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Determinants of delivery point choice among pregnant women in Ntenjeru North, Kayunga District, Uganda. A cross-sectional study.

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Abstract.

Background:

Choice of delivery point remains a critical determinant of maternal and neonatal outcomes, particularly in rural settings where access to skilled birth attendance is limited. This study aimed to explore the determinants influencing pregnant women's choice of delivery point in Ntenjeru North, Kayunga District.

Methodology:

A qualitative cross-sectional study grounded in an interpretivist approach was conducted among pregnant women and key informants. Purposive sampling was used to select 25 participants. Data were collected through in-depth semi-structured interviews in Luganda and English. Audio recordings were transcribed verbatim and analyzed using inductive thematic analysis following Braun and Clarke's framework. Ethical considerations, including informed consent and confidentiality, were strictly observed.

Results:

About 77.8% of women had low awareness of childbirth complications, limiting their perceived need for facility-based delivery. Cultural and familial preferences strongly influenced decisions, with 66.7% favoring home or TBA-assisted births due to trust, cultural compatibility, and comfort. Although 66.6% acknowledged the benefits of hospital care, including emergency services and pain management, negative perceptions, such as poor staff attitudes and hygiene, discouraged utilization. Economic constraints and accessibility challenges, including long distances and drug stock-outs, further influenced decisions. Male dominance in decision-making (77.8%) significantly limited women's autonomy.

Conclusion:

Delivery point choice in Ntenjeru North is shaped by a complex interplay of low health literacy, socio-cultural norms, economic barriers, and health system challenges.

Recommendations:

There is a need for the government to strengthen maternal health education, promote culturally sensitive care, improve health facility infrastructure, involve male partners in maternal health decisions, and integrate TBAs into formal referral systems are essential to increase facility-based deliveries and improve maternal outcomes.

Keywords: *Delivery point choice, maternal health, facility-based delivery, traditional birth attendants (TBAs), health-seeking behavior, Kayunga District.*
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Background.

In ancient Greece, childbirth typically took place at home. Women were usually assisted by midwives and female relatives. (Bates & Turner, 1985) While some sources mention the existence of separate birthing rooms within the home, these were not universally common. The choice to give birth at home was primarily driven by cultural norms and the limited availability of specialized medical facilities. Childbirth was viewed as a natural process, and home was considered a safe and comfortable environment for women to labor and deliver. Furthermore, religious and societal customs surrounding childbirth often involved rituals and practices best performed within the familiar setting of the home. Though the practice of going to temples to pray for a successful childbirth did exist, the actual birthing process generally took place at home. This aligns with broader ancient practices, where home births were the prevalent norm. (Goodwill et al, 1997) However, by the post-World War II era, hospital births became more common, driven by medical advancements, state policies, and changing societal expectations (Al-Gailani, 2018). (Chinkhumba et al., 2014) discusses how maternal and perinatal deaths are clustered

around the time of delivery, highlighting the importance of access to appropriate care during this critical period. (Chaka et al., 2019) notes that children delivered in health facilities are more likely to survive than those born at home, linking facility births to access to skilled providers and timely interventions. (Saleem et al., 2014) emphasizes the high risk of maternal and newborn deaths in low-income countries, particularly during and after delivery, underscoring the need for improved access to quality care. These sources, along with many others, support the idea that the choice of delivery location plays a crucial role in maternal mortality. Maternal mortality, defined as the death of a woman during pregnancy or within 42 days of its termination from any cause related to or aggravated by the pregnancy, remains a significant global health concern. (Alkema et al., 2015)

