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Birthplace Decision Making Experiences of the Ugep Women of Southern Nigeria

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Walden University
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Abstract

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MPH, University of Liverpool, 2015

MSc, ESUT Business School, 2007

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Education and Promotion

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Abstract

The purpose of this basic qualitative study was to explore and describe how behavioral, normative, and control beliefs shape women's birthplace decision-making experiences. The study sought to better understand how Ugep women of southern Nigeria decided where to give birth after attending antenatal care. Using the theory of planned behavior as a framework, a purposeful sample of nine women aged 25 to 35 years who attended antenatal clinic at least twice at the selected primary health facility but gave birth at home during the past year was recruited. Data collection was through face-to-face, semistructured interviews. Audio recordings of interviews were transcribed and organized for analyses using ATLAS.Ti (*ATLAS.Ti: The Qualitative Data Analysis & Research Software*, n.d.); data were analyzed using descriptive and in vivo coding during the first cycle and pattern coding during the second cycle. The study found that most participants had positive behavioral and normative beliefs towards homebirths but negative beliefs towards health facility births. All participants perceived that they had no capacity to give birth at the health facility (behavioral control) due to financial difficulties, transportation, distance from the health facility, and the unfriendly attitudes of health providers. Additionally, while participants attended antenatal clinic (ANC) to receive health education and care, they did not receive essential birth preparedness and complication readiness education. Behavioral, normative, and control beliefs impact women’s decision of where to give birth. Programs designed to increase skilled birth attendance utilization through health facility births need to address these beliefs.

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Dedication

I dedicate this research to frontline healthcare providers all over the world. You sacrifice so much, sometimes too much to keep our world safe; yet only during pandemics that threaten our very existence do people remember what you do. Thank you for your service and your kindness.

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Acknowledgments

When I started this journey in 2018, I didn't really have the end in mind. As I write this today, I remember the many times I had wanted to quit because of work, family, and school pressures and issues. I did not quit. My family stood by me throughout, urging me on and giving me reasons why I shouldn't let go. I owe them this achievement

I have also had very supportive colleagues at work. Individuals who kindly listened to my PhD journey stories and then responded with words of encouragement and also stood-in for me when I needed time. I say thank you to great colleagues at the Center for Communication Programs (CCP) and recently at Genesis Analytics.

For the quality of this dissertation, yes, I can feel it; I thank the faculty at Walden University, especially Dr. Jill Nolan, my committee chair who patiently kept pointing towards the right direction as I worked through my dissertation, and to my two committee members Dr. Victoria Williams, who helped lay the foundation, and Dr. Mia Richter, who delightfully used the adjective, "our" and the pronoun "us" in relation to this work. It was indeed our dissertation.

Finally, let me thank Dr. Summer Parrots, the URR for all the support she provided. God bless you all

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Chapter 1: Introduction to the Study

Introduction

In this qualitative study, I explored how women's behavioral, normative, and control beliefs influenced their choice of birthplace. A better understanding of how women decide where to give birth can enable policymakers and program planners to design programs that can increase the use of skilled birth attendants and ultimately reduce maternal mortality. I used the theory of planned behavior (see Ajzen, 1991) to align my research questions with the interview guide and analyzed the beliefs, norms, and attitudes that influenced the birthplace choice decision making of the Ugep women of southern Nigeria.

Sub-Saharan Africa continues to experience a disproportionately high maternal mortality ratio compared to other regions of the world. Although the global maternal ratio declined from 385 deaths for every 100,000 live births in 1990 to 216 deaths for every 100,000 live births in 2015, this 43.9% decline fell short of the millennium development goal target of a 75% decline (Alkema et al., 2016). According to Alkema et al., it also concealed the disparities among regions, with sub-Saharan Africa reporting 546 deaths per 100,000 live births compared to 12 deaths for every 100,000 live births in the developed areas. Women need skilled birth attendance during pregnancy and after delivery to address preventable causes of maternal mortality, including bleeding, anemia, pregnancy-related hypertensive disorders, and obstructed labor and infections (World Health Organization, 2019).

However, despite improvements in primary health care and associated infrastructure in sub-Saharan Africa, skilled birth attendance has remained suboptimal (Doctor et al., 2018). According to Doctor et al. (2018), only 17.6% of births in rural sub-Saharan Africa occur in health facilities and 35.1% of births in urban areas.

There are diverse reasons why sub-Saharan African women prefer home births by traditional birth attendants and other community midwives. One of these reasons is the lack of physical access due to distance from health facilities and healthcare costs (Wilunda et al., 2017). The other reasons are psychosocial factors, including the belief that pregnancy and childbirth are natural events, cultural expectations of control over childbirth, distrust of health facilities, and dependency on spouses for health decision-making (Atukunda et al., 2020). In the rest of Chapter 1, I present the background, the problem statement, the purpose of the study, the research questions, and the theoretical foundation. I then discuss the nature of the study, its significance, and the potential limitations, challenges, and barriers.

Background

Pregnancy, labor, and childbirth used to be part of the culture of women giving birth at home with the assistance of traditional midwives and family members, but historical records indicated very high maternal mortality rates in advanced countries between 1880 and 1935 (Loudon, 2000). However, Loudon reported that from 1935, maternal mortality rates (MMR) in the developed countries declined sharply from 400 deaths/100,000 live births to less than 10 in 1980 due to improvements in maternity care. In 2017, the average MMR for Africa was 525 deaths/100,000 live births compared to the

European average of 13/100,000 live births (World Health Organization, 2019). African countries need to improve maternal care massively to achieve the target of reducing global MMR from 211/100,000 to less than 70 by 2030 (United Nations, 2015, 2020).

The inequality in MMR between developed and less developed countries is primarily due to poor maternal care (World Health Organization, 2016). Antenatal care (ANC) provided by skilled birth attendants significantly correlates with lower maternal mortality in sub-Saharan Africa (Merdad & Ali, 2018). According to the World Health Organization (2016), ANC attendance and health facility delivery enable women to receive life-saving services, including health education and promotion. Still, many sub-Saharan African women do not utilize available ANC (Okedo-Alex et al., 2019), and even when they do, they give birth at home instead of the health facility (Abubakar et al., 2017; Ayele et al., 2019; Chukwuma et al., 2017; Okedo-Alex et al., 2019).

Educational attainment, distance to a health facility, knowledge of danger signs of pregnancy, attitudes of health care providers, and aversion to male birth attendants strongly determine ANC and skilled birth attendant utilization (Abubakar et al., 2017; Ayele et al., 2019; Chukwuma et al., 2017; Ogbo et al., 2020; Okigbo & Eke, 2015; Siyoum et al., 2018). However, very few studies have examined why women in sub-Saharan Africa fail to give birth at the health facility even after attending ANC at least four times, as recommended by the World Health Organization.

The quality of ANC attendance, rather than just the frequency, might be the missing link (Hodgins & D'Agostino, 2014). Additionally, women in sub-Saharan Africa perceive pregnancy and childbirth as natural events that do not require a health facility

(Shiferaw & Modiba, 2020). I did not find any study exploring sub-Saharan African women's perception that pregnancy and childbirth are natural events that do not require health facility intervention, which might be the other missing link.

My dissertation on birthplace decision-making experiences of the Ugep women of Southern Nigeria explored how Ugep women decide where to give birth after attending ANC, especially in relationship with their ANC experiences and their perceptions/beliefs regarding pregnancy and the childbirth process. This research is unique because it focused on an underresearched area in the developing world-- the ANC experience of women and their pregnancy and childbirth beliefs. The findings from this study could enable health services managers and decision makers to design maternity care services that address women's needs and respond to their beliefs about pregnancy and childbirth. Ultimately, the findings could help contribute to reducing Nigeria's maternal mortality, neonatal, and infant mortality rates. I present the problem statement, the purpose of the study, my research questions, and then briefly discussed the study's theoretical framework below.

Problem Statement

Nigeria's maternal mortality ratio is one of the highest in the world, with one out of every 34 women in Nigeria dying of pregnancy and childbirth-related causes in 2019 (National Population Commission (NPC) [Nigeria] & ICF, 2019). According to the World Health Organization (2015), a primary strategy for reducing maternal and infant mortalities is ensuring that women deliver in a health facility.

Health facility delivery gives women access to skilled attendants, equipment, drugs, and prompt referrals to higher-level care in emergencies. In one study in Ethiopia, the researchers found that children delivered at home were two times more likely to die before or shortly after birth than those born at a health facility (Yadeta et al., 2020). Although Yadeta et al.'s study supports the World Health Organization position, findings from other studies have suggested otherwise (see Gabrysch et al., 2019; Kunkel et al., 2019). For example, in Kenya, a 24% increase in health facility deliveries between 2009 and 2013 did not lead to changes in perinatal mortality; instead, Gabrysch et al. (2019) found that children born in health facilities had a higher risk of dying than those born at home. Therefore, the quality of care and the availability of emergency obstetric services may be the critical factors rather than the mere presence of health facilities and their use by pregnant women (Cavallaro et al., 2020).

According to the NCP, Nigeria, and ICF (2019), only 39% of live births in Nigeria occur in a health facility, while a skilled provider attends only 43% of deliveries. Women who participate in ANC are more likely to utilize skilled birth attendants (SBA). The frequency of ANC visits and the nature and the number of services women received during ANC have been independently significantly associated with SBA use (Ayele et al., 2019; Chukwuma et al., 2017; Ogbo et al., 2020; Okigbo & Eke, 2015). However, among women attending ANC, SBA utilization remains suboptimal. Pooled Demographic and Health Survey (DHS) data collected between 2006 and 2015 from 28 African countries revealed that 30% of women attending ANC do not give birth at a health facility

(Chukwuma et al., 2017). A study in northern Nigeria put this figure at 74.1% (Abubakar et al., 2017), and another in Ethiopia at 29.2% (Ayele et al., 2019).

Although ANC services include health education for women, ANC classes have remained, primarily, a platform for the screening, referral, diagnosis, and treatment for such conditions as hemorrhage, anemia, pregnancy-related hypertensive disorders, and obstructed labor and infections (Carroli et al., 2001; Hodgins & D'Agostino, 2014). A study in Ethiopia (Siyoum et al., 2018) revealed that most of the 13.5% of women who gave birth at home after attending ANC did not know about the danger signs of pregnancy. This finding may mean that ANC classes are not paying adequate attention to pregnancy and childbirth preparedness education or that the method used for this education is insufficient. Additionally, many sub-Saharan African women believe that pregnancy and childbirth are natural and require no unnecessary medical interventions (Shiferaw & Modiba, 2020). However, I did not find any study that explored the relationship between this belief and health facility birth.

Purpose of Study

In this basic qualitative study, I explored and described how behavioral, normative, and control beliefs shaped women's birthplace decision-making experiences. I sought to understand better how Ugep women of southern Nigerian decide where to give birth after attending ANC. I also explored women's ANC experience and how this experience shaped their decision of where to deliver.

Research Questions

- Research Question 1: How do behavioral, normative, and control beliefs and attitudes influence birthplace choice decision making for Ugep women of southern Nigeria aged 25 to 35 years old who received health education during ANC at a primary health facility?
- Research Question 2: What are the skilled birth attendance utilization facilitators experienced by Ugep women of southern Nigeria aged 25 to 35 who received health education during ANC at a primary health facility?
- Research Question 3: What are the skilled birth attendance utilization barriers experienced by Ugep women of southern Nigeria aged 25 to 35 who received health education during ANC at a primary health facility?

Theoretical Foundation

I used the theory of planned behavior (TPB) as the theoretical framework for this study. The TPB identifies three determinants of human social/health behavior that are accessible and can be manipulated. These determinants include behavioral beliefs (perceived positive versus adverse outcomes of performing a specific behavior), normative beliefs (perceived social pressure to act or not to perform the behavior), and control beliefs (perceived barriers or enablers of behavior -self-efficacy or behavioral control; Ajzen, 1991). These beliefs are the TPB explanatory constructs, and the theory holds that the more favorable the behavioral (attitudes) and the normative (subjective) beliefs, the greater the perceived self-efficacy (perceived behavioral control), and the

stronger the intention to perform the behavior. According to Ajzen (1991), once there is an intention to perform the behavior, enacting it becomes a matter of time and chance.

According to the TPB, the women in the sample may have chosen to deliver at home because they had little or no intention to give birth at the health facility in the first place. This intention is influenced by the three TPB domains: behavioral beliefs, normative beliefs, and control beliefs. I classified each of these domains into facilitators and barriers to giving birth at the health facility; I also developed my interview questions based on these domains.

Nature of the Study

This study was a basic qualitative inquiry focused on participants' experiences and how they described this experience (see Percy et al., 2015). The use of a basic qualitative methodology was in line with the purpose of this dissertation, which was to gain a deeper understanding of how behavioral, normative, and control beliefs and attitudes shape women's birthplace decision-making experiences. Semistructured in-depth interviews were conducted among a purposively selected group of Ugep women who chose to deliver outside the health facility even after attending the ANC clinic (see Patton, 2014). The purposive group sampling strategy enabled me to focus on only participants who can provide rich information on the topic of inquiry. A small homogenous sample allowed me to describe participants' experiences in depth (see Patton, 2014). In-depth interviews are the most appropriate data collection method when the researcher's interest is in experiences shared by participants (Rosenthal, 2016). The focus of this study was one of the primary health facilities in Ugep. With permission from the health facility, I spoke

with women during their postnatal visits to offer those who attended ANC at the clinic but did not have their babies there a chance to participate in the study. Those who gave their consent were then recruited as participants.

Definitions

Antenatal care (ANC): Care provided to a pregnant woman and her unborn child at a health facility to prepare the woman for delivery and motherhood as well as prevent, detect, and manage pregnancy related complications (Lincetto et al., 2018).

Home births: Deliveries outside of the health facility attended by traditional birth attendants.

Maternal death: "The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (Ronsmans & Graham, 2006).

Maternal mortality ratio: The number of maternal deaths for every 100,000 live births during the same time (Ronsmans & Graham, 2006).

Postnatal care: Care given to the mother and her new born beginning from the birth of the child and for the first six weeks of life (World Health Organization, 2010).

Skilled birth attendant: A trained health professional who has been accredited to manage uncomplicated pregnancies and childbirth and to identify, manage, and refer pregnancy and childbirth-related complications (World Health Organization, 2004).

