

Analysis of Antenatal care Attendance and Delivery Preferences among Married Women in Iwo Local Government Area of Osun State, Nigeria

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Abstract: This study examines antenatal care (ANC) attendance and delivery preferences among married women in Iwo Local Government Area of Osun State, Nigeria, based on data collected from a field survey conducted in 2024. A significant proportion of respondents (79.5%) delivered their most recent child in a hospital or health facility, highlighting a positive trend toward institutional childbirth. However, 20.5% of women still opted for home deliveries, driven by factors such as financial constraints, lack of transportation, and cultural preferences. Reasons for choosing hospital delivery included the ability of hospitals to manage complications (71.9%) and spousal advice (20.1%), while 56.1% of home births were due to premature labor, often preventing timely access to healthcare facilities. ANC attendance was notably high, with 79.0% of respondents attending ANC services, primarily to monitor pregnancy, check fetal position, prevent complications, and receive immunizations. However, 21.0% did not attend ANC, suggesting barriers such as financial constraints, distance, and lack of support. The study underscores the importance of maternal health education and improving access to healthcare services, particularly in rural and underserved areas. It also highlights the need for targeted interventions to reduce home deliveries and increase ANC attendance, addressing the socio-economic and logistical challenges faced by women in the region. Enhanced engagement of men in maternal health decisions and addressing the quality of healthcare facilities are critical for improving maternal and child health outcomes.

Keywords— Antenatal Care (ANC), Delivery Preferences, Maternal Health, Determinants of Healthcare Utilization

1. Introduction

Maternal health remains a cornerstone of public health, particularly in developing countries where maternal morbidity and mortality rates remain alarmingly high. Maternal and child health have been central to global development agendas, receiving focused attention under both the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs) [1]. Between 1990 and 2015, the MDGs led to significant progress in reducing maternal and child mortality rates globally by 43.9% and 48% respectively [2, 3]. Despite these improvements, stark disparities persist across and within countries. Antenatal care (ANC) is a crucial health intervention designed to monitor the wellbeing of pregnant women and their unborn children, identify potential complications, and prepare expectant mothers for safe childbirth [4]. ANC encompasses a comprehensive set of healthcare services provided throughout pregnancy to ensure a healthy gestation and safe delivery, while also preventing complications for both mother and child. It includes the prevention, detection, and treatment of conditions such as anemia, malaria, malnutrition, pre-eclampsia, sexually transmitted infections (STIs), and the prevention of mother-to-child transmission of HIV.

As a routine healthcare service for asymptomatic pregnant women, ANC also involves screening for latent complications and providing guidance on lifestyle, pregnancy management, and delivery planning. The World Health Organization (WHO) [5], has long emphasized the importance of ANC as part of its Safe Motherhood Initiative, initially recommending a minimum of four visits per pregnancy. However, in 2016, WHO revised its guidelines to advocate for at least eight ANC contacts, aimed at improving maternal and perinatal outcomes through early detection and timely management of complications. Regular ANC attendance, in particular, has been shown to have a protective effect against newborn deaths. Countries with low ANC coverage often experience higher maternal mortality ratios (MMRs). As a foundational component of the Safe Motherhood Initiative, ANC plays a vital role in preventing maternal and neonatal deaths. Despite its well-documented benefits, the uptake of ANC services and delivery preferences continue to vary significantly across different regions and socio-demographic groups.

Delivery preference refers to a pregnant woman's choice or inclination regarding how and where she wants to give birth. Pregnancy, childbirth, and the postpartum period can expose women to numerous health risks. One critical decision during this time is the choice of delivery method, which significantly impacts maternal and neonatal outcomes [6]. Vaginal delivery, often requiring minimal intervention, is considered the most physiologically appropriate method. However, the choice must be guided by thorough clinical assessment of both mother and fetus, and influenced by various individual and systemic factors. Recent research has underscored the association between the use of maternal health services and reduced maternal and infant mortality. According to WHO reports, between 2007 and 2014, approximately 83% of pregnant women worldwide attended at least one ANC visit, but only 64% completed the recommended four visits. This indicates that while awareness and initial contact with healthcare providers are improving, continued engagement throughout pregnancy remains a challenge [7].