While global rates have declined, disparities persist. Current estimates from the World Health Organization indicate that approximately 287,000 maternal deaths occurred in 2020. (WHO, 2024) Most of these deaths (95%) occurred in low and lower-middle-income countries. (WHO, 2024) Sub-Saharan Africa carries the highest burden, accounting for roughly 70% of global maternal deaths. (WHO, 2024). While significant progress has been made in reducing maternal mortality worldwide, the pace of decline has been uneven across regions. (tesfay et al., 2022) Substantial disparities persist between high-income and low-income countries. (Okonji et al., 2023) Achieving further reductions in maternal mortality, sustainable development goal 3 aims to ensure health lives and promote well-being for all through easy access to quality health, with a target to reduce global mortality ratio to less than 70 per 100000 live births by 2030 (McCauley et al., 2018) Maternal mortality remains a significant global health challenge, and Uganda, despite progress, continues to grapple with a high maternal mortality ratio. According to the Ministry of Health (2017), Uganda's maternal mortality ratio was 336 deaths per 100,000 live births. Though this represents a substantial decline from previous decades, it still falls short of global targets. (Abortion and Post-abortion Care in Uganda, 2017) Access to skilled healthcare professionals during childbirth is crucial for reducing these preventable deaths. Despite improvement in health care access, a considerable number of pregnant mothers in Uganda, especially in rural areas, still opt for home deliveries, often with traditional birth attendants (TBA). (Namazzi et al., 2015; Wilunda et al.,2014).

A traditional birth attendant is a person who assists a woman during childbirth and who initially acquired her skills by delivering babies herself or working with other TBAs (Matlala, 2023). TBAs are often older women respected within their communities, particularly in rural, remote, and medically underserved areas. While TBAs play a vital role in providing primary maternity care in many developing countries (Garcés et al., 2019), their training and integration into formal healthcare systems vary. Some TBAs undergo training programs to improve their skills and knowledge, while others continue to practice based on traditional knowledge passed down through generations. (Carlough & McCall, 2005) highlights that even trained TBAs may not be equipped to handle all complications during childbirth, but they can play an essential role in referring women to appropriate medical facilities when necessary. In some regions, like Timor-Leste, TBAs have been incorporated into the health system, performing tasks like outreach, education, and referrals (Sarmento, 2014). This study aimed to examine factors influencing pregnant women's choice of delivery points in Uganda.

Methodology.

Research design.

This study adopted a qualitative research design grounded in an interpretivist philosophical approach to explore the determinants of delivery point choice among pregnant women in Ntenjeru North, Kayunga District. The interpretivist paradigm is particularly suited for this study as it emphasizes understanding the subjective meanings and social contexts that shape women's decisions about childbirth locations. Through in-depth interviews and thematic analysis, the research captured participants' lived experiences, cultural beliefs, and personal perceptions regarding facility-based versus home/TBA deliveries. The study employed purposive sampling to select pregnant women and key informants (health workers, TBAs) who provided rich insights into the research problem. Data collection focused on semi-structured interviews, enabling participants to share their perspectives freely while ensuring key themes are explored. Thematic analysis was used to identify patterns and develop meaningful interpretations of the data, following Braun and Clarke's (2006) framework.

Study Area.

The research was conducted in Ntenjeru North County, Kayunga District, located in Central Uganda. The area's healthcare infrastructure was limited, with few well-equipped health facilities serving a dispersed population across five villages. The socio-cultural context of Ntenjeru North makes it particularly suitable for this study, as traditional beliefs and practices significantly influence health-seeking behaviors. This setting provides rich ground for investigating the complex determinants of delivery point choices among pregnant women.

Target Population.

The primary study participants were pregnant women aged 15-49 years in their third trimester, as they were actively considering delivery options. Recently delivered mothers (within 12 months postpartum) were also included to capture actual delivery experiences and decision-making processes. Secondly, healthcare providers (midwives or

nurses) and traditional birth attendants were included to understand service delivery perspectives. This multi-stakeholder approach ensured comprehensive insights into both demand-side (women's perspectives) and supply-side (health system) factors influencing delivery location choices.

Inclusion and Exclusion Criteria.

Inclusion.

The study included women aged 15-49 years who were either in their third trimester of pregnancy or had delivered within the past year. Participants must have been residents of Ntenjeru North for at least six months to ensure familiarity with local healthcare options and must voluntarily consent to participate.