Sub-Saharan Africa: All African countries that lie south of the Sahara Desert.

Ugep: A town of about 250,000 people and the headquarters of Yakurr Local Government Area in Cross River State, Southern Nigeria.

Traditional birth attendants (TBAs): Individuals recognized within their communities as attending to women during pregnancy and childbirth. These individuals may have acquired their skills through experience or learning from other TBAs (World Health Organization, 1992).

Assumptions

This study focused on women who attended antenatal clinics at one of the primary health care facilities in Ugep but decided to deliver at home instead of at the facility. An assumption was made that women who met the inclusion criteria including age, receipt of care, and location of birth would volunteer to participate in the study. This assumption was important because I sought to understand the decision-making experiences of only women who met the above criteria. A second assumption was that participants were honest in their descriptions of the factors they considered while deciding where to give birth. This assumption was critical because nonfactual reports would lead to wrong conclusions from the study.

Scope and Delimitations

Although skilled birth attendant utilization in sub-Saharan Africa is generally low (Okedo-Alex et al., 2019), this study focused only on why women failed to deliver at the health facility even after attending antenatal clinic. Increasing antenatal clinic attendance is crucial for increasing health facility births (World Health Organization, 2015). Therefore, it becomes worrisome if a significant proportion of women who attend ANC

do not deliver at the health facility. Consequently, I narrowed the scope of my dissertation to this aspect of the problem to respond to this concern.

Geographically, this study was limited to the Ugep women of southern Nigeria. Ugep is a small town of about 200,000 inhabitants (Population & World, 1950), mainly of the Yako ethnic subgroup of the Ekoi tribe. Ugep is the headquarters of the Yakurr local government area of Cross River State. Like similar towns in Nigeria, it has a secondary health facility (general hospital) and a several primary health facilies. Ugep also has a post office, a magistrate court, and a customary court. In addition, there are several primary and secondary schools as well as a couple of tertiary schools. The Yako people are mostly subsistent farmers and traders, while some are in the government services. The younger generation of Yako are mostly educated and can communicate in the English language.

All participants in this study were women who had lived continuously in Ugep for more than 1 year, were between the ages of 25 and 35 years, had given birth at home within 1 year of the study, and had attended ANC at the selected primary health facility (study site) during that pregnancy. The valuable lessons offered by these findings can be transferrable to similar contexts and situations (see Cope, 2014; Houghton et al., 2013; Smith, 2018b). I have described the study setting and procedures clearly and comprehensively to help others decide the applicability of my findings to their specific contexts, as is expected of transferability in qualitative research (see Stewart & Hitchcock, 2016). Additionally, I have ensured that my deep knowledge of the study

community, people, norms, and culture has not led to conclusions that are preconceived but not supported by the data.

Limitations

I am from the study community. My personal experiences with the culture, traditional birth attendants, and traditional medicine have influenced how I crafted the participants' questions, how participants' responses were interpreted, and the final presentation of these interpretations. One potential limitation was how to ensure that the researcher's position is transparent and that personal biases were not reported as findings (see Morse et al., 2002). Tied to this limitation were the issues of existing relationships between myself and the participants, and the power dynamics that come with these (see Aguinis & Solarino, 2019). I was continuously mindful of my position as an “expert” in the eyes of community women who may also consider me “their own” because I am from the research community. I addressed this limitation by engaging in ongoing reflexivity and reflexive record-keeping, acknowledging my biases and separating these from participants' accounts and perspectives, and presenting wealthy and verbatim participants' narratives. In addition, I carried out peer validation as well as member-checking to increase the truth value of the study (see Chenail, 2011; Noble & Smith, 2015). I also presented transparent accounts of my relationship with participants to enable other researchers to understand the research setting and context better.

The second potential limitation was that the interviews were conducted in the Loká language because most participants did not speak English. Many people do not write Loká, and I could not find a trained/professional Loká-English translator. I found a

way around this by transcribing the interviews directly from audio (Loká) to text (English). It was time consuming and tedious, but it provided me the immersion I needed for my data. The third potential challenge was the issue with self-reported research--social desirability bias. Participants say things that they think the interviewer wants to hear or make them appear in a particular way even when what they say is inaccurate. I reduced this challenge by first pretesting the questionnaire. Additionally, I ensured that the questions were neutral and asked in a professional manner (see Bergen & Labonté, 2020).

Significance of Study

Researchers studying the association between ANC attendance and skilled birth attendant's utilization have focused on the frequency of attendance and the number of services received by women (Ayele et al., 2019; Okigbo & Eke, 2015). In some quantitative studies, women who delivered outside of the health facility after attending ANC have cited the comfort of home birth, the attitudes of health care workers, financial difficulties, and the long-distance to health facilities as their reasons (Abubakar et al., 2017). Still, there is a gap in the literature regarding Nigerian women's pregnancy and childbirth-related beliefs, how Nigerian women experience ANC, and how their beliefs and ANC experiences may contribute to deciding where to give birth. This study has contributed to filling this gap. In addition, this study has contributed to the understanding of why many women in Nigeria chose to give birth outside of the health system even after attending ANC. This research is unique because it focused on an underresearched area in the developing world--the ANC experiences of women.

The findings of this study have deepened understanding of how women experienced ANC and how this experience shaped their decision of where to deliver. Because ANC attendance is positively associated with delivery at a health facility (World Health Organization, 2018), understanding women's ANC experiences could aid health education and promotion practitioners design more effective health education/promotion activities during ANC. The findings could also enable health services managers and decision makers to make policies that emphasize health education/promotion, including the importance of SBA during ANC. Ultimately, this research's findings could contribute to reducing Nigeria's maternal, neonatal, and infant mortality rates. Positive social change happens when the enabling environment is created for otherwise marginalized or underserved population segments to achieve their full potential (Lechner et al., 2017; Olubanwo, 2020). This work contributes to positive social change because it can help women who cannot use existing health services tell their stories. These stories could galvanize the action required to change the situation (improve maternity care services) when they are shared with relevant stakeholders, including health services providers, community leaders, and policy/decision makers.

Summary

There is an urgent need to address the considerable disparity in maternal deaths between sub-Saharan Africa women and their peers in the more developed countries. One way to do this is to ensure that pregnant women in sub-Saharan African countries attend the antenatal clinic as prescribed and deliver at the health facility with SBA. This study has contributed to understanding why some women in the subregion give birth at home

unassisted by SBA even after attending antenatal clinic. This understanding can help policymakers, program planners, and health educators improve maternity care services. In Chapter 2, I review the empirical literature on pregnancy, maternal mortality, and maternal care to situate my research within existing knowledge and practice.

Chapter 2: Literature Review

Introduction

Nigeria's maternal mortality ratio is one of the highest in the world, with one out of every 34 women in Nigeria dying of pregnancy and childbirth-related causes (NPC [Nigeria] & ICF, 2019). A primary strategy for reducing maternal and infant mortalities is to ensure that women deliver in a health facility. Health facility delivery gives women access to skilled attendance, equipment, drugs, and prompt referrals to higher-level care if emergencies arise (World Health Organization, 2015). In one study in Ethiopia, the researchers found that children delivered at home were two times more likely to die before or shortly after birth than those born at a health facility (Yadeta et al., 2020). Although Yadeta et al's study supports the World Health Organization position, findings from other studies have suggested otherwise (see Gabrysch et al., 2019; Kunkel et al., 2019). For example, in Kenya, a 24% increase in health facility deliveries between 2009 and 2013 did not lead to changes in perinatal mortality; instead, Gabrysch et al. (2019) found that children born in health facilities had a higher risk of dying than those born at home. Therefore, the quality of care and the availability of emergency obstetric services may be the critical factors rather than the mere presence of health facilities and their utilization by pregnant women (Cavallaro et al., 2020).

According to the NCP, Nigeria, and ICF (2019), only 39% of live births in Nigeria occur in a health facility, while a skilled provider attends only 43% of deliveries. There is evidence that women who participate in ANC are more likely to use SBA than those who do not. Additionally, the frequency of ANC visits and nature and the number

of services women received during ANC have been independently significantly associated with SBA use (Ayele et al., 2019; Chukwuma et al., 2017; Ogbo et al., 2020; Okigbo & Eke, 2015). However, among women attending ANC, SBA use remains suboptimal. Pooled DHS collected between 2006 and 2015 from 28 African countries revealed that 30% of women attending ANC do not give birth at a health facility (Chukwuma et al., 2017). A study in northern Nigeria put this figure at 74.1% (Abubakar et al., 2017), and another in Ethiopia at 29.2% (Ayele et al., 2019).

While ANC services include health education for women, ANC classes have remained, primarily, a platform for the screening, referral, diagnosis, and treatment for such conditions as hemorrhage, anemia, pregnancy-related hypertensive disorders, and obstructed labor and infections (Carroli et al., 2001). A study in Ethiopia Click or tap here to enter text. revealed that most of the 13.5% of women delivered at home after attending ANC did not know about the danger signs of pregnancy (Siyoum et al., 2018). These findings indicate that ANC classes are not paying adequate attention to pregnancy and childbirth preparedness education or that the method used for this education is insufficient. In this study, I sought to better understand how Ugep women of southern Nigeria decide where to give birth after attending ANC. The purpose of this basic qualitative study was to explore and describe how behavioral, normative, and control beliefs shaped women's birthplace decision-making experiences. I sought to understand better how Ugep women of southern Nigeria decide where to give birth after attending ANC.

In the first section of this chapter, I present my literature search strategy followed by a review of the TPB as a framework for understanding and predicting health behavior and a guide for designing behavior change interventions. I then explore relevant literature regarding TPB constructs and domains to women's childbirth place decision-making experiences. In the next section, I provide a global overview of maternal health and outcomes before discussing the Nigerian situation, especially related to the use of skilled birth attendance by pregnant women. In the final section, I explore available research on women's birthplace decision-making experiences within the context of facilitators and barriers.

Literature Search Strategy

The primary purpose of research is to gain knowledge about the subject of interest, and a secondary goal is to add to existing knowledge. Therefore, a researcher must start with what is known (existing literature) by systematically reviewing and synthesizing available knowledge in ways relevant to the matter under study (Pezalla, 2016). One way to review and synthesize existing literature efficiently and comprehensively is to have a literature search strategy that enables the researcher to find all the publications needed in a manner that is not biased towards certain types of literature (Aromataris & Riitano, 2014). After reviewing my research questions, I came up with search words and terms that helped me find the appropriate materials. These included *pregnancy, childbirth or delivery, institutional or health facility delivery, homebirths, maternal mortality, theory of planned behavior, skilled birth attendant, traditional birth attendant*, and *birthing options*.

I then reviewed the Walden University library and identified the databases that housed the materials needed. I chose the following databases for further exploration: CINAHL & MEDLINE combined search, ProQuest Nursing & Allied Health, PubMed, and Science Direct. Before I started my search, I browsed through Google Scholar using the above search terms to determine if these search terms were appropriate and the kinds of materials out there. I then stipulated some criteria to streamline my search process. In my criteria, I specified for inclusion only papers that were peer-reviewed, papers that were original journal articles, and papers that were not published before 2015, except seminal works or publications related to methods. Once my inclusion criteria were ready, I began my search, searching single terms and combining them, and with additional terms including *sub-Saharan Africa* and *Nigeria.*

Theoretical Foundation

The TBP extends the theory of reasoned action (TRA). The TRA proposes that behavior is a function of behavioral intention and that attitudes towards the behavior and subjective norms influence behavioral intention (Ajzen & Fishbein, 1970, 1977). However, a critical issue with the TRA is that it applies only to volitional behavior because it does not account for other barriers and facilitators of behavior enactment (Ajzen, 2020; Conner & Sparks, 2005). To address this issue, Ajzen (1991) added perceived behavioral control as the third determinant of behavioral intention after attitudes and subjective norms, effectively changing the TRA to the TPB. The TPB holds that behavioral intention mediates the influence of attitudes, subjective norms, and perceived behavioral control on behavior.

Additionally, perceived behavioral control and actual behavioral control directly predict behavior (Ajzen, 1991). According to the theory, an individual's beliefs about a behavior determine their attitudes towards that behavior (value-outcome expectations). On the other hand, subjective norms are shaped by normative beliefs (what other significant individuals do or think about the behavior), and perceived behavioral control is determined by control beliefs. These beliefs are shaped by the individual's background characteristics, including demographics, personality traits, and environmental influences (Ajzen, 1991).

Some researchers have strongly criticized the TPB, pointing out that the TPB unduly emphasizes rational thought at the expense of emotional influences on behavior (Sheeran et al., 2013). Other researchers have claimed that past behavior is the strongest predictor of behavior and not behavioral intention (McEachan et al., 2011) and that beliefs can directly influence behavior without the mediating role of intention (Araujo-Soares et al., 2013). Other researchers have outrightly called for the retirement of the theory (Sniehotta et al., 2014); however, there has been little or no support for calls to retire the TPB. Its flexibility and easy applicability to diverse behaviors have continued to make it the theory of choice among human behavior researchers (Miller, 2017).

Rather than call for its retirement, others have argued that considering the valuable contributions of the TPB to the understanding of health behavior, it should be extended and strengthened as necessary (Conner, 2015). In defending the TPB, (Ajzen, 2011, 2014, 2020) took the time to address the concerns raised by critics. He argued that

a misunderstanding of the theory had fueled much of the criticism and that the TPB lends itself to the addition of variables and components to the extent that these new additions are not redundant. For my dissertation, the TPB identified three determinants of human social/health behavior that are accessible and can be manipulated. These determinants include behavioral beliefs (perceived positive versus negative outcomes of performing a specific behavior), normative beliefs (perceived social pressure to perform or not to perform the behavior), and control beliefs (perceived barriers or enablers of behavior--self-efficacy or behavioral control). These beliefs are the theory's explanatory constructs, and the TPB holds that the more favorable the behavioral (attitudes) and the normative (subjective) beliefs, the greater the perceived self-efficacy (perceived behavioral control), and the stronger the intention to perform the behavior. Once there is an intention to perform the behavior, acting becomes a matter of time and chance (Ajzen, 1991). I applied these domains to understand the facilitators and barriers women consider to decide where to give birth. I also developed my interview questions based on these domains of the TPB.