In sub-Saharan Africa, where maternal mortality rates are among the highest globally, the disparities in ANC utilization are even more pronounced. [8]. Although 69% of pregnant women in the region attend at least one ANC visit, a significantly smaller proportion completes the minimum four visits. The limited coverage is largely due to factors such as inadequate health infrastructure, poverty, cultural practices, and lack of education. In Nigeria, the most populous country in Africa, the maternal mortality ratio remains critically high at over 500 deaths per 100,000 live births, accounting for approximately 13% of global maternal deaths. While efforts have been made to improve access to maternal health services, the utilization of ANC remains suboptimal, particularly in rural and northern parts of the country. According to the Nigeria Demographic and Health Survey (NDHS) 2018, about 61% of women received at least one ANC visit during pregnancy, but only 51% completed four or more visits. This marks a modest improvement from previous years, yet still falls short of WHO's revised standard. Nigeria remains a major contributor to global maternal, neonatal, and under-five mortality rates, accounting for approximately 13%, 9.4%, and 14% of such deaths, respectively [9]. These high mortality rates are closely linked to the underutilization of maternal healthcare services. The poor utilization of ANC services in Nigeria is influenced by several factors, including maternal age, level of education, household wealth, urban-rural residence, religious and cultural beliefs, and perceived quality of healthcare services. Rural areas in particular face greater challenges due to geographic inaccessibility, economic hardship, and traditional beliefs that sometimes discourage the use of formal healthcare. In response, the Nigerian government and development partners have implemented various interventions, including free maternal and child health programs, community-based health insurance schemes, and the training and deployment of skilled birth attendants. However, these efforts must be strengthened and better targeted to address the persistent inequalities and improve overall ANC coverage and quality. This study investigates the level of antenatal care attendance and delivery preferences in Nigeria, focusing specifically on Iwo Local Government Area (LGA) in Osun State, South-Western Nigeria. Iwo LGA presents a unique context where traditional beliefs intersect with modern healthcare systems. Although government and private healthcare services are available, women still encounter significant barriers to accessing quality ANC and delivery services. Cultural norms, the influence of family members, and attitudes of healthcare providers all play roles in shaping maternal healthcare decisions. Therefore, this study seeks to examine the level of antenatal care attendance and delivery choices among married women in Iwo Local Government Area, with the goal of informing targeted interventions and policies aimed at improving maternal health outcomes in the LGA.

2. Statement of research problem

Despite the proven benefits of antenatal care (ANC) in reducing maternal and neonatal mortality, many women in Nigeria particularly in rural settings like Iwo Local Government Area (LGA) of Osun State continue to underutilize these services. Cultural beliefs, limited education, poverty, and poor access to health facilities significantly influence ANC attendance and delivery preferences. This underutilization contributes to high rates of preventable maternal and infant deaths. There is a pressing need to understand the specific determinants influencing ANC uptake and delivery choices among married women in Iwo LGA, to guide targeted interventions that will improve maternal health outcomes in the region. Many studies on antenatal care preference have been conducted by various authors. For instance Idowu, Israel, & Akande, [10]. assessed the utilization, perceived quality, satisfaction levels, and determinants of antenatal care (ANC) utilization among women of reproductive age in Oshogbo, Osun State. Findings revealed that 73.9% of respondents had at least four ANC visits. Key barriers to ANC usage included high cost, long waiting times, distance to clinics, and unsatisfactory service quality. This was limited to urban Communities of Oshogbo

Imo [11]. examined how women's autonomy in decision-making impacts antenatal care utilization and institutional delivery services. Results indicated that autonomy positively influenced the likelihood of attending at least eight ANC visits but had a complex relationship with early initiation of ANC. Abubakar, Dalhatu, Hamza, & Galadima, [12]. explored why women who attended antenatal care opted for home deliveries in Bagwai Town, Kano. The majority (74.1%) of women aged 25-35 chose home delivery due to factors such as the presence of male healthcare workers and staff attitudes. Olasunkanmi, & Olorunsola, [9]. Investigated why women in Akoko North-East and North-West prefer traditional maternal health services. Findings highlighted reasons such as spiritual beliefs, cultural practices, cost-effectiveness, and compassionate care. Ewa, Lasisi, Maduka, Ita, Ibor, & Anjorin, [13]. examined factors influencing women's choices of antenatal care and delivery centers in Ibadan North. It identified issues such as service quality, accessibility, and cultural beliefs as significant determinants. Akinyemi, Solanke, & Odimegwu [14]. examined maternal healthcare services utilization and the Nigerian urban poor: Evidence from the 2013 Demographic and Health Survey.

Despite these contribution by various authors, studies on antenatal care and Delivery Preferences among Married Women in Iwo Local Government Area of Osun State, Nigeria remain limited. Therefore, this study assess the level of antenatal care attendance and delivery preference among married women in Iwo Local Government Area which is the gap this study fill and contribute to knowledge.

3. Study Area

The study area lies at approximately latitude $7^{\circ}58'N$ and longitude $4^{\circ}28'E$, with an average elevation of 246 meters above sea level. The LGA experiences a tropical climate characterized by two distinct seasons: a wet season extending from March to October, and a dry season from November to February. Annual rainfall ranges between 2,000 mm and 2,200 mm, with average maximum temperatures reaching $32.5^{\circ}C$. The area also records a relatively high mean humidity level of 79.9%. Administratively, the LGA is divided into six agricultural blocks—Ayedire, Irewole, Isokan, Ejigbo, Ola-Oluwa, and Iwo. While Iwo represents the urban nucleus, the remaining blocks are predominantly rural and agriculturally oriented. Agricultural activities form the backbone of the local economy, with major crops including cocoa, kolanuts, yam, timber, and, more recently, cucumber. Livestock farming is also practiced, primarily involving the rearing of cattle, sheep, and goats.