Exclusion.

Women with high-risk pregnancies under specialized care and women who can't conceive again, provided they were not health workers or TBAs, were excluded from the study. Non-residents and those unwilling to participate were also excluded to maintain focus on established community members with relevant lived experiences.

Sample Size Determination.

The study interviewed approximately 25 participants according to (Guest et al, 2006), like 5 adolescent mothers, 5 multiparous mothers, and 5 primiparous mothers, with recruitment continuing until data saturation is achieved. This sample size allowed for in-depth exploration of experiences while remaining manageable within the study timeframe. Additionally, 5-8 key informants were selected, including healthcare providers (2 midwives), 2 traditional birth attendants, and 2 village health team members. This ensured diverse professional perspectives on maternal healthcare delivery in the region.

Sampling Technique.

I used non-probability purposive sampling techniques. Purposive sampling was used to select women representing varied demographics to capture diverse experiences. Choosing some TBAs and midwives ensured inclusion of women with different delivery experiences (facility-based, home, TBA-assisted) to capture the full spectrum of influencing factors.

Data Collection Methods and Tools.

Data collection methods.

Primary data was collected through in-depth interviews in both Luganda and English language using semi-structured guides, which allowed for both focused discussion and spontaneous exploration of emerging themes. Key informant interviews gathered professional perspectives on service delivery.

Tools Used.

Tools included a digital voice recorder (with consent), pen, notebook, and a brief demographic questionnaire. All instruments were developed specifically for this study and refined through pilot testing to ensure cultural appropriateness and effectiveness in capturing relevant data.

Validation of Instruments.

The research instruments underwent rigorous validation processes to ensure quality. Content validity was established through review by the research supervisor, who assessed whether the tools adequately covered all relevant constructs. Face validity was confirmed via pilot testing with 5 participants from a neighboring village with similar characteristics. This ensured that the tools effectively capture intended information while being culturally appropriate.

Reliability of Instruments.

Instrument reliability was assessed through several measures. The interview guide demonstrated good internal consistency from member checking and peer debriefing to ensure its credibility, indicating the questions consistently measured the same underlying constructs. For data analysis reliability, a code-recode procedure established coding consistency, with two researchers independently coding 10% of transcripts to check inter-coder agreement. These measures ensured the tools yield consistent interpretations, which enhanced the study's dependability.

Data Entry and Analysis.

All audio recordings were transcribed verbatim and managed using Sonix software for systematic organization and analysis. Securing participant confidentiality and research data integrity. Data analysis followed Braun and Clarke's (2006) and inductive thematic analysis approach: familiarization, coding, theme development, theme review, theme definition, and report production. Regular team discussions validated interpretations and enhanced analytical rigor throughout the process.

Ethical Considerations.

Written informed consent was obtained from all participants, with special provisions for minors (15-17 years); a written guardian consent or verbal assent was required to ensure voluntary participation.

Strict confidentiality protocols included anonymization using identification codes, secure data storage, and aggregate reporting. Participants might withdraw anytime without consequence, and a social worker was on a call for the trauma referrals system to provide psychosocial support

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if needed.

Result.

Demographic characteristics of participants.

Table 1, Participant Distribution

category	Frequency (women)
Pregnant women	18
midwives	2
TBAs	3

Table 2, Distribution of pregnant women (n=18)

Age group (years)	number
15-24	5
25-34	11
35-49	2

Key observation: The majority of respondents (11 out of 18) were in their peak reproductive years (25-34), aligning with Uganda's demographic trends (UBOS, 2024).

Table 3Participant's education level.

Education level	**number**	**Percentage (%)**
No formal education	5	22
primary	13	56
secondary	3	13
tertiary	2	9

Key observation: the majority of pregnant women 56% stopped at primary as their highest level of education, while 22% had no formal education. This mirrors findings from the (UDHS 2016), which show lower facility delivery rates among less educated women.