Application of TPB to Health Behavior and Birthplace Decision Making

Despite criticisms discussed above, researchers and program implementers have continued to apply the TPB to understand an extensive range of health behaviors and design interventions to change behaviors. The general finding is that TPB variables are significantly correlated with intention and behavior (Li et al., 2019; McDermott et al., 2015; Steinmetz et al., 2016). The TPB has been applied to sexual health, HIV, and contraceptive use behaviors (Eaton & Stephens, 2019; Mo et al., 2019; Siuki et al., 2019;

Tseng et al., 2020), nutrition-related behaviors (Lee & Contento, 2019; Li et al., 2019; McDermott et al., 2015), blood donation behavior (Aschale et al., 2021), as well as to treatment adherence (Elyasi et al., 2020), exclusive breastfeeding (Bajoulvand et al., 2019), protection from the sun (Starfelt Sutton & White, 2016), and substance use behaviors (Hasking & Schofield, 2015; Kennedy, 2017). The TPB has also been used to study physical activity (Chevance et al., 2017; Gourlan et al., 2018; Stolte et al., 2017), cervical cancer screening (Wollancho et al., 2020), and COVID-19 related behaviors (Das et al., 2020). In their cross-sectional study to examine girls' sexual intentions towards their partners, Tseng et al. (2020) found that the girls' perceived behavioral control and subjective norms were associated with their intention to use condoms and contraceptives. Li et al. (2019) carried out a systematic and meta-analytic review to investigate the relationship between the TPB variables and healthy eating behaviors among adults. The authors established a significant correlation between all TPB variables and healthy eating behaviors and that intention had the strongest association with behavior. Findings from a randomized control trial in Iran to investigate the impact of a TPB-based weight control intervention showed that while baseline measures indicated no differences between the control and intervention groups, the group that received a TPB-based intervention exhibited an increase in all the TBP domains at the end of the intervention (Sanaeinasab et al., 2020).

While the TPB has been extensively applied to understand health behaviors and design interventions to influence these behaviors (Steinmetz et al., 2016), it has only recently been used in women's childbirth preferences studies (Ahmad Tajuddin et al.,

2020). Ahmad Tajuddin et al. used the TPB as a guide to explore why women in Malaysia preferred homebirths over delivery at a health facility. First, the authors designed their interview questions using the TPB domains of intention: behavioral beliefs, normative beliefs, and control beliefs as subcategories. Secondly, during coding and analysis, these domains became themes around which the authors grouped and discussed respondents' place of childbirth experiences. In this study, women's intentions to deliver at home were conceptualized as the outcome of a combination of their strong behavioral belief (preference for a quiet and relaxing birth environment), their normative beliefs ("pregnancy is a natural process, not a disease") and their behavioral control beliefs (at home they are in charge of the process). A related study in Tanzania used the TPB to explain couples' intention to have their baby at the health facility (Moshi et al., 2020a). The authors used a cross-sectional survey to measure respondents' perceived behavioral, normative, and control beliefs regarding health facility births. They found that while there was a positive correlation between attitudes, perceived behavioral control, and intention to deliver at the health facility, the relationship was not statistically significant. This explained why the intent to deliver at the health facility was not strong enough and contributed to the low rate of health facility delivery in the area.

Literature Review of Key Variables and Concepts

Maternal Mortality Rates

The World Health Organization (2019) estimated that globally, 295,000 women died from pregnancy and childbirth-related causes in 2017, translating into a MMR of 211 maternal deaths for every 100,000 live births. Compared to estimates made in 2000,

global MMR has reduced by 38%, indicating some progress towards the achievement of sustainable development goal 3.1 that the United Nations set in 2015; the goal was to reduce global MMR to less than 70 for every 100,000 live births by 2030 (United Nations, 2015, 2020). However, the global average MMR hides the steep disparities that exist among different regions of the world. For example, the average MMR for the Africa region in 2017 was 525 maternal deaths for every 100,000 live births compared to 13 maternal deaths per 100,000 live births in Europe during the same period. This means that while one out of every 39 girls and women in Africa have a lifetime risk of dying from pregnancy or childbirth, only one in every 4,300 girls and women face such a risk (World Health Organization, 2019).

The disparity in maternal outcomes between different world regions is attributable to differences in women's access to skilled birth attendance. The United Nations has estimated that trained and experienced healthcare providers attend to 90% of births in high and upper-middle-income countries. However, less than 50% of all deliveries in low and lower-middle-income countries benefit from skilled birth attendance (United Nations, 2020). Seventy-five percent of maternal deaths globally are caused by severe bleeding, infections, high blood pressure during pregnancy, complications from delivery, and unsafe abortions (Say et al., 2014). According to the World Health Organization (2019), these mortality causes can be prevented or addressed by trained and SBA but become deadly when women give birth outside the formal health system, common in sub-Saharan Africa, Southeast Asia, and the eastern Mediterranean. The proportion of women who

give birth in the health facility must be increased appreciably to reduce maternal mortality in these regions (World Health Organization, 2019).

Women's Birthplace Preferences

It is noteworthy that even in the global north, where there is availability and access to skilled birth attendance, many women would prefer home births over health facility delivery. An overriding reason why women in the advanced countries prefer homebirth is their need for autonomy over the birth process as well as their perception that birth is personal, natural, and not a disease (Hollander et al., 2017; Holten & de Miranda, 2016; Leon-Larios et al., 2019; Preis et al., 2018; Rigg et al., 2017; Westergren et al., 2019). Holten and de Miranda (2016) reviewed 15 qualitative studies conducted in five countries-- Sweden, United States, Australia, Canada, and Finland, and identified five influences on women's birthplace preferences. These influences included the perceptions that birth is a natural process, hospitals are dangerous, women can only control decision making with homebirths, and birth is a personal and spiritual experience. For example, a study in Spain revealed that women choose home birth because they found it rewarding, positive, and empowering because homebirths gave them a more personal experience and autonomy over decisions regarding labor and delivery (Leon-Larios et al., 2019). Women in sub-Saharan Africa also believe that birth is a natural process that should take place at home and not at the hospital (Shiferaw & Modiba, 2020). However, researchers here have focused more on the physical barriers and facilitators of skilled birth attendant utilization (Abubakar et al., 2017; Alemayehu & Mekonnen, 2015; Ayele et al., 2019; Boah et al., 2018; Chukwuma et al., 2017; Dufera et

al., 2020; Ogbo et al., 2020; Okigbo & Eke, 2015; Shiferaw & Modiba, 2020; Siyoum et al., 2018; Teklesilasie & Deressa, 2018).

Findings of these studies confirm the barriers to health facility deliveries as summarized by the (World Health Organization, 2019), namely poverty, distance to health facilities, lack of information, inadequate and poor-quality services, and cultural beliefs and practices. Ayele et al. (2019) found that over 70% of the Ethiopian women they surveyed gave birth at home without the assistance of SBA. The mother's educational level, distance to the health facility, and knowledge of danger signs of pregnancy were factors associated with home births. The authors found out that more educated women, women who attended four or more ANC sessions, and women responsible for deciding where to give birth were more likely to deliver at the health facility. Others have collaborated these findings (Chukwuma et al., 2017; Dufera et al., 2020; Okigbo & Eke, 2015).

Abubakar et al. (2017) examined women's preference for unskilled home birth even after attending antenatal clinic and found that 20% said they preferred homebirths because of perceived negative health provider attitudes, 15.5% were opposed to male birth attendants. In comparison, 8% felt safer at home. Shiferaw & Modiba (2020) found that women believed pregnancy and childbirth are natural events that should occur at home and not at the hospital; this may explain why many women in the sub-region deliver at home even after attending the required ANC sessions.

Birth Attendants

Traditional Birth Attendants

Traditional birth attendants (TBA) are individuals recognized within their communities as attending to women during pregnancy and childbirth. These individuals may have acquired their skills through experience or learning from other TBAs (World Health Organization, 1992). Although TBAs are almost no longer in existence in advanced countries, they remain a crucial component of the health systems of low and middle-income countries. TBAs and other unskilled individuals account for 25% of deliveries in these countries (UNICEF, 2016), but there are huge disparities among and within countries. For example, in Nigeria, while the average national prevalence of TBA utilization between 1999 and 2018 is about 20.6%, it is 32% in northwestern Nigeria, 29.6% in the southwest, and 6.4% in the southeast (Ogbo et al., 2020).

Although TBAs attend to births and remain the first point of call for many pregnant women in sub-Saharan Africa and other low-income regions, they usually are not a part of the formal health system, and have been associated with adverse pregnancy and childbirth outcomes (Sageer et al., 2019). Some countries have outrightly banned TBAs from attending deliveries without a concomitant increase in access to skilled birth attendance (Cheelo et al., 2016), while others have employed conditional cash transfers to women to promote uptake of skilled birth attendance while phasing-off TBAs gradually (Goudar et al., 2015). Irrespective of the approach each country uses, TBAs have remained the preference of a significant proportion of women in sub-Saharan Africa and the reasons for this preference have included: distance to health facility and lack of

transport, disrespectfulness of providers at health facilities and the friendliness of TBAs and the cultural sensitivity of the services they provide (Gurara et al., 2020; Tabong et al., 2021).

In the 1990s, the World Health Organization (WHO) promoted the training and integration of TBAs into national formal health systems to reduce maternal, neonatal, and child mortalities (Bergström & Goodburn, 2001; World Health Organization, 1992). However, a decade later, such programs did not yield the envisaged benefits (Sibley et al., 2012). The WHO is now focusing on expanding access to skilled birth attendance for all women (World Health Organization, 2004, 2015, 2018). Despite this strategic shift from TBA training and integration, TBAs remain a crucial part of the Nigerian health system. TBAs who received training from the formal health sector have helped increase prompt referrals of pregnant women to health facilities (Mustapha et al., 2020), and promoted child immunizations, and distributed condoms, oral contraceptives, insecticide-treated bed nets (Iwu et al., 2021).

Skilled Birth Attendants

An SBA is a trained health professional accredited to manage uncomplicated pregnancies and childbirth and identify, manage and refer pregnancy and childbirth-related complications (World Health Organization, 2004). While the WHO definition provides a guide to who an SBA is, the cadre of health providers reported as SBAs and their official titles differ from country to country (Hobbs et al., 2019). For example, Malawi has eleven cadres identified as SBAs as opposed to only four in Nigeria. The Nigerian SBAs include Obstetrician, General Doctor, Registered Midwife, and

Registered Nurse Midwife. Obstetricians are trained for ten years post-secondary school, general doctors for seven years, registered midwives- three years, and registered nurse-midwives are trained for four years (A. Adegoke et al., 2012).

Table 1

EmOC Signal Functions

Basic EmOC	Comprehensive EmOC
1. Administer parenteral antibiotics	Perform functions 1-7
2. Administer uterotonic drugs	8. Perform surgery, e.g., caesarian section
3. Administer parentheral anti-convulsant	9. Perform blood transfusion
4. Manually remove the placenta	
5. Remove retained products (manual vacuum extraction, dilation, and curettage)	
6. Perform assisted vaginal delivery (vacuum extraction, forceps delivery)	
7. Perform neonatal resuscitation	

Adapted from *Monitoring emergency obstetric care: A handbook* by the World Health Organization, 2009 (http://whqlibdoc.who.int/publications/2009/9789241547734_eng.pdf) in the public domain.

Two of the critical strategies for reducing maternal mortality are skilled birth attendance during normal delivery and the capacity of SBAs to promptly provide emergency obstetric care (EmOC) when needed. The WHO recommends a set of EmOC "signal functions" that SBAs should perform during obstetric emergencies to reduce maternal deaths from hemorrhage, pre-eclampsia, and eclampsia (World Health Organization, 2009). These services are divided into basic and comprehensive categories. (See Table 1)

The World Health Organization recommends at least five basic EmOC centers for every 500,000 people, one of which should provide comprehensive services. There is evidence that women who utilize skilled birth attendance in facilities with EmOC services have better chances at survival than those who do not (World Health Organization, 2004, 2015). Unfortunately, not all cadres reported as SBAs can perform some EmOC functions due to disparities in training duration and curricula (Adegoke et al., 2012; Rajbhandari et al., 2019; Ueno et al., 2015).

The International Confederation of Midwives (ICM) recommended essential competencies for midwifery practice that cover four categories to reduce these disparities. These are general competence, pregnancy, ANC competencies, care during labor and birth, and ongoing care of women and newborns (International Confederation of Midwives, 2019). The ICM recommendations provide a framework for SBA training throughout the world. While the basic three-years midwifery training curriculum closely meets the ICM standards, the community health extension worker (CHEW) and the junior community health extension worker (JCHEW) do not meet these standards (A. A. Adegoke et al., 2013).

Birthing Options

There are generally three birthing options: (a) natural birth without recourse to medical interventions and drugs, (b) vaginal birth that is medically managed using monitoring equipment, forceps/vacuum extractors, and medicated pain control, and (c) cesarean birth (Walker, 2009). According to Walker, during actual natural birth the

mother depends only on her instincts and requires only the support of a companion. In sub-Saharan Africa, this companion may or may either be a TBA or SBA. In developed regions where homebirths have been appropriately integrated into formal maternity care, planned natural births at home do not increase the risk of adverse outcomes (de Jonge et al., 2015). Although many women opt for an actual natural delivery (Hollander et al., 2017; Holten et al., 2018; Reed et al., 2017), typical these days, especially in advanced countries, is the medicalization of birth (Clesse et al., 2018).

Summary and Conclusions

I reviewed the literature on maternal mortality globally and in sub-Saharan Africa regarding maternity care and women's childbirth preferences. I found that globally and in sub-Saharan Africa, women mostly prefer home births. The common reasons for this preference include autonomy over the birth process and the perception that pregnancy and birth are natural events that do not require biomedical interventions. However, while women in developed countries who give birth at home also enjoy skilled birth attendance, women who give birth at home in sub-Saharan Africa do not benefit from professional maternity care. This difference in maternity care levels contributes to the disparity in maternal, prenatal, and neonatal mortality ratios between developed regions and sub-Saharan Africa.