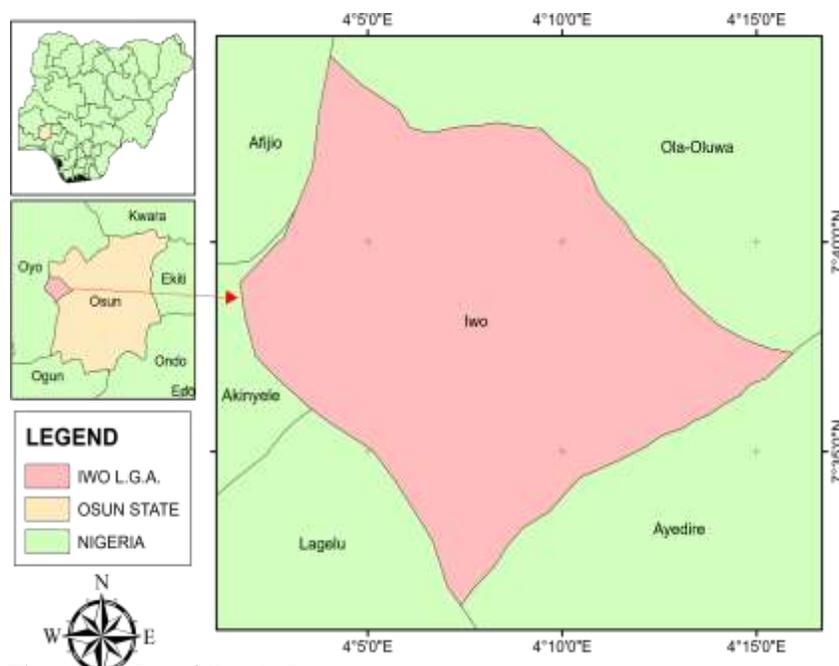


Figure 1: Map of the study area
Source: Adopted from the Administrative map of Osun State

However, pig farming is notably limited, largely due to the religious composition of the population, which is predominantly Muslim. The Odo-Ori market in Iwo serves as a significant commercial hub for agricultural produce, drawing traders from both within and beyond Osun State. According to the 2006 National Population Census, Iwo Local Government Area had a population of 191,377, comprising 98,312 males (51.4%) making it one of the largest LGA in the State [15].

4. Materials and Methods

The research was carried out in Iwo Local Government Area of Osun State, Nigeria, which comprises thirteen (13) council wards. These wards were first arranged in alphabetical order, after which a systematic sampling technique was employed to select the study locations. Specifically, every second and fourth ward in the sequence was chosen, yielding a total of six (6) wards: Isale Oba I, Isale Oba II, Molete I, Molete III, Oke Adan II, and Oke Oba I. This approach was adopted to minimize selection bias. Subsequently, purposive random sampling was utilized to select respondents from each of the selected wards, resulting in a total sample of two hundred (200) married women. This group included both currently married women and those who were previously married. Questionnaires were evenly distributed across all selected wards. Data collected were analyzed using both descriptive and inferential statistical techniques. Descriptive statistics, including frequency distributions and percentages was used to summarize the socio-economic characteristics of respondents and the nature of antenatal care attendance and delivery preferences.

5. Result and discussions

5.1 Socio-Demographic Characteristics of Respondents:

The age group 35–39 years has the highest representation, with 38 respondents, accounting for 19.0% of the total sample. This suggests that this age group is the most prominent among the respondents, possibly indicating peak reproductive and economically active years. The next most represented groups are: 25–29 years with 25 respondents (12.5%), 30–34 years with 23 respondents (11.5%) 40–44 years with 22 respondents (11.0%).

Table 1 Distribution of Respondents by Age Group

| Age group | Frequency | Percentage |
|--------------|------------|------------|
| 19-24 | 21 | 10.5 |
| 25-29 | 25 | 12.5 |
| 30-34 | 23 | 11.5 |
| 35-39 | 38 | 19.0 |
| 40-44 | 22 | 11.0 |
| 45-49 | 21 | 10.5 |
| 50-54 | 19 | 9.5 |
| 55-59 | 15 | 7.5 |
| 60-64 | 14 | 7.0 |
| 65 and above | 1 | 0.5 |
| Total | 200 | 100 |

