, and Akpotor [16] reported the influence of family members, affordability, proximity, and staff attitudes among mothers attending an infant welfare clinic in Nigeria. That study also included 100 participants, but a shared sample size does not establish methodological equivalence or make the samples representative of one another. The Basrah responses concerning family and husband preferences can be discussed as comparable topics, while differences in recruitment, childbirth settings, measurement, and social context must remain explicit. Family participation in planning should also be distinguished from a woman's ability to express and act on her own preferences.

Questions about staff behaviour, hygiene, information, and companion access concern the experience of maternity care. The synthesis by Bohren et al. [7] and the review of childbirth mistreatment [12] explain why interpersonal care and service conditions are relevant to maternity service use. Nevertheless, a low endorsement of staff friendliness as a reason for choosing a setting does not prove that staff were unfriendly. Likewise, low endorsement of equipment availability

does not demonstrate that equipment was absent. The present questionnaire measures stated reasons, not an objective service-readiness assessment or a complete satisfaction scale. Future studies should distinguish these constructs and use clearly defined measures for each.

The reported ANC and vaccination findings require similarly careful interpretation. At least four ANC visits were reported by 74%, but this category cannot identify the timing or content of care, nor can it establish attendance at the minimum eight contacts recommended in WHO's ANC model [3]. Vaccination completion was reported by 75%, but the vaccine, schedule, timing, and verification method were unspecified. These results therefore describe respondents' answers rather than confirmed adherence to a defined maternity-care standard. Baba et al. [13] examined ANC attendance and previous delivery experiences alongside other influences on choice in Ghana, supporting further investigation of the continuity between antenatal counselling and delivery planning.

Finally, the reported threshold classifications should not be treated as tests of statistical significance or as a validated ranking of causal importance. Most consistent item means can be reproduced directly from yes/no counts, so they provide a different presentation of the same responses rather than independent evidence. The proximity and husband-preference discrepancies show why the original item records need checking. The distinction between perceived preferences, actual service use, and clinical quality remains central. WHO's quality standards and intrapartum guidance [2, 4] support a broader assessment that respects women's experiences while examining service capacity and referral arrangements. The current study can help identify topics for that assessment, but its unresolved data and reporting limitations prevent firm policy conclusions.

5. LIMITATIONS

The recruited sample of 100 women is small and has an incompletely specified selection process. Because the manuscript gives conflicting accounts of purposive and random selection, the findings cannot be considered representative of all women in Basrah. Recruitment through maternity services may also omit women who do not attend those services. The cross-sectional design does not establish temporal or causal relationships, and no inferential analyses were provided to assess demographic associations or independent predictors.

The measurement procedures require clarification, including the reference pregnancy, administration method, category definitions, translation procedures, and rationale for the item threshold. Cronbach's alpha alone does not validate a set of heterogeneous reasons for choosing a setting. The inconsistent age frequencies, unclear final age and previous-children categories, incompatible proximity responses, husband-preference mean, and first-baby item limit reproducibility. The absence of a valid delivery-location distribution prevents analysis of the study's principal outcome as a clearly defined categorical variable.

Self-reported reasons may be affected by recall, social desirability, and the circumstances in which questionnaires were completed. Site-specific recruitment totals, missing-data procedures, and the precise statistical software version were not supplied. Ethical approval details and the data-sharing arrangements also remain incomplete. These limitations mean that the results should be treated as provisional descriptive observations pending verification against the original questionnaires and analysis output.

6. CONCLUSION

The supplied responses indicate that choosing a preferred doctor, family involvement, prior birth experiences, and practical circumstances were frequently reported considerations in childbirth-location choice among the recruited women. The largest reported age group was 20–25 years, secondary education was the most frequent educational category, and rural residents formed the majority. Most respondents reported a history of obstetric difficulties, normal BMI classification, at least four ANC visits, and vaccination completion according to the questionnaire categories. These characteristics describe the sample; they do not establish associations with delivery setting.

Eight questionnaire items met the reported mean threshold of 1.50, although the proximity item cannot be validated from its supplied counts and score. Unresolved inconsistencies in the age data, obstetric-history responses, item means, and delivery-location percentages preclude identification of a definitive leading determinant or a reliable public–private distribution. Before further analysis, the source records should be reconciled, recruitment and measurement procedures clarified, and delivery location defined consistently. Subsequent research could combine clearly specified survey measures with interviews about provider choice, family participation, transport, affordability, and experiences of care. Such work would provide a stronger basis for responsive maternity-service planning in Basrah.

Author Contributions

All authors contributed equally to the research, reviewed the manuscript, and approved the final version for publication.

Conflict Of Interest

The authors declare that they have no conflicts of interest related to this research.

Funding Information

This research received no external funding.

Consent Statement

The manuscript reports that participants consented to take part and completed questionnaires without recording their names. The form of consent and the relevant ethics approval details require author confirmation.

Data Availability Statement

The de-identified data can be obtained from corresponding author.

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