Women who attend ANC learn about the dangers of pregnancy and childbirth and are encouraged to deliver at the health facility so that SBA can handle these dangers should they arise. This study has contributed to answering the question of why sub-Saharan African women choose to give birth at home even after attending ANC and

learning about the risks of doing this. I also reviewed the literature on the application of the TPB to health behaviors and birthplace decision-making. Generally, researchers agree that the TPB variables: behavioral beliefs, normative beliefs, and control beliefs determine behavioral intention. The research also indicates that intention is the strongest determinant of behavior. Women who have positive attitudes towards health facility delivery, and have supportive significant others as well as belief in their ability to deliver at the health facility are more likely to give birth at the health facility. In Chapter Three, I delve deeper into the nature of the research, methodology, and the procedures that I followed.

Chapter 3: Research Method

Introduction

The frequency of ANC visits and the nature and the number of services women received during ANC are independently significantly associated with SBA use (Ayele et al., 2019; Chukwuma et al., 2017; Ogbo et al., 2020; Okigbo & Eke, 2015). However, among women attending ANC, SBA utilization remains suboptimal. Pooled DHS data collected between 2006 and 2015 from 28 African countries revealed that 30% of women attending ANC do not give birth at a health facility (Chukwuma et al., 2017). A study in northern Nigeria put this figure at 74.1% (Abubakar et al., 2017), and another in Ethiopia at 29.2% (Ayele et al., 2019).

Additionally, many sub-Saharan African women believe that pregnancy and childbirth are natural and require no unnecessary medical interventions (Shiferaw & Modiba, 2020). However, I did not find any study that explored the relationship between this belief and health facility birth. This basic qualitative study explored and described how behavioral, normative, and control beliefs shaped women's birthplace decision-making experiences. I sought to better understand how Ugep women of southern Nigerian decided where to give birth after attending ANC. In the earlier sections of Chapter 3, I describe the research design and its rationale, my role as the researcher, and my methodology. Later in the chapter, I discuss trustworthiness and ethical procedures.

Research Design and Rationale

Research Questions

- Research Question 1: How do behavioral, normative, and control beliefs and attitudes influence birthplace choice decision making for Ugep women of southern Nigeria aged 25 to 35 years old who received health education during ANC at a primary health facility?
- Research Question 2: What are the skilled birth attendance utilization facilitators experienced by Ugep women of southern Nigeria aged 25 to 35 who received health education during ANC at a primary health facility?
- Research Question 3: What are the skilled birth attendance utilization barriers experienced by Ugep women of southern Nigeria aged 25 to 35 who received health education during ANC at a primary health facility?

Central Concepts of the Study

The central concepts of this study are (a) attitudes, (b) subjective norms, (c) perceived behavioral control, and (d) ANC attendance and birthplace decision making. Attitude refers to the positive or negative feelings an individual has about enacting a particular behavior. Behavioral beliefs, individuals' beliefs regarding the likely outcomes of performing a specific behavior, determine attitude. Subjective norms, determined by normative beliefs, are the subjective expectations and actions of significant (influencing) others, for example, spouse, family, friends, and others. Perceived control is the individual’s perceived ability to perform the behavior. Perceived control is influenced by control beliefs, which refer to an individual’s beliefs about the presence of barriers to and

facilitators of performing a specific behavior and the power of these barriers and facilitators (Ajzen, 2012). Attitudes towards behavior, subjective norms around a particular behavior, and perceived control determine an individual's intention to perform a specific behavior. Modifying this intention is the objective of most behavior change interventions (Ajzen, 2012, 2020). Women who attend ANC are more likely to give birth at a health facility (Ayele et al., 2019); however, Chukwuma et al. (2017) found that about 30% of women do not give birth at a health facility even after attending ANC. It is, therefore, worthwhile to explore the relationship between ANC attendance and birthplace decision making.

Research Tradition and Rationale

My research questions were deliberately explorative because I intended to gain a deeper understanding of Ugep women's beliefs, attitudes, and experiences regarding the use of SBA. Asking these open-ended questions and limiting myself to women in a specific context reflected a constructivist research tradition. Ontologically, constructivists believe that truth is subjective and not an objective reality "out there," as expounded by positivists (G. J. Burkholder & Burbank, 2016). Epistemologically, constructivists believe that knowledge and meaning are socially constructed and not created by applying values-free scientific methods (Patton, 2015). Although positivism and constructivism have been the dominant philosophical worldviews, two other orientations have gained ground in recent years: transformative orientation and pragmatism (Creswell & Creswell, 2018).

Researchers with a positivist orientation rely on a quantitative research tradition and use a deductive process to compare variables and test theory. On the contrary, I depended on qualitative research traditions, which are primarily inductive in approach and geared towards building concepts, hypotheses, or theories. The qualitative traditions are aligned with constructivist orientations (Creswell & Creswell, 2018). Traditionally, qualitative research had three distinct approaches, phenomenology, ethnography, and grounded theory, but these later expanded to include narrative inquiry and qualitative case studies (Kahlke, 2014). However, qualitative research has evolved to include a design commonly known as the basic qualitative design. The defining characteristic of the basic qualitative design is that while it draws on elements and tools from the foundational qualitative approaches mentioned above, it does not claim total allegiance to any of these methodologies (Kahlke, 2018; Merriam & Tisdell, 2016). I used the basic (generic) qualitative design for this study. This design enabled me to answer my somewhat straightforward research questions while responding to unforeseen situations in the field.

Role of the Researcher

While quantitative researchers have their experiments and survey instruments and are mostly not in close contact with their research participants, qualitative researchers are their research instruments. Qualitative researchers interact closely with participants while collecting data, and the research findings are cocreated through the social interaction between researcher and participants (Maxwell, 2018). In line with the constructivist worldview, qualitative research cannot be values-free; the researcher's social

location/identity and positionality impact the research (Gillani, 2021; Ravitch & Carl, 2016). The researcher's identity and positionality are defined by researcher subjectivity and research relationships.

Researcher subjectivity refers to the beliefs, values, and tendencies that the researcher brings to the research. In contrast, research relationships describe the complex social interactions among the researcher, participants, gatekeepers, and other individuals relevant to the investigation (Maxwell, 2018). According to Maxwell (2018), researcher subjectivity (bias) and research relationships could be valuable resources in qualitative research if handled appropriately; they could also distort research findings and diminish rigor and reliability. Reflexivity is one tested way to ensure that researcher subjectivity and research relationships do not distort research and hamper understanding. Reflexivity is an ongoing process of reflection and action through which investigators examine their social identity and positionality in relationship with the study and account for these at every stage of the research process (Barrett et al., 2020).

My role in this study was that of an observer-participant. I chose the social and research problem I intended to study, selected the philosophical orientation and theory that informed my research design, and identified the publications I included in my literature review. I also designed my question guide, purposively selected research participants, collected data through interviews, analyzed the data, and wrote up a report of my findings. My social location/identity and positionality influenced how I handled each of the listed activities. I had an uncle who was a traditional birth attendant, and he lived near us and less than a kilometer from a secondary health facility. He attended to

pregnant women long before the hospital was built, and he continued assisting many women after then. I do not recollect any incidents of maternal deaths among the women he helped. My mother worked as a nurse assistant for several years, and after leaving this job, she became the midwife in my community, attending to homebirths. I remember women coming back to thank her afterward.

I have three children, and all were born in a hospital, but this has not changed my mindset that childbirth is a natural process that women can handle with minimum assistance. With two master's degrees and currently studying for a Ph.D., I know there is convincing evidence that delivery in a health facility in Nigeria is much safer for the mother and the child than delivery without skilled attendance. I am interested in this study to understand why all those women preferred my uncle or mother instead of going to the health facility. It is also possible that I wish to make a case for a more natural birth process. According to Ravitch and Carl (2016), I had to constantly remind myself of my positionality and social identity in a reflexive manner as I embarked on this inquiry as they impacted my interpretations of participants' narratives. I kept a research (reflexive) journal and used memos to account for my perspectives and intersections with participants' accounts.

Methodology

Population and Selection Criteria

The universal population for this study was women who live in Ugep, Cross River State of Nigeria, and who attended an antenatal clinic at the Ugep primary health care center (maternity). The subpopulation of interest was women who attended ANC at the

study site but did not deliver there. Based on my selection criteria, all the women who participated in this study were between the ages of 25 and 35, were Yakö by culture, and attended antenatal classes at the study site at least two times before their last delivery. Additionally, they all gave birth at home, within 1 year before the study. Ugep women who were not residing in Ugep during their last pregnancy and delivery were excluded from this study. I spoke about my research with the community health officer (CHO) in charge of the study site. She granted me access to women attending ANC and postnatal clinics at the site through a written approval.

Sampling Strategy, Saturation, and Sample Size

I used homogenous sampling, a variety of purposeful sampling, for this study. Purposeful sampling enables the researcher to select only participants with the experiences and the information needed to answer the research questions. A homogenous sample makes it easier to study the common characteristics of the participants (Patton, 2015). In addition, purposeful sampling is cost-efficient (Gill, 2020), and a homogenous sample enables the researcher to achieve data saturation sooner than later (Guest et al., 2006). The twin issues of sample size and saturation in qualitative research have been extensively debated (Guest et al., 2006; Hennink et al., 2016; Sim et al., 2018). Although there is no agreement on how many interviews should be conducted, saturation has become a gold standard in qualitative research.

In an earlier study, Guest et al. (2006) accomplished data saturation--the point at which no new data are discovered--at the 12th interview. Thus, they recommended that a sample size of 12 was adequate for most qualitative studies. Hennink et al. (2016) took

this further and examined sample size through code saturation--the point at which no new codes emerged--and meaning saturation--the point at which now new meanings were discovered. Hennink et al. accomplished code saturation after nine interviews and meaning saturation between 16 and 24 interviews. In their opinion, Sim et al. (2018) recognized the need for researchers to propose sample sizes during research design but also argued that it is difficult for a researcher to determine their exact sample size before data analysis begins.

Based on Guest et al.(2006) and Hennink et al.(2016), I planned to interview 12 participants for this study. Because I used a semistructured questionnaire based on the TPB, I had a rough idea of codes and themes beginning from the pilot and initial interviews. After the first six interviews, I started data analysis and interviewed more participants until I accomplished code and meaning saturation after interview nine. As Sim et al. (2018) noted, the sample size is context-specific and depends on the researcher's interpretation of the data.

Instrumentation

My research questions required exploring participants' experiences, attitudes, beliefs, and values; interviewing is an appropriate data collection method for such purposes. According to Crawford and Lynn (2016), interviews enable the researcher to collect verbal responses and additional nonverbal information, including voice tone, nuance, and body language. Researchers can choose from three forms of interviews depending on their study context: unstructured interviews, semistructured interviews, and structured interviews. As their names imply, unstructured interviews are the least rigid,

while structured interviews are the most stringent (Crawford & Lynn, 2016). For this study, I used the face-to-face semistructured interview.

The semistructured interview is conducted using a predetermined interview guide or outline that enables the researcher to probe for additional information during the interview depending on the responses provided by each participant. The interview guide helps the researcher cover all anticipated topics but leaves her some flexibility for creativity (Patton, 2015). I developed the interview guide/protocol after I took the following steps. First, I reviewed the literature on my subject of inquiry and identified issues that would inform my questions. Second, I checked my selected theoretical framework to ensure that critical concepts, constructs, and variables were covered in my interview. Third, I reviewed the methodology literature to appreciate the style and terminology used for crafting interview questions within my chosen research traditions.

From reviewing the literature on the birthplace choices of sub-Saharan African women, I identified barriers to health facility delivery and facilitators of homebirths (see Abubakar et al., 2017; Siyoum et al., 2018) as critical issues that I should explore through my interviews. Therefore, I crafted my interview questions to explore these vital issues through the lens of the TPB (attitudes towards place of delivery, subjective norms, and perceived control). See Appendix A.

Pilot Testing

Although I had developed the protocol for my semistructured interviews, I was not sure that the questions in it would work as intended. Participants may not have understood these questions, and the questions may not have covered all the points I

needed to answer my research questions. Maxwell (2018) recommended that researchers should pilot test their interview guide among people who share the same characteristics with intended participants to avoid confronting these issues during data collection. Pilot testing provides the researcher an opportunity to refine the interview questions, improve the research design, and increase research trustworthiness (Malmqvist et al., 2019). I conducted three pilot interviews using the same inclusion criteria and recruitment procedures discussed above and below. However, these interviews were with participants recruited from a health facility that is different from the study site. The three pilot interviews enabled me to refine my questions to make translation into the local language easier and without loss in meaning. In addition to this benefit, pilot testing in a different facility provided an opportunity to compare participants' responses from different study settings (see Hayashi et al., 2019). I found similar response patterns from the pilot study and substantive study participants.

Recruitment, Participation, and Data Collection

I received written permission from the chief health 0fficer (CHO) in charge of the selected health facility to recruit participants for my study from this site with the assistance of the health facility. I then received ethical approval from the Cross River State Ministry of Health (# CRSMOH/RP/REC/2021/140) followed by Walden IRB approval (# 12-10=21-0864227). After the IRB approvals, the research site and I agreed on a date and time for me to visit the site so I can introduce the study to potential participants (women attending post-natal clinic). I introduced the research to the group of women attending post-natal clinic including its purpose and the criteria for participating

in the study, and then passed around my phone number (written on a card) and asked those who are interested in participating in the study to give me a call or send me and SMS at their earliest convenience. I acknowledged each call or SMS and informed the volunteer that I will call back to arrange for an appropriate date, time and venue for the interview. As soon as I had twelve volunteers, I politely declined additional offers as this was the maximum number of interviews I planned to conduct, as discussed earlier. I then called each volunteer to ask them to say the interview date, time and venue that is convenient for them. I discussed with each volunteer to help them select a venue where they can talk freely without interruptions and without fear of others listening in on their responses.

During the interview, I first welcomed the volunteer and then shared with her the contents of the informed consent form. If the volunteer agreed with the contents of the form and wished to proceed with the interview, I had her sign the informed consent form. I then started the interview by collecting the relevant demographic information. Each interview lasted about 40 minutes, and I personally conducted it in the Lokä language. I also recorded each interview using the voice recorder that came with my iPhone 12 ProMax to translate and transcribe later. At the end of the interview, I thanked each participant and offered them a token of N2,000 ($5) for transportation expenses and refreshments. I also asked each participant if she is willing to be invited during a subsequent meeting that I will organize to provide feedback on their accounts' interpretations.