Source: Source: Field Survey, 2024

The youngest age group, 19–24 years, accounts for 10.5%, suggesting a moderate number of young adult participants. Similarly, the 45–49 years age group also makes up 10.5%, indicating balance between younger and middle-aged respondents. Older age groups, particularly 50–54 (9.5%), 55–59 (7.5%), and 60–64 (7.0%), show a decreasing trend in participation, possibly reflecting declining engagement or eligibility (e.g., reproductive relevance) in the context of the study. The age group 65 and above is minimally represented with only 1 respondent (0.5%), suggesting that very few participants are in the elderly category, possibly due to the study's focus on women of reproductive or near-reproductive age. In Summary, the data indicates that the majority of respondents fall within the 25–44 years range, aligning with typical reproductive age among women, which is relevant considering the study's focus on antenatal care and delivery preferences. The age distribution thus reflects an appropriate and targeted population group for the research objectives. The highest proportion of respondents, 32.0%, reported having no formal education, making this the most common category. This may reflect educational limitations among women in the study area, especially older or rural populations. A nearly equal proportion, 31.0%, have attained post-secondary education, indicating a significant presence of women with higher education, likely reflecting a growing trend of female educational empowerment in parts of the community. Primary education accounts for 22.5%, suggesting that a considerable portion of the population has at least basic literacy and numeracy skills. Only 14.5% of respondents attained secondary education, which appears relatively low compared to both primary and post-secondary levels.

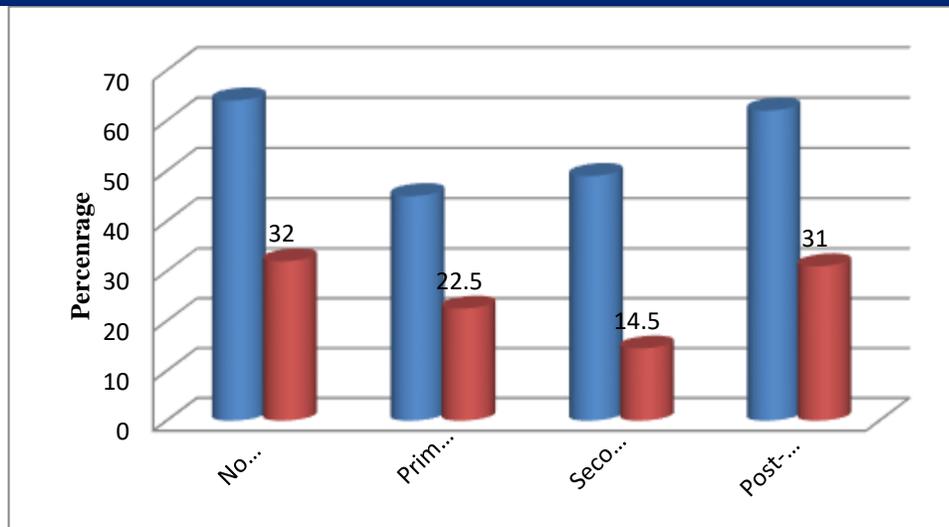


Figure 2. Level of Education

Source: Field survey, 2024

This might point to a dropout trend between primary and secondary schooling or limited access to secondary education facilities. The data reveals a bimodal distribution, with the majority of respondents concentrated at the extremes—those with no formal education (32%) and those with post-secondary education (31%). This contrast may highlight disparities in access to education across different socio-economic, age, or geographic groups within the study area. The presence of a substantial number of educated women could have implications for health-seeking behavior, such as antenatal care attendance and informed delivery choices. Conversely, the significant portion without formal education may face challenges in accessing or understanding maternal health services, which is crucial for interpreting the broader context of the study.

The most common occupation among respondents is petty trading/business (26.0%), indicating that many women are engaged in informal or small-scale commercial activities. This may be due to its accessibility and flexible nature, which suits many women's domestic responsibilities. Civil service (23.5%) is also highly represented, suggesting a considerable number of women are engaged in formal employment, possibly linked to higher education levels among some respondents. Farming (13.0%) represents a significant share, reflecting the rural and agrarian character of parts of the study area. A combined 37.5% of respondents are either housewives (12.5%), artisans (12.5%), or report no occupation (12.5%), suggesting that over one-third are economically inactive or engaged in subsistence-level or informal labor. With respect to income, a notable 24.0% of respondents have no fixed income, which likely corresponds with housewives, unemployed individuals, and those in subsistence agriculture or informal jobs without stable earnings. The income distribution shows that a majority earn less than ₦30,000 monthly: 58.0% earn below ₦30,000, indicating low income levels which may influence access to quality healthcare, especially paid services like antenatal care or skilled delivery. However, 19.5% of respondents report earning ₦40,000 and above, suggesting a notable portion of the population falls within a more financially stable bracket. These individuals may be better positioned to access and utilize formal maternal health services.