The education profile supports Atukunda et al's 2020 observation that limited education correlates with reduced health literacy. This creates barriers to understanding g the benefits of facility deliveries, consistent with UNICEF 2023 reports on rural-urban knowledge disparities.

Knowledge levels

Theme 1: Low Awareness of Complication (LAC).

(14/18 PW) Most women underestimated risks, with (77.8%) and were unable to name more than two potential childbirth complications. For example, (PW12, age 28) "*I know bleeding can happen, but that's normal in childbirth."*

The limited awareness of childbirth complications highlights a significant gap in maternal health education, particularly among women with primary education (56% of participants), which aligns with UBOS (2024), where rural women lack formal maternal health education.

Low awareness of complications reduces women's perception of risks, discouraging facility-based deliveries (Rosentock, 1974). Unlike urban areas, where education correlates with facility births (Kivuva et al., 2021). Misconceptions about "normal" complications could deter women from seeking facility-based care, increasing maternal and neonatal mortality risks.

Attitudes.

Theme 2: Cultural and Familial Preference at Home/TBA (CFPH/TBA).

(PW03, age 24)."*For my first birth, I went to the hospital. But for others, my mother-in-law said home was better."*

(PW15, age 32)."*We trust TBAs because they speak our language and know our customs."*

Preference distribution for delivery locations

6/18, PW (33.3%) preferred health facility

12/18 (66.7%) preferred home births /TBAs.

Cultural familiarity and trust in TBAs strongly influenced delivery choices. Family and community opinions, particularly from elders, play a critical role in decision-making. The preference for home or TBA-assisted births with extra care reflected deep-rooted cultural norms and mistrust in formal healthcare systems (e.g., hospital throws placenta in trash), which acted as a barrier, as supported by Dantas et al. (2020).

Perceptions

Theme 3: Perceived Advantage of Hospital Care (PAHC)

Emergency equipment.

(12/18 PW) said that hospital emergency care (e.g., eclampsia management) has helped them well, and it's as important as they appreciated in their direct quotes**.**
(PW05, age 29). "*….uuuh…. yaah. At least in the hospital, if bleeding starts, they have machines and blood. At home, you just pray."*
(PW13, age 34*). "…. hoooo (slowly move head sideways) … My sister survived eclampsia because the hospital had injections; a TBA would've buried her."*

Pain relief

(9/18PW) confessed that the hospital has drugs in case of much pain
(PW08, age 26), *"….at least they gave me an injection to stop the pain during labor. At home, you suffer silently*."
(PW17, age 31). *"Hospitals have drugs, but the midwives shout at you to 'push' like you're a cow" (said it frankly)*

Hygiene standards

(7/18 PW) unappreciated hospital hygiene.
(PW10, age 27). *(Put on a gloomy face and narrowed the eyes)."The health center smells of medicine, but home births smell of blood."*

Theme 4: Perceived Advantage of TBA/Home Care (PATC).

Cultural rituals.

(15/18 PW) appreciated the cultural practices (like herbal use) from TBAs**.**
(PW04, age 35). (Passionately stated), TBAs bury the placenta under a banana tree for the baby's prosperity. Hospitals throw it in the trash!"
(PW14, age 24).*"At home, my mother-in-law burns herbs to protect me from evil spirits. Hospitals forbid this.*"

Economic accessibility.

(14/18 PW) said accessing TBAs is cheaper than in hospitals, as they cited cost (e.g., TBAs accept chickens vs. hospital fees)**.**
(PW06, age 30). ". haaa…. *At the hospital, they demand money for gloves and drugs. A TBA accepts a chicken or nothing ……. can u imagine……."*
*(*PW11, age 28). "*My husband said hospital delivery costs 50,000 UGX. At home, we spend only on a razor."*
These statements reveal how economic realities often override knowledge of medical benefits.