Data Analysis Plan

My data included transcripts, notes, and memos from one-on-one interviews. I used number identifiers for example P1, P2 and so on during transcription to differentiate the responses of each participant from another. This method would ensure that participants remain anonymous. I used content analysis through a combination of inductive and deductive methods. According to Patton (2015), inductive analysis uses data from a specific study to generate insights, results, new notions, or theories. In deductive analysis, the researcher determines how much of the data in the specific qualitative study supports pre-existing explanations, concepts, and theories. Recently, qualitative researchers have successfully used a combination of inductive and deductive approaches in the same research to achieve analytical comprehensiveness (Azungah, 2018; Gibbs, 2021). For example, during the initial analysis, Azungah (2018) generated codes from the existing literature and the study's theoretical framework (deductive approach), but reverted to an inductive approach by developing themes from the study data.

Irrespective of the data analysis approach used, coding is at the core of analysis in qualitative research since it is the source of the patterns that researchers look for, to create meaning. Coding enables the researcher to identify relevant data, divide it up, group it, regroup it, and link it to make meaning and explain the phenomenon under study (Saldana, 2016). I used first and second-cycle coding methods to analyze my data. According to Saldana (2016), first cycle or initial methods enable you to generate codes (inductively or deductively), while second cycle methods are advanced ways of

reorganizing data from first cycle coding into categories and themes. For the first cycle coding, I combined structural, descriptive, and In vivo codes. I then used pattern codes to establish patterns and focused codes to label categories and themes for second cycle coding.

After transcribing my interview scripts, I uploaded them with my field notes into ATLAS.ti 9 (*ATLAS.Ti: The Qualitative Data Analysis & Research Software*, n.d.) to store my data, code, retrieve, link, and compare. I chose this software because it is reasonably priced and easier to use than others that offer the same value (*Compare - PAT RESEARCH: B2B Reviews, Buying Guides & Best Practices*, n.d.). To ensure that data connects to specific research questions, I followed the sequence of the interview guide during analysis because I developed the interview guide based on the research questions.

Issues of Trustworthiness

Qualitative research seeks to find meaning and increase knowledge, but it is useless if those who read a qualitative research report do not trust its findings. The extent to which people are confident in qualitative research processes and results is described as trustworthiness (Connelly, 2016). According to Connelly, trustworthiness has been accepted as a necessary attribute of qualitative research; however, what constitutes trustworthiness continues to be a subject of debate. The four standard criteria for determining trustworthiness are credibility, transferability, dependability, and confirmability (Forero et al., 2018; Houghton et al., 2013). What do these criteria mean?

Credibility

Credibility refers to the extent to which qualitative research findings represent the views, perspectives, and feelings of the research participants and the researcher's stated research intentions (Connelly, 2016; Forero et al., 2018). Each researcher is expected to utilize strategies to increase the credibility of their work, and these strategies include engaging with the research setting and participants extensively, peer debriefing, triangulation, and member checking (Houghton et al., 2013). The context of each study determines the set of strategies to use, and in my research, I used peer debriefing and member checking to increase the credibility of my work. Peer debriefing is a qualitative research practice where the researcher engages an outsider, mostly a peer to provide feedback on ongoing analysis (Shenton, 2004). Member checking on the other hand is the practice of returning back to interviewees to either clarify earlier responses or obtain additional information occasioned by emerging insights (Patton, 2015). I contacted a colleague of mine who is faculty at the University of Calabar, Nigeria and he debriefed with me after my transcriptions, and during data analysis. I also had a follow-up meeting with each of my participants at the end of data analysis, shared summaries of my findings (interpretations) and got their feedback.

Transferability

Transferability in qualitative research is akin to external validity in quantitative research. However, transferability does not infer generalizability (Smith, 2018a); instead, it means that lessons and findings from one study context can be helpful to others in similar settings (Houghton et al., 2013). According to Houghton et al., researchers can

ensure transferability by presenting thick and rich descriptions of all aspects of the study. In addition to writing thick and rich descriptions, selecting information-rich participants and achieving data saturation are the other two strategies (Forero et al., 2018). Therefore, I used a purposeful sample in my study, presented thick descriptions, and achieved data saturation on my ninth interview. I used inductive and deductive analysis during my first cycle coding to ensure that themes emerging from the literature and from my study's findings were all accounted for. I continued this process until no new themes emerged.

Dependability

The question most often associated with dependability is that, if the same study is repeated with the same participants, within the same context, and with the same coders would the findings be the same? (Forero et al., 2018). Dependability is somewhat similar to reliability in quantitative research. While social context hardly remains stable, researchers can attempt to make their findings dependable by being reflexive throughout the study, keeping a reflexive journal, and maintaining an audit trail of processes and decisions (Amin et al., 2020; Hadi & José Closs, 2016; Houghton et al., 2013). In addition, Forero et al. (2018) recommended detailed thick descriptions and the dependence on more than one source of data or methods, triangulation to ensure comprehensiveness and validity. I maintained a reflexive journal in my study and recorded details of my processes and decisions in a separate research journal. Interviewing multiple individual participants using the same question guide is also an excellent example of data source triangulation (Carter et al., 2014).

Confirmability

Confirmability is to qualitative research what objectivity is to quantitative research (Connelly, 2016). It refers to the extent to which study findings can be confirmed or agreed upon by other researchers (Forero et al., 2018). The strategies recommended for ensuring confirmability include maintaining an audit trail, being reflexive, and utilizing triangulation (Amin et al., 2020; Hadi & José Closs, 2016). Throughout this study, I kept a researcher's journal to record the processes and procedures I followed, and my reflections and insights as they evolved. When studied side by side with the thick descriptions that I have provided in my research report, my journal records can enhance the confirmability of my study.

Research Ethics

The three ethical principles of respect for persons, beneficence, and justice were applied to all stages of this study, from participant recruitment through data collection, data analysis, storage, and dissemination of results. Respect for persons required that I recognize and acknowledge an individual's autonomy to decide whether to participate in research or withdraw from the study at any time during the process (see Barrow et al., 2020). Closely aligned with the principle of respect for persons is the requirement for informed consent. Each participant should be provided with adequate information regarding the study: its purpose, including who the findings are for and how their results will be used, what questions will be asked, any potential risks and benefits, and participant anonymity and confidentiality (Patton, 2015). According to Patton, the researcher should provide this information during the recruitment and repeat it before the

interview. Once I received IRB Approval (#12-10-21-0864227) from Walden University and began my recruitment, I reviewed the informed consent form with my potential participants. I then proceeded with only those participants who signed and returned their forms.

Beneficence implies that the researcher should ensure that no harm befalls research participants, and where there exists potential harm, the researcher is obliged to amplify benefits and minimize harm (Barrow et al., 2020). Anonymity and confidentiality are two means of reducing harm to participants, and the researcher is obligated to ensure that the privacy of research participants is respected and protected (Cox, 2016). I ensured authentic anonymity in this study by using numbers as identifiers instead of collecting and storing their identifying information. I also did not see any potential harm for participants except the inconvenience and the time they spent on interviews.

All participants were interviewed within their homes as they chose and I offered each a cash gift of $5 after the interview for them to use as they chose. I have stored all information from this study, including audio recordings, interview transcripts, field notes, researcher's journals, and memos, in my passworded laptop. I am the only one with access to this laptop. I have also backed up everything using my paid-for Dropbox account that offers easy access and maximum security. I plan to delete these data five years after the completion of this study.

The principle of justice applied to research ethics requires that the researcher treats all individuals fairly and equitably. Therefore, all individuals should have a fair chance at being selected as participants in research, and that all groups should equitably

bear the benefits and burdens of research. My target population was women attending ANC at the study site and I introduced my research to all those who were available. I then gave opportunity for every woman to volunteer. This was the limited way I ensured fairness in recruitment, as this gave each woman a chance to be recruited.

Summary

In Chapter 3 I discussed my research methods with a focus on the design of my study. I also discussed my role as a researcher, data collection and analysis plan, and potential ethical issues. In the next chapter, I report the results from my fieldwork, including the pilot study, study findings, evidence of trustworthiness, recommendations, and implications

Chapter 4: Results

Introduction

In this basic qualitative study, I aimed to explore and describe how behavioral, normative, and control beliefs shape women's birthplace decision-making experiences. In addition, I sought to better understand how Ugep women of southern Nigeria decide where to give birth after attending ANC. Finally, I explored women's ANC experience and how this experience shaped their decision of where to deliver. Three research questions guided this study:

- Research Question 1: How do behavioral, normative, and control beliefs and attitudes influence birthplace decision making for Ugep women of southern Nigeria aged 25 to 35 years old who received health education during ANC at a primary health facility?
- Research Question 2: What are the skilled birth attendance utilization facilitators experienced by Ugep women of southern Nigeria aged 25 to 35 who received health education during ANC at a primary health facility?
- Research Question 3: What are the skilled birth attendance utilization barriers experienced by Ugep women of southern Nigeria aged 25 to 35 who received health education during ANC at a primary health facility?

In this chapter, I discuss the research setting and participant demographics and provide details on data collection, data analysis, trustworthiness, and results, including quoted responses from participants during the semistructured interviews.

Pilot Study

Pilot testing provides the researcher an opportunity to refine the interview questions, improve the research design, and increase research trustworthiness (Malmqvist et al., 2019). I conducted three pilot interviews using the same inclusion criteria and recruitment procedures discussed above and below. However, these interviews were with participants recruited from a health facility that is different from my study site. The three pilot interviews enabled me to refine my questions to make translation into the local language easier and without loss in meaning. In addition to this benefit, pilot testing in a different facility provides an opportunity to compare participants' responses from different study settings (Hayashi et al., 2019). I found similar response patterns from pilot study and substantive study participants.

Setting

I received local IRB approval (CRSMOH/RP/REC/2021/140) from the Cross River State Health Research Ethics Committee on November 17, 2021, and Walden University's IRB approval notification (#12-10-21-0864227) on December 10, 2021. I conducted my pilot interviews between December 20 and 31, 2021, and substantive data collection began on January 1, 2022. I collected data through individual face-to-face interviews using a semistructured questionnaire. I received permission from the head of the Ugep Primary Health Care center to conduct my research at this center.

I worked through the nurse designated to support my work to meet with women after the postnatal clinic to introduce my study. After presenting my proposed research and my need for volunteers, I passed around my phone number (written on a card). I

asked women who met the inclusion criteria and were interested in participating in the study to call or send me an SMS at their convenience. I used this approach instead of asking for volunteers on the spot to allow the women to think through the information I provided them before deciding to join the study. Also, this method prevented peer pressure because some women may volunteer because their peers in the group have volunteered.

I acknowledged each call and text message and then called each volunteer back to ask them to say the most convenient interview date, time, and venue. I discussed with each participant to help them select a venue where they could talk freely without interruptions and fear of others listening in on their responses. As soon as I achieved the number of participants I required, I politely declined all additional offers.

After welcoming the participant at each interview, I reviewed the informed consent form with her. If she agreed with the contents and wished to proceed with the interview, I gave her the informed consent form for her signature. I started the interview once the participant signed the informed consent form. All nine original volunteers gave informed consent to participate in the study. All the participants preferred the veranda of their homes as venue for the interview. The interviews took place over 4 weeks, as finding a suitable date for some participants was difficult. I conducted each interview in Loká (the local language) and recorded it for later transcription from audio to text. I referred to individual participants as Participant 1 (P1), Participant 2 (P2), and so on to ensure their confidentiality.

Demographics

All the participants in this study self-identified as females (women) who lived in Ugep, Cross River State of Nigeria, and who attended antenatal clinic at the Ugep primary health care center (maternity) at least twice during their last pregnancy but delivered either at home or in church. The nine participants aged between 25 and 35 were all of the Yakö clan and had given birth within 1 year before this study. Table 2 provides detailed demographic data from the research participants.

Table 2

Participants' Demographics

Participant	Age	# of children	Age of youngest surviving child (months)	Place of delivery
P1	35	3	3	Church
P2	30	6	3	Church
P3	30	1	4	Home
P4	35	3	4	Home
P5	27	2	3	Home
P6	25	1	3	Home
P7	30	4	3	Home
P8	30	2	4	Church
P9	25	1	2	Home

Data Collection

I collected data for this study from January 2022 through March 2022. All interviews lasted between 30 and 35 minutes, and I conducted all interviews on the

veranda of participants' houses. I observed that each participant chose the time between 9:00 and 10:00 am for their interview. The period 9:00 to 10:00 am was the quietest time at home because older children were away at school and husbands were away at work or on the farm, leaving the woman alone at home with younger children. It is also a time belt during which mothers have finished their first set of morning chores, and children take an after-breakfast nap. I asked participants the same questions using my semistructured questionnaire (see Appendix B) but followed up with probes to clarify earlier responses or get additional information. After the initial awkwardness that I addressed through ice breakers, the participants became comfortable about their participation in this study and freely shared their pregnancy and childbirth experiences with me.

Although all participants had given consent for the interview, I still asked each participant to confirm their permission to record the interview. Once I received the confirmation, I turned on the voice recorder application on my iPhone 12 ProMax phone. Using a phone ensured that recording went on unobtrusively during the interview because cell phones are an ubiquitous sight. After the sixth interview, I noticed common patterns and emerging themes from among the responses, and by the ninth interview, no new themes emerged. Meeting saturation is not unusual as there is evidence that most qualitative studies involving homogenous study populations achieve code-meaning saturation between the ninth and the 17th interview (Hennink & Kaiser, 2022). Data collection happened as planned and discussed in Chapter 3. I recorded each interview using my iPhone13 ProMax recorder. After I transcribed each interview, I met again with

the participant to share a summary of their responses. All participants confirmed that my transcriptions were a true reflection of their responses.

Data Analysis

My data included transcripts, notes, and memos from my one-on-one interviews. After transcribing the audio recordings of my interviews, I uploaded them with my field notes into ATLAS.ti 9 (*ATLAS.Ti: The Qualitative Data Analysis & Research Software*, n.d.) to store my data and code, retrieve, link, and compare. I used first and second-cycle methods to code my data (see Saldana, 2016). I applied an inductive approach to all nine scripts during the first cycle and produced 38 codes. According to Patton (2015), the inductive analysis uses data from a specific study to generate insights, results, new notions, or theories. During the second coding cycle, I categorized codes under four recurring themes. Three of these categories, (a) attitudes towards homebirths and health facility births, (b) subjective norms around homebirths and health facility births, and (c) behavioral control) came from the TPB, which was my study's theoretical framework (deductive analysis).