Table 2 Distribution of Respondents by Occupation and Incomes

| Occupation | Frequency | Percent |
|-----------------------|------------|------------|
| None | 25 | 12.5 |
| Civil service | 47 | 23.5 |
| Farming | 26 | 13.0 |
| Pettytrading/business | 52 | 26.0 |
| Artisan | 25 | 12.5 |
| Housewife | 25 | 12.5 |
| Total | 200 | 100 |
| Monthly income | | |
| No fixed income | 31 | 24.0 |
| ₦5000- ₦10,000 | 21 | 10.5 |
| ₦10,000- ₦15,000 | 18 | 9.0 |
| ₦15,000- ₦20,000 | 21 | 10.5 |
| ₦20,000- ₦25,000 | 17 | 8.5 |
| ₦25,000- ₦30,000 | 20 | 10.0 |

| | | |
|-------------------|----|------|
| ₦30,000- ₦35,000 | 16 | 8.0 |
| ₦35,000- ₦40,000 | 17 | 8.5 |
| ₦40,000 and above | 39 | 19.5 |

Source: Field Survey, 2024

The occupational and income economically diverse civil servants and business

| | | |
|--------------|------------|------------|
| Total | 200 | 100 |
|--------------|------------|------------|

data reflect a socio-population, ranging from owners to unemployed and

low-income individuals. The high prevalence of informal occupations and low income levels could be significant barriers to consistent antenatal care attendance and informed delivery choices. Conversely, the presence of a substantial proportion with higher income and civil service jobs suggests that some respondents may have better access to healthcare, information, and decision-making autonomy.

The data reflects a predominantly Muslim population, which aligns with the religious demographics commonly observed in Southwestern Nigeria, particularly in areas like Iwo, Osun State, where Islam has a strong historical and cultural presence. The relatively smaller number of Christians (22.5%) still represents a significant religious minority, potentially influencing social norms, health-seeking behavior, and delivery preferences in diverse ways. The complete absence of respondents identifying with traditional or pagan religions suggests a strong shift toward mainstream religious affiliations (Islam and Christianity), possibly due to modernization, urban influence, or religious conversions over time. The implications of the study is that, since religious beliefs can significantly shape health behaviors and maternal health choices, such as preferences for antenatal care, place of delivery, or acceptance of modern medical practices, the predominance of Islam in this sample may have notable implications: For example, certain Islamic teachings or cultural practices may affect women's autonomy in seeking care or require spousal approval.

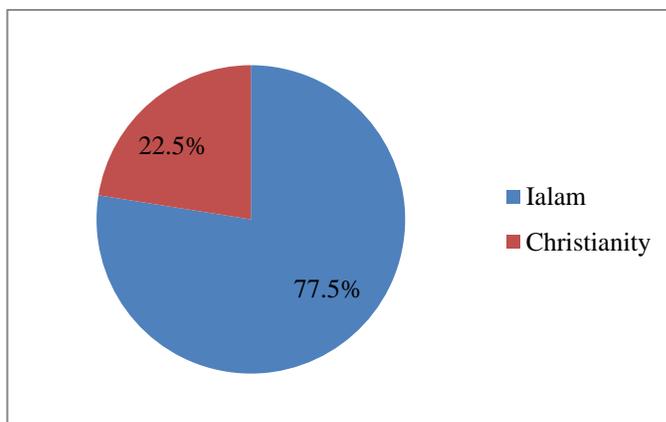


Figure 3 Distribution of Respondents by Religion

Source: Field Survey, 2024

Religious leaders or teachings may also influence attitudes toward hospital deliveries or female healthcare providers. This demographic profile can help guide culturally sensitive public health interventions or awareness campaigns tailored to the dominant religious group, while also addressing the needs of the Christian minority. The vast majority of the respondents (92%) are currently married, which is consistent with the study's focus on antenatal care attendance and delivery preferences among married women. This dominant group likely forms the core population of interest for understanding maternal health behaviors within family settings.

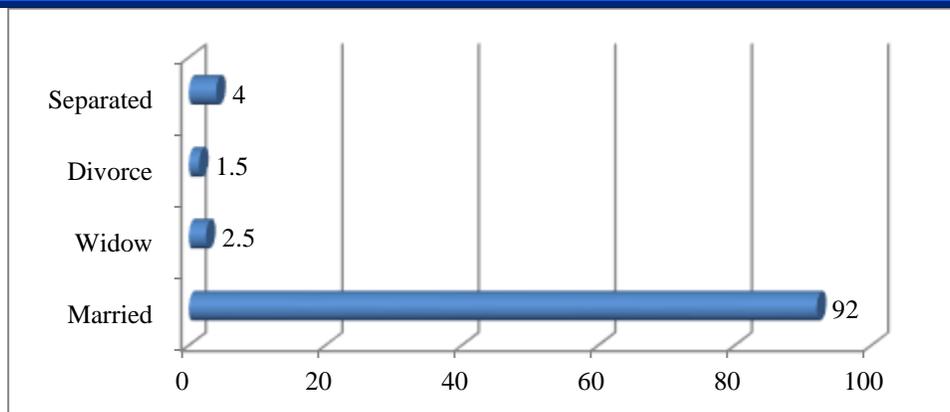


Figure 4 Distribution of Respondents by Marital status
 Source: Field Survey, 2024

The remaining 8% are not currently married, but include: Widows (2.5%), Divorced (1.5%), Separated (4.0%). These subgroups, though small, may still provide important insights, particularly in understanding how lack of spousal support or marital disruption could affect access to and utilization of maternal health services. Implications for the Study is that, the high proportion of married women supports the validity of findings related to spousal influence, household decision-making, and cultural expectations regarding childbirth and antenatal care. Women who are widowed, divorced, or separated may face unique challenges such as financial constraints, emotional stress, or limited social support, all of which could impact their healthcare-seeking behavior. When designing interventions or policies, it is important to consider the minority groups as well, ensuring that programs are inclusive of women in non-marital or disrupted marital situations.