Comfort and autonomy

(16/18PW) said that TBAs are flexible in labor positions and familial support.
Key quotes.
(PW01, age 22). *"At home, I labor in my own bed with my sisters cheering me. .....My LOAD ……Hospitals are lonely and cold.*"
(PW16, age 33). "*TBAs let me squat or walk during labor. Hospitals force you to lie down like a patient"(eyes widely open)*

Table 4, summary of perceived advantages/disadvantages by location

Facility-based care	Facility care (%)	TBA/home care (%)
Emergency equipment (12/18)	66.6	---
Pain relief (9/18)	50	---
Hygiene (7/18)	38.8	---
Cultural ritual (15/18)	---	83.3
Lower cost (14/18)	---	77.7
Familiar environment (16/18)	---	88

Women acknowledged hospitals' life-saving capacity (66.6%) but rejected them due to cultural dissonance (83.3%).
While hospitals are recognized for emergency care, TBAs are perceived as more culturally aligned, affordable, and comforting. Negative perceptions of hospital hygiene and staff attitudes further deter facility use.
There was a big difference between what health workers recommend and what people actually choose because of money issues and traditions, so there is a need to integrate culturally sensitive practices (e.g., placenta rituals) and improve patient-centered care to bridge this gap.

Practices

Decision-making dynamics

Theme 5: Male Dominance (MD)

(14/18 PW), (77.8%) reported male partners made final decisions

(PW09, age 26) "*He pays the bills, so he decides where I deliver."*

(PW013, age 20) "*My husband doesn't have much money, so going to the hospital when there is another possible option is like stressing him more. So, I have to support him where I can.*"

Decision-making influencers

(14/18 PW) influenced by husband

(3/18 PW) mother/ mother-in-law

(1/18 PW) self-decision.

Male dominance in decision-making reflected gendered financial control and societal norms, hence limiting women's autonomy in maternal health choices.

The practice matches the literature's identified gap in male involvement, where male decisions acted as cues to action, overriding women's self-efficacy.

Additional findings

Health System Barriers

Both midwives reported: (MW01, age 48) "*Stock-outs of essential drugs make mothers lose trust in facilities."*

Long Distances

5/18 women cited long distances. (PW11, age 40)."*The health center is 12km away - how will I get there in labor… as you know?"*

Cultural Conflict in Care

All 3 TBAs emphasized: "*We bury placentas properly, unlike hospitals that throw them away"* (TBA02)

(7/18PW, age 30) Women feared hospital staff would "disrespect our traditions" (PW14)

Systemic issues like resource shortages and geographic barriers exacerbated reliance on TBAs

Table 5, Summary of key themes

Objective	themes	Supporting data
Knowledge	LAC	77.8%
Attitudes	CFPH/TBA	55.5%
Perceptions	PAHC	<68%
	PATC	>70%
Practices	MD	77.8%

Key

Low Awareness Complication (LAC)

Cultural and Familial Preference at Home/TBA (CFPH/TBA)

Perceived Advantage of Hospital Care (PAHC)

Perceived Advantage of TBA/Home Care (PATC)

Male Dominance (MD)

Discussion of key findings

Knowledge levels and delivery point choices

The study revealed that 77.8% of pregnant women (14/18) had low awareness of childbirth complications, perceiving risks like bleeding as "normal" (PW12). This aligns with UBOS (2024), which highlights gaps in maternal health education in rural Uganda. The findings support the HBM construct of perceived susceptibility; when women underestimate risks, they are less likely to prioritize facility-based deliveries (Rosenstock, 1974). Contrastingly, urban studies (Kivuva et al., 2021) show that higher education correlates with better knowledge and facility use, underscoring the need for targeted rural health literacy programs.

Attitudes and cultural preferences

66.7% of women (12/18) preferred home/TBA deliveries due to cultural trust and familial influence (e.g., PW15: "TBAs speak our language"). This reflects the HBM's perceived barriers (cultural dissonance) and cues to action (family advice). Similar findings were reported by Dantas et al. (2020), where community norms overrode medical recommendations. The tension between traditional practices (e.g., placenta burial) and hospital protocols exacerbates this preference, suggesting a need for culturally sensitive care integration.