In contrast, the fourth category, ANC attendance and birthplace choice, emerged inductively from the data. As mentioned in Chapter 3, qualitative researchers have recently used inductive and deductive approaches in the same research to achieve analytical comprehensiveness (Azungah, 2018; Gibbs, 2021). For example, during the initial analysis, Azungah (2018) generated codes from the existing literature and the study's theoretical framework (deductive approach) but reverted to an inductive approach by developing themes from the study data.

The first theme, attitudes towards home and health facility births, reflected participants' behavioral beliefs regarding where they should give birth-- at home/church or the health facility. I used this theme to describe participants' attitudes towards home/church delivery and health facility delivery and how these influenced their birthplace choice. The second theme, subjective norms, referred to how participants perceived what significant others felt or thought about home and health facility delivery. I used this theme to describe how this perception influenced participants' birthplace choices. The third theme, behavioral control, referred to participants perceived and actual capacity to deliver at home or the health facility. I used this theme to describe how behavioral control influenced participants' choice of where to give birth. The fourth theme, ANC attendance and birthplace choice, captured participants' ANC experience. This theme enabled me to demonstrate how the ANC experience of participants influenced their choice of birthplace. In the results section of this chapter, I present quotes from participants in the context of the research purpose and address my three research questions.

Evidence of Trustworthiness

For my research to be trustworthy, it must be credible, transferable, dependable, and confirmable (see Stahl & King, 2020). I increased the credibility of my research through member checking and peer debriefing. After transcribing my audio interviews, I returned to each participant with the transcript of their interview. We reviewed the transcripts together, and each participant confirmed that the transcripts truly reflected the responses they gave during the interview. This technique is called member checking. I

also was in regular touch with a colleague who is faculty at the University of Calabar, Nigeria. He was interested in my topic and enthusiastically reviewed my work, including my proposal, transcripts, and analysis. This technique is called peer debriefing in qualitative research. Member checking and peer debriefing are two techniques recommended to increase the credibility of qualitative research (Stahl & King, 2020).

I used a purposeful (information-rich) sample in my study, provided thick descriptions, and ensured that I achieved meaning saturation during data collection, all to increase the transferability of my research. Additionally, I used inductive and deductive analysis during my first and second cycle coding to account for the themes emerging from the literature and my study's findings. Others have used these techniques similarly (see Amin et al., 2020a; Forero et al., 2018; Houghton et al., 2013). Finally, I maintained an audit trail of my processes and decisions, kept a journal of my reflections, and provided thick and rich descriptions that make my study palpable to ensure dependability and confirmability (seAmin et al., 2020; Stahl & King, 2020).

Results

In this study, I aimed to explore and describe how behavioral, normative, and control beliefs shape participants' birthplace decision-making experiences. I interviewed nine Ugep women of southern Nigeria who attended ANC at a health facility but gave birth at home using a semistructured question guide. In the following section, I present findings from the data analysis to answer the following research questions.

- Research Question 1: How do behavioral, normative, and control beliefs and attitudes influence birthplace choice decision making for Ugep women of

southern Nigeria aged 25 to 35 years old who received health education during ANC at a primary health facility or home?

- Research Question 2: What are the skilled birth attendance utilization facilitators experienced by Ugep women of southern Nigeria aged 25 to 35 who received health education during ANC at a primary health facility or home?
- Research Question 3: What are the skilled birth attendance utilization barriers experienced by Ugep women of southern Nigeria aged 25 to 35 who received health education during ANC at a primary health facility or home?

Four themes emerged during data analysis: attitudes, subjective norms, behavioral control, and ANC attendance and birthplace choice.

Theme 1: Attitudes Towards Home and Health Facility Births

Attitudes towards a specific behavior are the product of an individual's behavioral beliefs. Those who hold positive attitudes towards a behavior are more likely to intend and perform that behavior (Ajzen, 2012, 2020). For example, there is evidence that women who had positive attitudes towards homebirths give birth at home instead of at the health facility (see Ahmad Tajuddin et al., 2020; Moshi et al., 2020b). Most of the participants in this study expressed positive attitudes towards homebirths and negative attitudes towards health facility delivery. Participants who had negative attitudes to hospital births believed childbirth was a natural event that did not require hospitals, homebirth providers were more caring, and there was divine protection from God. They also felt that hospitals were expensive and health workers were rude and unfriendly.

However, a few participants viewed health facility delivery positively because they believed that health facilities were equipped to handle emergencies that could arise from pregnancy and childbirth. Nevertheless, these participants still gave birth at home because they did not have the resources (money and transportation) they needed for hospital delivery.

Most participants spoke along the same lines regarding their attitudes towards home births. P1 had this to say:

> You know, in the church, you are surrounded by people you know, and they are very caring. Apart from helping you give birth, they pray for you, and you know that nothing terrible will happen to you in God's house.

P2 stated,

> Giving birth is not the same as being sick. Even animals give birth on their own; how much less human beings. So, instead of making women feel like giving birth is a sickness, why can't the people at the hospital support women and encourage them to deliver normally?

P3 discussed,

> I don't think giving birth at home or in the church is wise. I gave birth at home because labor came suddenly without any warning. There was no transportation to the hospital, and we did not even have money to pay for delivery at the hospital when labor came. I think the best place to have a baby is at the health facility. The people there are trained, and they understand the human body. If something goes

> wrong with you or your baby, they will have the experience and the equipment to help you.

P5 put it this way:

> Although delivery at home is painful, it is okay. I simply have my baby at home, and I like it. Giving birth is a natural process, and a woman who is not experiencing any issues with her pregnancy does not need to go to the hospital for delivery. There are people in the community who can assist you in delivering when it is time. I think the hospital services are there for most women who go through difficulties while trying to give birth. I don't face problems, so I don't bother myself about the hospital. God is always by my side

P6 claimed,

> I preferred giving birth at home because the nurses in the hospital seemed to be impatient. I would have been operated upon if I had gone to the hospital. The labor was quite tricky, and it was God that intervened. I have heard stories from older women. They say that they operate on you at the hospital when labor takes longer than expected. I didn't want anybody to operate on me. I wanted to deliver like a normal woman

P8 added,

> I attended a church service when the labor came up, and a nurse was invited to assist me because the baby was already coming out. I used to take some routine drugs I got from the hospital, which made us pass out urine regularly, and so when I felt water coming out, I thought it was normal, not knowing it was a sign

> of labor. I couldn't even trek back home. I didn't even feel pain. I enjoyed the one at home more than the one at the hospital. Going through childbirth in the hospital is stressful and makes one feel guilty about being pregnant because of how the nurses treat you.

P4 and P9 felt differently about delivery in the health facility. P4 stated,

> Giving birth at home is not the best, especially if you do not have a trained person to assist you. For my last child, I did not plan to deliver at home. I suddenly began to feel labor and could not think of going to the hospital, especially as it was already past midnight. There is nothing wrong with giving birth at the hospital. After all, even if you do not deliver there, you will still go there when you or your baby are sick. If we can trust them when we are sick, why can't we trust them to look after us during delivery?

In response to another question, P4 seemed to have contradicted her earlier belief about health facility birth, indicating a lack of privacy as a barrier and a belief in supernatural forces that could harm mother and child. She noted,

> The problem with hospital delivery is that you may be exposed to spiritual attacks because the hospital is a public place. Sometimes, you may get bewitched by enemies who may be bent on ensuring the loss of life of mother or child, or even both. Unfortunately, these problems may also happen to some women who have given birth safely in the hospital and returned home.

P9 shared,

> I don't think it is pleasant [to give birth at home]. I had mine at home because the time labor came was close to midnight, and I lived far from the hospital. You may get maximum protection. You will pay less money. the attendant nurse may also consider you to do part of the payment and pay the balance later

Beliefs about the expected outcomes of giving birth at home or at the health facility influenced participants' decisions regarding where to give birth. Most participants expected positive outcomes for homebirths and but negative outcomes for health facility. A few had positive beliefs about health facility births, but these beliefs were overridden by other barriers.

Theme 2: Subjective Norms (Normative Beliefs)

Subjective norm refers to individuals' perceived social pressure to carry out a specific behavior. It might be injunctive, that is, the expectation of approval or disapproval of the behavior by important individuals or groups. It could also be descriptive, meaning that significant others engage in the behavior or not (Ajzen & Schmidt, 2020). When perceived self-efficacy is low, individuals are more likely to form behavioral intentions based on subjective norms (Barbera & Ajzen, 2020). Therefore, subjective norms are important in women's birthplace choice decision-making experience.

P1 described her experience of social pressure to deliver at church as follows:

> I usually talk to my friend's mother when I am pregnant. She teaches me how to take care of myself. She attends the same church my husband and I attend, and

she is very respected in the church. I am not the only woman who delivers in the church. There are others too

P2 stated,

During the antenatal clinic, I met a woman who told me she had delivered in their church…so I started going to that church with her. I later convinced my husband to attend the church with me. When I later told my husband that I would have my baby at the church, he said it was okay

P3 shared,

My elder sister was around when labor came suddenly. She asked my husband and me not to panic because she had given birth at home more than once too. So she supported us and was there until another woman- a retired nurse who usually assists women in giving birth in the community came.

P4 added,

My mother retired as a nurse. So, when I am pregnant, I spend more time with her so she can look after me. I think I am lucky because not every pregnant woman has a retired nurse as a mother. So, when labor came suddenly that night, my mother knew what to do. P5 added, "My mother. She gave birth to six of us and never delivered in the hospital. My husband is also supportive."

P8 claimed,

My husband. He supports and reminds me about ANC. My mother too, who is experienced, also supports hospital delivery. I know my aunty, who had 12 children, 11 of which were born at home. Only one she had to deliver at the

hospital because of bleeding. She will give birth at home and personally use a blade to cut the placenta.

Most of the participants in this study were influenced by significant others regarding where they should give birth. These significant others were siblings, mothers, ANC peers, and fellow church members. All the influencers had also given birth at home or in the church. There is sometimes conflict when the husband supports ANC attendance, but the participant looked up to an aunty who had all her children at home. Normative beliefs lead to subjective norms and subjective norms influence where women decide to give birth. The prevailing norms among the participants in this study favored home births over health facility deliveries.

Theme 3: Behavioral Control (Control Beliefs)

Behavioral control refers to the presence of factors that can enable or disable engagement with the behavior in question. It could be perceived (accessible beliefs) or actual (Ajzen, 2020). Most participants described common impediments to giving birth at the health facility. All the participants described financial difficulties and the many bills one has to pay at the hospital for deliveries as a significant barrier to skilled birth attendant use. The other obstacles mentioned were lack of transportation to the hospital at the onset of labor, poor conditions at the health facility, rude attitudes of health providers, and the fear of caesarian section. In addition to the barrier of financial difficulties, one participant mentioned that how much you pay depended on the sex of the child and that having a male child was more expensive. P1 summarized her experience as follows:

> I have never given birth at the hospital. My water broke when I was just seven months during my first pregnancy. I thought it was minor, so I decided to go to church, where they prayed over me. However, the man of God asked me to return to the hospital if this situation persists because it may be a sign of delivery. I got there and was asked to look for my file, which I did but could not find, and this made me not go back there. I don't like how the nurses treat me when I take my child or myself there when we are sick and during ANC. They are always shouting, and they make you feel like a fool. This is why I go to the hospital only when my child or I am sick because I do not have an option.

P2 stated,

> In the health facility, you see many women in the same room… lying on beds that have become so old they look like they will break down at any moment. In addition, the nurses are rude, and still, they ask you to pay for this and that… I don't think a hospital is a good place for childbirth. I do not have money of my own to deliver at the hospital even if I wanted to. The money will come from my husband…and so it would be up to him.

P3 discussed,

> First, it is the financial charges attached to services at the hospital. They are pretty expensive, and it is one of the reasons I was not moved to go to the hospital. It is costly because they give you a long list with many items that must be bought complete; otherwise, you would receive poor attention… there are many things involved. I will need money, and it depends on when labor comes. For example, if

> labor comes at night, I might not find a motorcyclist to take me to the hospital… and even if I find one, I may deliver on the road…

P4 added,

> They should reduce financial expenses to benefit the poor and less privileged. Sometimes women are not allowed to go home after childbirth until they can clear their bills. I think this is one of the reasons some women are scared of going to the hospital…If labor comes during the day and I find a means to get to the hospital, I am confident that I can comfortably deliver at the hospital.

P6 claimed,

> I have heard stories from older women. They say at the hospital, they perform a caesarian section when labor takes longer than expected. I didn't want anybody to operate on me. I wanted to deliver like a normal woman. Nurses usually give pregnant women a list of items that must be bought before they can attend to them properly, not minding if they have money. As I earlier mentioned, their demands are too high for me, and I don't have money. You will see women with a long list of items to buy. After delivery, they make you pay specific fees according to the sex of the baby, so I find it difficult.

P7 asserted,

> Delivery is better done at the hospital, but that is when you have enough money. You will be discharged only when they notice mother and child are okay. Let the nurses sometimes consider the financial positions of women. We are all different, coming from different economic backgrounds

P8 shared,

> I can't say. But I know that most women who deliver at the hospital get a caesarian section. Most women are scared of the operation. And this operation is sometimes a result of the attitude of some pregnant women. Some overeat because of their pregnancy, causing the baby to be too big to come quickly. Some do not exercise their body out of laziness, which also affects the baby. Most women don't want to go to the hospital because of its high expenses; therefore, these bills must be reduced to attract women

According to the TPB, perceived and actual behavioral control are key determinants of behavioral intention. The lower the perceived and actual control over a behavior the less likely the enactment of that behavior. All the women in this study had low perceptions about their ability to give birth at the health facility; they also had no actual control over this behavior.