6. Place of Delivery

The figure categorizes the place where respondents delivered their most recent child: 79.5% of the respondents delivered in a hospital or health facility. 20.5% delivered at home. A strong majority (nearly 8 out of 10 women) opted for hospital deliveries, indicating a high level of institutional childbirth.

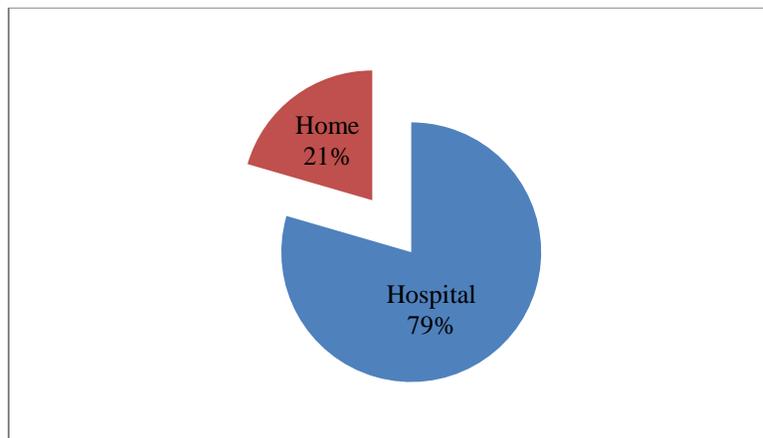


Figure 5 Distribution of Respondents by Place of delivery
 Source: Field Survey, 2024

This suggests a relatively good level of awareness and access to maternal healthcare services among the respondents. However, a notable minority (20.5%) still deliver at home, which could reflect barriers such as: cultural or traditional preferences, financial constraints, distance to health facilities, lack of education or awareness, influence of spouses, family, or religious beliefs. The implications of the finding is that, the 79.5% hospital delivery rate is encouraging and reflects progress toward safe motherhood practices and possibly the impact of public health campaigns or improved healthcare infrastructure in the area. However, the 20.5% home delivery rate still represents a significant public health concern. Home deliveries, especially without skilled birth attendants, increase the risks of maternal and neonatal complications or death. Understanding the socio-economic, cultural, and educational factors influencing the choice of delivery place will be essential for tailoring effective maternal health interventions.

7. Reasons for hospital delivery

The table lists the primary reasons given by respondents for choosing a hospital as their place of delivery: The majority (71.7%) cited the hospital's ability to manage complications as the main reason. 20.1% were influenced by their husband's advice. 5.7% had experienced previous childbirth complications, prompting them to seek professional care. A small proportion (2.5%) had other, unspecified reasons. The dominant reason—fear of complications—indicates a strong awareness of the potential risks associated with childbirth and the perceived trust in formal healthcare facilities to handle emergencies. This suggests that maternal health education campaigns may be effective in highlighting the benefits of hospital delivery. The fact that 1 in 5 women (20.1%) were motivated by spousal advice underlines the important role men play in influencing maternal health decisions in this cultural context. This insight can be used to involve men more intentionally in antenatal education and outreach programs. Only a few respondents (5.7%) cited past negative experiences as the reason, indicating that while prior complications are a motivator, proactive decision-making based on general knowledge or advice plays a larger role. The finding align with [16] who reported similar results.

Table 3 Distribution of Respondents by Reasons for hospital delivery

| Reasons for hospital delivery | Frequency | Percentage |
|---|------------|------------|
| Hospital can handle complications better | 144 | 71.9 |
| Advised by my husband | 23 | 20.1 |
| I got problems during previous childbirth | 9 | 5.7 |
| Others | 4 | 2.5 |
| Total | 159 | 100 |

Source: Field Survey, 2024

The 2.5% under "others" may include reasons like proximity to the hospital, affordability, or family influence, but these were not specifically captured. The implication is that the findings point to the importance of perception and trust in healthcare quality as a driver of hospital delivery. It also emphasizes that male involvement can significantly impact women's health choices, suggesting that engaging men in maternal health programs could improve uptake of skilled birth attendance. Programs aimed at reducing home births could benefit from reinforcing the message about the hospital's capacity to manage complications, while also addressing economic or logistical barriers [12].