Theme 4: ANC Attendance and Birthplace Choice

All the participants in this study attended ANC at least two times before they gave birth, but none of them gave birth at the health facility as expected. At the ANC, health providers are expected to counsel pregnant women about healthy eating, provide them with nutritional supplements as required, and teach them about the danger signs of pregnancy. In addition, they perform maternal and fetal assessments to offer preventive measures and treat common physiological symptoms. Additionally, health providers are expected to help women develop birth preparedness plans (World Health Organization, 2016). Since women who attend ANC have access to the health facility, one may expect

that if all the measures outlined above are implemented as proposed, these women should also give birth at the hospital. Most of the participants shared similar ANC attendance experiences. All participants revealed that they valued ANC and enjoyed attending it. During ANC, the nurses taught them how to take care of themselves and their babies, checked and treated them for ailments, and advised them to come to the hospital if they experienced bleeding or other complications. Some participants enjoyed ANC because of the praise, worship, and prayers that usually happen there. Only a few mentioned that the nurses asked them to report to the hospital on their expected delivery date (EDD). According to P9,

> We are taught how to take care of ourselves as women and how to take care of our bodies to prevent body odor. They tell us it is better to deliver in the hospital to reduce the risk of maternal and child mortality. They advise us to register early, and at some point, they give us an expected date of delivery to aid us.

P1 echoed P9:

> They teach us valuable things at the ANC, like how to take care of ourselves, our homes, our babies when they are newly born, and even how a baby's food should always be covered to avoid flies from perching on it. They also teach us to report to the hospital if we experience water or any bloody discharge from our private part. I wanted to learn these things; that's why I usually attend ANC about 3 or 4 times, even though the nurses are always rude. It is the rudeness of the nurses and the cost of hospital delivery that I do not like.

P2 agreed but had a different motivation for attending ANC:

> We are taught how to take care of ourselves when we are pregnant. I prefer delivery at the church but attend ANC just not to make people think that I don't want to go to the hospital because of lack of money. I go to the hospital because I can be checked and given treatment when I have malaria and other ailments. So, I combine hospital and church services to get a better result, and it's been working well for me.

P3 added another dimension:

> At the ANC, we start with praise and worship to glorify God and go through a prayer session. We are then taught many things concerning pregnancy and its management, including other things we never understood very well. We are also taught to maintain good hygiene levels. Children's foods must always be covered to avoid flies. We are also to keep our environment clean such that we don't have to litter our environment with dirt. Although they did not say we must deliver at the hospital, if I have money, I will give birth at the hospital…It is still the issue of financial expenses because it seems you must have enough money to have a baby. Any woman coming to ANC without sufficient money is not treated with respect.

> P4 stated: "We are taught in ANC that the hospital is the best place to visit to get proper body check-ups and that babies born in the hospital are given adequate care to support health and wellbeing."

P5 claimed,

> We start by doing praise and worship. We then carry out some exercises designed for pregnant women. The nurses will now check us according to the numbers given earlier. Next, a pastor comes in, prays for us, and gives us advice. We are also advised to go for a scan, although I never went for a scan. We are taught how to take care of our babies when born and the drugs we need to administer to them when we notice signs of illness. They also encourage us to come to the hospital for proper medical care, especially when we experience bleeding or any other complications that may arise that may become dangerous to the health of mother and child. I don't believe these things will happen to me; that's why I don't bother to deliver at the hospital.

P7 stated,

> They taught us to come to the hospital following the expected delivery date they had given us. They told us always to eat plenty of fruits and drink plenty of water regularly to improve our baby's health. And that we should come to the hospital anytime we experience any form of discomfort. But coming to the hospital all involve money.

P8 added: They tell us about pregnancy, how to take care of ourselves, the things we need to buy in preparedness for delivery, they check our bodies and give us drugs. they teach us about the kinds of foods we should be eating.

All the participants attended ANC and enjoyed attending it because they receive valuable information regarding their bodies, pregnancy and childbirth. They value the health checks and treatment they receive for the ailments they experience. They also

enjoyed the praise and worships sessions and the exercises that the nurses facilitate to keep them fit. However, except for one participant who mentioned that she was given an expected date of delivery (EDD) none of the participants mentioned that they received birth preparedness and complication readiness education (BPCR). BPCR increases skill birth attendant utilization (Izudi et al., 2019), but seems to be lacking in the ANC package that this study participants received.

Summary

In this chapter, I explored key findings from one-on-one interviews with nine participants and categorized them into four themes informed by the TPB. The TPB is my theoretical framework, and I developed my semi-structured interviews using its key concepts, behavioral beliefs (attitudes), normative beliefs (subjective norms), and control beliefs (behavioral control). I added the fourth category, ANC attendance and birthplace choice, to enable me to explore why participants attend ANC but do not give birth at the health facility. Using the TPB as my analytical framework, the findings suggest that while participants may be disposed to give birth at the health facility, positive attitudes towards home delivery, subjective norms around homebirths, and financial difficulties are barriers to health facility births. In Chapter 5 (my final chapter), I will present my interpretation of the findings, discuss the study's limitations and make recommendations for improvements.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

in this basic qualitative study, I aimed to explore and describe how behavioral, normative, and control beliefs shape women's birthplace decision-making experiences and how women's ANC experience shaped their decision of where to deliver. From the literature review, I found many studies that identified educational attainment, distance to a health facility, knowledge of danger signs of pregnancy, attitudes of health care providers, and aversion to male birth attendants as determinants of ANC and skilled birth attendant utilization. This study was conducted because few researchers have explored why women give birth at home even after attending ANC. These studies identified the quality of ANC services and women's perception of pregnancy and childbirth as natural events that do not require a health facility as the key barriers to skill birth attendant utilization.

My research findings support the view that ANC services may be suboptimal and that women's perception of pregnancy and childbirth as natural events influence their decision-making experience. In addition, this study identified key findings including women's normative beliefs (subjective norms) and control beliefs (belief in their capacity to deliver at home or the health facility) as critical determinants of where a woman chooses to give birth. The findings from this study could enable health services managers and decision makers to design maternity care services that address women's needs and respond to their beliefs about pregnancy and childbirth. In this chapter, I discuss my

findings, the study limitations, my recommendations, and the implications of this study, and also make conclusions about the peer-reviewed literature I presented in Chapter 2.

Interpretation of the Findings

Behavioral Beliefs

All the participants in this study attended ANC as recommended but gave birth at home or church. Most had positive attitudes towards home/church delivery but negative attitudes towards health facility delivery. Attitudes towards a behavior shape an individual's intention to enact the behavior, and the individual's behavioral beliefs shape these attitudes. In other words, an individual's attitude towards a specific behavior is determined by what that individual believes would be the outcome of performing that behavior (Ajzen, 1991). I found three recurring behavioral beliefs among study participants that contribute to their positive attitudes towards home births and negative attitudes towards health facility deliveries. These behavioral beliefs include childbirth as a natural/divine event, home birth is safer, and hospital birth is expensive.

Childbirth Is Natural

Findings from this study showed that the participants believe that pregnancy and childbirth are natural events that do not require medical interventions. This belief influenced their decision to give birth at home. P5 stated, "Giving birth is a natural process, and a woman who is not experiencing any issues with her pregnancy does not need to go to the hospital for delivery." According to P2, "Giving birth is not the same as being sick. Even animals give birth on their own, how much more, human beings." P2's analogy of women and animals highlighted women's need for autonomy during childbirth

and their belief that this autonomy is lost to health providers when one gives birth at the health facility. This finding aligns with findings in similar studies elsewhere. For example, one qualitative study that explored Swedish women's perceptions of childbirth revealed that while women prefer to be in control of the birth process, they are open to assistance from a trusted individual (Westergren et al., 2019). Similar studies elsewhere support the findings that most women believe that birth should happen at home because it is personal, natural, and not a disease (Ahmad Tajuddin et al., 2020; Leon-Larios et al., 2019; Preis et al., 2018; Shiferaw & Modiba, 2020).

Homebirth Is Safer

Most participants in this study felt safer giving birth at home than at the hospital because, at home or church, they are surrounded by the people they know and trust, while family and church members also pray for them. They believe that God will keep them safe in the privacy of their homes or churches as opposed to the hospital, which is a public place. For example, P1 stated, "You know, in the church, you are surrounded by people you know, and they are very caring. Apart from helping you give birth, they pray for you, and you know that nothing bad will happen to you in God's house." Additionally, women in this study expressed their fear of cesarean section because they did not feel safe giving birth at the health facility. These findings align with earlier studies that found that the fear of health facilities, fear of cesarean section, religious beliefs, and comfort and traditions of homebirth are barriers to skill birth attendant utilization (Adatara et al., 2020; Alatinga et al., 2021; Gardiner et al., 2021). Some participants felt that health facilities were safer but could not give birth there due to financial difficulties, distance

from the health facility, and labor time. I further discuss these barriers under control beliefs.

Health Facility Births Are Expensive

All participants in this study, including those with positive attitudes towards health facility delivery, believed that health facility births are expensive and beyond their means. For example, according to P7, "It is less expensive when you deliver at home, unlike at the hospital where you are made to pay so many bills." While some participants would prefer health facility birth if they could afford it, the perception that hospitals are expensive is an obstacle that prevents them from giving birth at the hospital. Participants in this study generally had positive attitudes towards home birth and negative attitudes towards delivery in a health facility.

According to the findings, these positive attitudes towards home births are a product of the participants' behavioral beliefs, including the belief that childbirth is natural, home birth is safer, and hospital birth is expensive. According to the TPB, behavior enactment is preceded by an intention to perform that behavior. This intention is influenced by behavioral attitudes, which are determined by behavioral beliefs (Ajzen & Schmidt, 2020). In deciding where to give birth even after attending ANC, the women in this study considered their behavioral beliefs. These beliefs led to positive attitudes towards home births and contributed to the women's decision to give birth at home. It should be noted that the belief that health facilities are expensive (behavioral belief) is distinct from the experience of financial difficulties (control belief). The latter is discussed under control beliefs below.

Normative Beliefs

Findings from this study indicated that women consider the opinions and actions of their peers or family members when deciding where to give birth. Most of the women in this study knew other women who had attended ANC but gave birth at home without adverse consequences. For example, according to P2,

> During the antenatal clinic, I met a woman who told me she had delivered in their church, so I started going to that church with her. When I later told my husband that I would have my baby at the church, he said it was okay.

While P5 stated, "My elder sister was around when labor came suddenly. She asked my husband and me not to panic because she had given birth at home more than once too."

These findings suggest that homebirths are the norm in the communities from which participants were selected; norms translate into perceived social pressure to perform or not to perform a particular behavior (see Ajzen & Schmidt, 2020), in this case, to give birth at home. These findings aligned with a similar study in which women's homebirth preference was due to their normative and behavioral control beliefs (see Ahmad Tajuddin et al., 2020). However, according to Barbera and Ajzen (2020), individuals with low perceived self-efficacy are more likely to make decisions based on subjective norms. As seen in the next section, most of the participants in this study had a low self-efficacy perception (control beliefs), and subjective norms played a critical role in their birthplace decision-making process.

Control Beliefs

Belief in one's capacity to perform a specific behavior (self-efficacy) contributes to one's intention to perform that behavior. Such a belief is called control belief, leading to behavioral control. Behavioral control can be perceived or actual, and the absence of control or low perception of it reduces an individual's intention to perform the behavior in question (Ajzen & Schmidt, 2020). The findings showed that all the women in this study believed they could not give birth at the health facility. Their control beliefs can be categorized into five: financial difficulties, lack of transportation, negative attitudes of health care providers, the poor state of health facilities, and fear of caesarian section.

Financial Difficulties

Findings from this study showed that women perceived they could not afford the expenses associated with giving birth at the health facility. Every participant referred to a long list of items women are mandated to buy and bring to the hospital before childbirth and other bills they are expected to pay. The contents of this list and why pregnant women are required to purchase these items need further research. According to P1, "It is expensive because one is given a long list with many items that must be bought complete; otherwise you would receive poor attention." Study participants, including those who held positive attitudes towards health facility births, could not give birth at the health facility because they simply did not have the money required. For example, P7 stated, "Actually delivery is better done at the hospital, but that is when you have enough money." This finding supports findings from earlier studies (Dufera et al., 2020; Kawakatsu et al., 2020; Ohaja & Murphy-Lawless, 2017) and aligns with the assertion

that women of lower economic status are less likely to use skilled birth attendance (see Yaya et al., 2019).

Lack of Transportation

This study revealed that women gave birth at home because labor started at night and had no transportation to the health facility. P3 described this barrier, "I don't think it is smart to give birth at home or in the church. I gave birth at home because labor came suddenly without any warning. There was no transportation to go to the hospital" In many places in Nigeria, motorcyclists are the predominant means of transport because they are cheaper, local, and can take their passengers to any place within the locality (Olubomehin, 2012). However, motorcyclists may not be available at night, except through special arrangements like other transporters. While a pregnant woman who is not yet due can easily climb a motorcycle, this is almost impossible for a woman in labor. Additionally, when a birth is unplanned and labor sudden, the woman may not only not find a motorcyclist but may also not have the money to pay for the fare if she finds one. Previous studies also identified lack of transportation as a barrier to health facility delivery (Siyoum et al., 2018; Yaya et al., 2018).

Findings from this study indicated that the distance between where participants lived and the health facility impacted their decisions on where to give birth. For example, P9 stated, "I had mine at home because the time labor came was close to midnight, and I stay far from the hospital." These findings indicate that in addition to financial difficulties, women in this study had no birth preparedness plans, and labor onset mostly took them by surprise. A cross-sectional study in Ethiopia found that a lack of written

birth plans independently predicted homebirths (Delibo et al., 2020). A related study found that birth preparedness is low among low-literate and low-income women (Gebreyesus et al., 2019), as was found in this study. The World Health Organization (2019) recognizes poverty and distance to health facilities as barriers to health facility deliveries Click or tap here to enter text.. These findings support similar findings from studies conducted in Ghana (Adatara et al., 2020; Alatinga et al., 2021), Ethiopia v(Ayele et al., 2019), and the Peruvian Amazon (Gardiner et al., 2021).

Negative Attitudes of Health Care Providers and Poor Environment

The findings from this study showed that women perceived SBA at the health facility as rude, unfriendly, and uncaring. For example, P1 stated,

> I don't like how the nurses treat me when I take my child or myself there when we are sick and also during ANC. There is always shouting, and they make you feel like a fool. This is why I go to the hospital only when my child or I am sick because I do not have an option.

P8 added, "Going through childbirth in the hospital is stressful and makes one feel guilty about being pregnant because of how the nurses treat you." The belief that health providers have hostile attitudes toward patients is one of the barriers to skilled birth attendant utilization. A similar study in Ghana Click or tap here to enter text. found that most participants had negative experiences with health workers during previous attempts to seek maternal and child care (Adatara et al., 2019). Earlier studies had also found that health care providers physically and verbally abuse women during childbirth (Bohren et al., 2015, 2017).

Additionally, most participants in this study believed that the health facility was not conducive for childbirth because of overcrowding and dilapidated infrastructure. P2 shared, "In the health facility, you see many women in the same room, lying on beds that have become so old they look like they will break down at any moment." There is evidence that primary health care facilities in Nigeria not only lack the human resources they need but also have inadequate or sub-standard equipment and facilities (Ayamolowo et al., 2020; Ntoimo et al., 2019).

Fear of Caesarian Section

Most participants in this study perceived cesarean delivery as abnormal and feared that health facility staff would rush to operate on women if labor took longer than expected. According to P6, "they say at the hospital, they perform a caesarian section when labor takes longer than expected. I didn't want anybody to operate on me. I wanted to deliver like a normal woman." This finding indicated that women in this study may not understand why and when cesarean sections are necessary. However, other studies have come up with similar results elsewhere in Nigeria (Adejoh et al., 2020) and even in some advanced countries, like France, where most women prefer vaginal births over cesarean delivery (Schantz et al., 2021).

ANC Attendance and Birthplace Choice

All the participants in this study self-reported that they attended ANC at least four times before they gave birth at home or church. Participants' reasons for attending ANC included medical check-ups and treatment for common ailments, lessons about looking after one's self during pregnancy, and the danger signs of pregnancy. While ANC

attendance has been associated with increased skilled birth attendance use (Damian et al., 2020; Schantz et al., 2021), none of the participants in this study gave birth at the health facility after attending ANC at least four times. This finding suggests that while ANC attendance is essential, the content and coverage of ANC may be more critical. In most low-income countries, the quality of ANC is poor, even among women who have complied with the recommended number of ANC visits (Benova et al., 2018). Women who received health education on BPCR were likelier to use skilled birth attendance (Izudi et al., 2019). Still, in Nigeria, most women who have attended ANC had little knowledge of BPCR (Anikwe et al., 2020). Additionally, Ahuru (2021) found that women's income had a stronger association with health facility delivery than ANC attendance. Findings from this study indicate that attending ANC is not enough motivation for health facility birth among participants as they had overriding considerations, including positive attitudes and supportive subjective norms for homebirths coupled with weak behavioral control towards health facility births.

Limitations of the Study

I have provided detailed and thick descriptions of the behavioral, normative, and control beliefs that the Ugep women of southern Nigeria considered when deciding where to give birth. In Chapter 2, I discussed some limitations, including my relationship with the study setting and social desirability bias. I used reflexive journaling, member-checking, and pilot interviews to address these limitations and improve the study's trustworthiness. Other limitations came to the fore during data collection and analysis. Firstly, findings from this study cannot be generalized and should be understood within

the context of the study. This shortcoming is typical of qualitative studies designed to gain insights using small and homogenous samples. Secondly, the participants in this study were all female, while the interviewer was a man (myself). While they all seemed relaxed, open, and shared their experiences enthusiastically, there is a chance that their stories would have been more robust if they had shared them with a female researcher. In addition, my sex could have influencede how participants coucdh their responses (see Roulston & Myungweon, 2018). A third limitation was that the study did not include questions regarding participants' marital, socioeconomic, and educational status. These factors impact health facility births (see Ahuru, 2021; Damian et al., 2020; Sserwanja et al., 2021), and I realized during data analysis that including them could have increased the robustness of this study.

Recommendations

Nigeria's maternal mortality ratio is one of the highest in the world, with one out of every 34 women in Nigeria dying of pregnancy and childbirth-related causes in 2019 (NPC [Nigeria] & ICF, 2019). According to the World Health Organization (2015), a primary strategy for reducing maternal and infant mortalities is ensuring that women deliver in a health facility. Health facility delivery gives women access to skilled attendants, equipment, drugs, and prompt referrals to higher-level care in emergencies. According to the NCP, Nigeria, and ICF (2019), only 39% of live births in Nigeria occur in a health facility, while a skilled provider attends only 43% of deliveries. Women participating in ANC are more likely to utilize SBA. The frequency of ANC visits and the nature and the number of services women received during ANC are independently

significantly associated with SBA use (Ayele et al., 2019; Chukwuma et al., 2017; Ogbo et al., 2020; Okigbo & Eke, 2015).

The findings from this study indicate that ANC attendance does not necessarily translate into health facility births and skilled birth attendant utilization. Based on the results of this study, health systems designers and managers must implement interventions that will reduce the cost of maternity care, improve provider-client interactions, and integrate birth preparedness and complication readiness education in ANC. The World Health Organization (2016) recommended five evidence-based interventions as a comprehensive ANC package. These interventions include nutrition, maternal and fetal assessment, preventive measures, treatment of common physiological symptoms, and health systems interventions to improve the utilization and quality of ANC. Within the recommended health systems interventions, the community mobilization component enhances communication and support, and also facilitates BPCR. BPCR has been found to facilitate health facility births (Anikwe et al., 2020; Izudi et al., 2019), and should be integrated into an ANC package that connects the hospital to the community and vice versa.

Findings from this study also show that poverty is a barrier to SBA utilization. Therefore, efforts must be made to improve women's social and economic status in the short and longer term, especially in rural areas, to enable them to utilize SBA. For example, health facility births increased significantly in Kenya when women's poverty was directly addressed through microfinancing and financial literacy training (Maldonado et al., 2020). In another study, Brals et al. (2019) found a significant increase in health

facility births when quality improvement at the health facility was complemented by introducing a low-cost, voluntary health insurance package. However, where these interventions are difficult to implement, the government should consider subsidizing or making childbirth in primary health centers free and ensuring no indirect costs are passed on to women.

This study provided detailed accounts of how behavioral and normative beliefs shape women's attitudes towards home and health facility births and how these beliefs ultimately influence where women decide to give birth. Health program planners and implementers should address these beliefs through community mobilization, and social and behavior change approaches to increase health facility births and skilled birth attendance. An evaluation of one such intervention in Tanzania revealed that women exposed to a national social and behavior change campaign to improve maternal health outcomes were likelier to give birth at a health facility (Kaufman et al., 2017). Similar results were found while evaluating a community-based mass media campaign in Malawi (Zamawe et al., 2016).

Additionally, the barrier of negative health provider attitudes is real and should be addressed. Health care providers should be trained, re-trained, and employed in numbers sufficient to prevent them from being overwhelmed with work. Finally, health program planners and managers should recognize women's right to give birth at home or church. Realizing this right implies that women should enjoy a positive pregnancy and childbirth experience wherever they choose to deliver. One way to ensure safe delivery at home is to enable SBA integrated within the formal health system to handle these deliveries. This

approach has been called "midwife-assisted planned homebirths" (Dayyabu et al., 2019). It has been found to reduce medical intervention in childbirth and improve maternal and perinatal outcomes (Davies-Tuck et al., 2018).

Implications for Positive Social Change

Human societies are often concerned with their continuity, and this continuity of species is ensured through reproduction. Maternal, perinatal, and postnatal mortalities and morbidities negatively impact this quest for continuity and human conditions. This study has contributed to deepening the understanding of how Ugep women of southern Nigeria decide where to give birth. Research on the association between ANC attendance and skilled birth attendant utilization has focused on the frequency of attendance, and the number of services women receive (Ayele et al., 2019; Okigbo & Eke, 2015). Some quantitative studies cite the comfort of home births, attitudes of health care workers, financial difficulties, and the long distance to health facilities as barriers to health facility births among women who attended ANC (Abubakar et al., 2017). However, there remains a gap in the literature regarding Nigerian women's pregnancy and childbirth-related beliefs and experiences. This study has contributed to filling this gap and increased understanding of why many women in Nigeria chose to give birth outside the health system even after attending ANC.

Understanding women's ANC experiences could aid health education and promotion practitioners design more effective health education/promotion activities during ANC. The findings could also enable health services managers and decision-makers to make policies emphasizing health education/promotion, including the

importance of SBA during ANC. Ultimately, this research's findings can contribute to reducing Nigeria's maternal, neonatal, and infant mortality rates. Positive social change happens when the enabling environment is created for otherwise marginalized or underserved population segments to achieve their full potential (Lechner et al., 2017; Olubanwo, 2020). This work contributes to positive social change because it would help women who cannot utilize existing health services tell their stories. These stories could galvanize the action required to change the situation (improve maternity care services) when they are shared with relevant stakeholders, including health services providers, community leaders, and policy/decision-makers.

Conclusion

This study was unique because I focused on an under-researched area, the ANC and childbirth experiences of Ugep women, and how these experiences influenced their birthplace choice decision making. The study is essential to improving maternal and perinatal health outcomes in Nigeria. The barriers and facilitators of health facility delivery were identified and discussed through four themes: behavioral beliefs, normative beliefs, control beliefs, and ANC experiences. The findings of this study could inform the design and implementation of community-based health education and behavior change interventions to improve trust and belief in the formal health system. Results from this study may also inform the design and implementation of structural interventions to increase access to primary health care facilities and improve SBA use. Women do not need to die while giving birth, neither do their babies, and these deaths and morbidities can, and should be prevented through increased SBA utilization

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Appendix A: Questions

I

Research Question	Interview Questions
RQ1: How do behavioral, normative, and control beliefs and attitudes influence birthplace choice decision making for Ugep women of southern Nigeria aged 25-35 years old who received health education during antenatal care at the primary health facility or home.	**Attitudes** (Theoretical construct) 1. How do you feel about giving birth at home? a. What do you like about giving birth at home? b. What are the benefits of giving birth at home? c. What do you dislike about giving birth at home? d. What are the adverse effects that might result from giving birth at home? 2. How do you feel about the idea of giving birth at the health facility? a. What do you like about giving birth at a health facility? b. What are the benefits that might arise from giving birth at the health facility? c. What do you dislike about giving birth at the health facility? d. What are the adverse effects that might result from giving birth at the health facility? **Subjective Norms** (Theoretical construct) 3. Who supported your decision to give birth at home? a. How important are these people in your life? b. Why do you think they encouraged you to give birth at home? c. How did your family feel? d. What do women in your community think about this? 4. If you decide to give birth at the health facility, who might support your decision? a. How important are these people in your life? b. Why do you think they will prefer you give birth at the health facility? c. How will your family feel? d. What do women in your community think about this? 5. Who can you think of that gives birth at home? a. How are you related to these people? 6. Who can you think of that gives birth at the health facility? a. How are you related to these people? **Perceived Control** (Theoretical construct) 7. What things make it easy for you to give birth at home? a. Tell me more about giving birth at home 8. What things make it difficult for you to deliver at the health facility a. If you want to give birth at the health facility, how certain are you that you can? b. What other factors can affect your ability to give birth at

	the health facility?
RQ2: What are the skilled birth attendance utilization barriers and facilitators experienced by Ugep women of southern Nigeria aged 25 – 35 who received health education during antenatal care at the primary health facility or home?	Questions 7 and 8 above are also aligned to RQ 2. **Relationship between ANC attendance and Birthplace decision making** 9. How did ANC attendance influence your decision not to deliver at the health facility? a. How many times did you attend ANC b. Tell me more about your ANC experience 10. What should they have done at the ANC to make you decide to deliver at the health facility? a. How do you think ANC services can be made better for you and other women? 11. The goal of this study is to understand how women decide where to give birth. Is there anything you would like to tell me about this topic?

Appendix B: Semistructured Questionnaire

Script before the interview:

I'd like to thank you for participating in this study. As previously mentioned, the purpose of my research is to explore ***how women decide whether to give birth at a health facility or home.*** *Women require proper care during pregnancy, during childbirth, and after delivery for them and their babies to remain safe and healthy. We would love to hear about your experience and perspectives on how you decided to deliver at home instead of the health facility.*

[Review aspects of consent form]

Earlier on, you completed a consent form indicating I have your permission to record our conversation.

Are you still okay with me recording our conversation today? ____Yes _____No

If yes: *Thank you, if at any time you would like me to stop recording or would like something off the record, please let me know. Please sign the consent form for me before we proceed.*

If no: *Thank you for the clarification, I will only be taking detailed notes during our conversation.*

The Interview

1. Let's start with you telling me about your self (Ice breaker)
    a. How is life as a woman and a mother in Ugep?
2. How do you feel about giving birth at home?
    a. What do you like about giving birth at home?

   b. What are the benefits of giving birth at home?
   c. What do you dislike about giving birth at home?
   d. What are the negative effects that might result from giving birth at home?

3. How do you feel about the idea of giving birth at the health facility?
   a. What do you like about giving birth at the health facility?
   b. What are the benefits that might arise from giving birth at the health facility?
   c. What do you dislike about giving birth at the health facility?
   d. What are the negative effects that might result from giving birth at the health facility?

4. Who supported your decision to give birth at home?
   a. How important are these people in your life?
   b. Why do you think they encouraged you to give birth at home?
   c. How did your family feel?
   d. What do women in your community think about this?

5. If you decide to give birth at the health facility who might support your decision? Who might be against your decision?
   a. How important are these people in your life?
   b. Why do you think they will prefer you give birth at the health facility?
   c. How will your family feel?
   d. What do women in your community think about this?

6. Who can you think of that gives birth at home?
    a. How are you related to these people
7. Who can you think of that gives birth at the health facility?
    a. How are you related to these people
8. What things make it easy for you to give birth at home?
    a. Tell me more about giving birth at home
9. What things make it difficult for you to deliver at the health facility
    a. If you want to give birth at the health facility, how certain are you that you can?
    b. What other factors can affect your ability to give birth at the health facility?
10. How did ANC attendance influence your decision not to deliver at the health facility?
    a. How many times did you attend ANC?
    b. Tell me more about your ANC experience
11. What should they have done at the ANC to make you decide to deliver at the health facility?
    a. How do you think ANC services can be made better for you and other women?

12. The goal of this study is to understand how women decide where to give birth. Is there anything you would like to tell me about this topic?

Thank you so much for your time. This has been an illuminating encounter for me, and hopefully for you too. I will go and listen to your responses and may come back to you if I need clarifications with anything you said. Will this be okay with you?