8. Reasons for home delivery

The table presents the reasons provided by 41 respondents who delivered at home instead of in a hospital: None of the respondents reported fear of male midwives as a reason for home delivery, which suggests that cultural or gender-related concerns may not be a significant factor in the decision for home delivery in this particular sample. 14.6% indicated that the reason they delivered at home was due to the lack of money.

Table 4 Distribution of Respondents by Reasons for home delivery

| Reasons | Frequency | Percentage |
|---|-----------|------------|
| Financial constraint | 6 | 14.6 |
| No means of transport | 8 | 19.5 |
| Hospital is dirty and services are poor | 2 | 4.9 |
| Rude nurses | 1 | 2.4 |
| Baby came too soon | 23 | 56.1 |
| T.B.A is cheaper & friendly | 1 | 2.4 |
| Total | 41 | 100 |

Source: Field Survey,

2024

This highlights financial constraints as a barrier to accessing hospital services, particularly for women in lower-income groups who may not have funds for transportation or hospital fees. 19.5% cited lack of transportation as a reason for delivering at home. This shows that in rural or underserved areas, limited access to reliable transportation can prevent women from reaching health facilities in time for delivery. 4.9% mentioned that the hospital environment was a factor, specifically that the hospital was dirty and the services were poor. This indicates that poor quality of healthcare facilities can lead some women to avoid institutional delivery. 2.4% mentioned rude nurses as a reason for avoiding hospital delivery.

This reflects a potential issue with attitudes of healthcare providers, which may discourage patients from seeking care in hospital settings. The largest group 56.1% of the respondents, delivered at home because their baby came too soon—likely meaning they went into labor unexpectedly and were unable to reach the hospital in time. This highlights the unpredictability of childbirth and the potential for emergency deliveries to occur at home due to timing or logistical issues. 2.4% delivered at home because traditional birth attendants (T.B.A.) are perceived as cheaper and more friendly. This suggests that, in some cases, cultural preferences or economic factors might encourage women to opt for home births with traditional birth attendants rather than seeking hospital care.

Financial constraints (14.6%) and transportation issues (19.5%) are significant barriers to hospital delivery, showing that many women cannot afford the cost or logistics of getting to a health facility in time for delivery. Fear of complications related to the timing of labor (56.1%) is the leading reason for home births. Women may have experienced premature labor or found themselves in situations where they could not reach a healthcare facility on time. The perception of traditional birth attendants being cheaper and friendlier may suggest that cost-effective, culturally acceptable options are valued by some women, despite potential risks associated with non-skilled birth attendance. The concerns about hospital cleanliness and poor services (4.9%) point to the importance of improving healthcare facility standards, both in terms of infrastructure and patient care, to increase hospital delivery rates [16].

9. Attendance of Antenatal

This table shows the number of respondents who attended antenatal care during pregnancy and those who did not and the result show that 79.0% attended antenatal care while 21.0% did not attend ANC. The majority (79.0%) of the women reported attending antenatal care, which is a positive indicator of maternal health awareness and behavior in the study area. It suggests that most women recognize the importance of monitoring their pregnancy with professional health services. However, 21.0% did not attend ANC, which is a significant minority. These women may be at higher risk of complications during pregnancy and childbirth due to the lack of early detection of issues and absence of health education offered through ANC services. The high ANC attendance rate could reflect effective public health messaging, better access to maternal health services, or higher levels of education among some women.

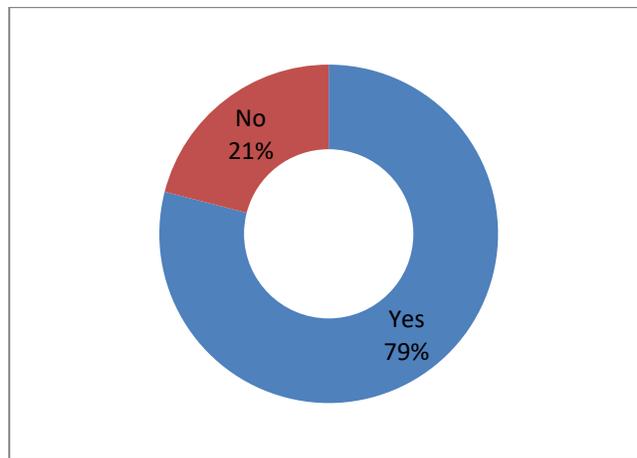


Figure 6 Respondents Attendance of antenatal

Source: Field Survey, 2024

However, the 21% non-attendance rate points to the need for further investigation into barriers to ANC, which may include: financial constraints, distance to health facilities, cultural or religious beliefs, lack of spousal or family support, negative past experiences with healthcare providers. This finding can guide targeted interventions to improve ANC attendance, especially among vulnerable or hard-to-reach populations [16].

10. Reasons for attending antenatal

This table provides insights into the various reasons women attended ANC during their pregnancy: The majority (74.5%) attended ANC to get their antenatal card, which is essential for monitoring the pregnancy and receiving any health services. This highlights the importance of official documentation in healthcare, which serves as a formal record for any interventions and progress during the pregnancy. 64.5% of respondents attended ANC to check the position of the baby (lie position). This is crucial for ensuring the baby is in the correct position for delivery and avoiding complications during childbirth. This indicates a high level of awareness about the importance of monitoring the baby's position for a safe delivery. 59.5% attended ANC to prevent pregnancy-related complications. This reflects health-seeking behavior, as women recognize the role of ANC in identifying and addressing potential risks such as hypertension, gestational diabetes, or infections. 56.0% attended ANC to receive immunization (e.g., tetanus toxoid vaccination). Immunization is a standard part of ANC services to protect both the mother and child from preventable diseases, showing that many women understand the value of preventive healthcare. 41.0% of respondents listed other reasons, such as general health checks or advice from healthcare providers, indicating that multiple factors contribute to a woman's decision to attend ANC. From the result, it can be observed that prevention and safety are the top priorities for most women when deciding to attend ANC. Whether for checking the baby's position, acquiring the antenatal card, or preventing complications, women are largely motivated

by proactive healthcare measures. The lower percentage (41.0%) of women attending for other reasons indicates that most motivations are centered on standard ANC services such as health monitoring, documentation, and immunization.

Table 5 Distribution of Respondents by reasons for attending antenatal

| Reasons | Frequency | | No | % | Total | | |
|--|-----------|------|------|------|-------|-----|-----|
| | Yes | % | | | Yes | % | |
| To acquire antenatal card | 149 | 74.5 | 51 | 25.5 | 200 | 100 | |
| To know the lie position of my baby | | 129 | 64.5 | 71 | 35.5 | 200 | 100 |
| I avoid getting problems during pregnancy. | | 119 | 59.5 | 81 | 40.5 | 200 | 100 |
| To get immunized. | | 112 | 56.0 | 78 | 39.0 | 200 | 100 |
| Others | | 82 | 41.0 | 118 | 59.0 | 200 | 100 |

Source: Field Survey, 2024

A significant proportion (35.5% - 40.5%) did not attend ANC for specific reasons, such as checking the baby’s position or avoiding pregnancy complications, which could indicate gaps in awareness or access to healthcare services. The high attendance rates for reasons related to monitoring pregnancy and ensuring safety suggest that health education campaigns emphasizing the importance of ANC for maternal and child health may be effective. The significant proportion of women who did not attend for specific reasons (e.g., lie position or avoiding pregnancy problems) suggests there may be barriers to care, such as: financial constraints, lack of transportation, inadequate healthcare access or facilities and cultural or educational barriers [16].

11. Conclusion

The study highlights key insights into antenatal care (ANC) attendance and delivery preferences among married women in Iwo Local Government Area of Osun State. A significant majority (79.5%) of women delivered in hospitals or health facilities, reflecting the positive impact of public health campaigns and improved healthcare infrastructure in the area. However, the 20.5% of women who opted for home deliveries, often due to financial constraints, lack of transportation, or cultural preferences, point to significant barriers that continue to hinder full access to institutional maternal care. Additionally, while the majority of women attended ANC (79.0%), a notable 21.0% did not, indicating the need for targeted interventions to address gaps in healthcare access, education, and support. The factors influencing both hospital and home deliveries underscore the importance of understanding the socio-economic, cultural, and logistical determinants of maternal health choices.

12. Recommendations

Based on the findings, the following recommendations are made:

- i. **Improve Healthcare Access:** To address the 20.5% of home deliveries, efforts by Osun State Government should focus on improving access to healthcare facilities, particularly in rural areas, by reducing transportation barriers and ensuring affordable healthcare services.
- ii. **Strengthen Maternal Health Education:** Public health campaigns should continue to promote the benefits of institutional deliveries and ANC attendance, emphasizing the risks of home births without skilled birth attendants and the importance of early prenatal care.
- iii. **Engage Men in Maternal Health Decisions:** Given the influence of spousal advice on delivery choices, it is crucial to engage men more actively in maternal health education and decision-making to foster a supportive environment for institutional deliveries.
- iv. **Enhance Healthcare Quality:** Improving the quality of healthcare facilities, including addressing cleanliness, patient care, and provider attitudes, could help mitigate concerns that lead women to avoid hospitals. Facilities should also be equipped to handle complications efficiently to build trust in institutional care.
- v. **Address Socio-Economic Barriers:** Economic constraints are a significant barrier to ANC attendance and institutional deliveries. Government and non-governmental organizations should explore ways to subsidize maternal healthcare costs, provide transportation assistance, and ensure the affordability of services for lower-income women.
- vi. **Target Vulnerable Populations:** Special attention should be given to marginalized groups, including low-income, rural, and less-educated women, by tailoring interventions that address their specific challenges and increase their access to maternal healthcare services. By implementing these recommendations, maternal health outcomes in the region can be improved, contributing to safer childbirth experiences and better health outcomes for both mothers and babies.

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