Perceptions of facility vs. home/TBA Care

Women acknowledged hospitals' life-saving capabilities (66.6% cited emergency equipment; PW05) but criticized their hygiene (38.8%) and staff attitudes (PW17: "Midwives shout like you're a cow"). Conversely, TBAs were perceived as affordable (77.7%), culturally aligned (83.3%), and supportive (88%). These findings mirror MOH (2024) reports on mistrust in facilities and align with the HBM's perceived benefits and barriers. The disparity between

hospital advantages and actual utilization underscores systemic issues like understaffing and resource shortages.

Male Dominance in Decision-Making

77.8% of women (14/18) reported male partner-controlled delivery choices (PW09: "He pays the bills"). This reflects gendered financial control and limits women's self-efficacy (HBM). The study corroborates UBOS (2023) data on male-dominated health decisions in rural Uganda and highlights a critical gap in male involvement interventions.

Systemic Barriers

Key informants noted drug stock-outs (MW01) and long distances (PW11: "Health center is 12km away"), reinforcing reliance on TBAs. These structural barriers align with Atukunda et al. (2020) and emphasize the need for policy-level improvements in healthcare access.

Conclusions.

Knowledge Levels

Pregnant women in Ntenjeru North exhibited low awareness of childbirth complications, with 77.8% unable to name more than two risks. Misconceptions (e.g., bleeding as normal) reduced perceived susceptibility, discouraging facility-based deliveries.

Limited maternal health education, especially among women with primary or no formal education (78% of participants), supported reliance on traditional practices.

Attitudes

Cultural and familial preferences strongly influenced delivery choices, with 66.7% of women favoring home/TBA-assisted births due to trust in TBAs' cultural alignment (e.g., language, rituals like placenta burial).

Negative attitudes toward hospitals (e.g., perceived disrespect from staff) acted as barriers, despite recognition of medical benefits.

Perceptions.

Hospitals were valued for emergency care (66.6%) but criticized for poor hygiene (38.8%) and staff attitudes. TBAs were preferred for affordability (77.7%), cultural rituals (83.3%), and comfort (88%).

Economic constraints (e.g., hospital fees vs. TBA payments in-kind) often overrode health considerations.

Practice.

Male dominance in decision-making (77.8%) limited women's autonomy, with husbands controlling choices due to financial authority.

Systemic barriers (e.g., drug stock-outs, long distances) reinforced reliance on TBAs, exacerbating gaps in skilled birth attendance.

Limitations

Sample size. A small sample size was chosen (n=25), limiting generalizability to a broader population in Uganda, so future research should consider mixed research methods. However, this sample size has clearly explored village-based challenges, especially in Kayunga district, which can help to make impactful interventions to improve maternal health in Kayunga district.

Self-reporting bias. Responses on perceptions (e.g., hospital experiences) may be influenced by recall bias, especially among postpartum women reflecting on past deliveries. However, a hand that strikes may forget, but the heart that bleeds does not.

Temporal constraints. The 3-month study period may not capture seasonal variations (e.g., rainy-season transport challenges) or long-term trends in delivery choices.

The Health Belief Model does not fully account for structural barriers (e.g., poverty, gender inequality) that emerged as pivotal in this study.

Recommendations

Policymakers and the government

Implement community-based programs to improve knowledge of childbirth risks and benefits of facility deliveries, targeting rural women and their families.

Collaborate with local leaders and TBAs to disseminate accurate information through culturally appropriate channels (e.g., radio dramas in Luganda).

Integrate TBAs into referral systems with incentives for facilitating facility deliveries, ensuring they are trained in emergency recognition.

Healthcare provides

Train midwives in respectful maternity care (RMC) so that they can handle pregnant mothers with empathy to address negative perceptions of hospital staff attitudes.

Accommodate cultural practices (e.g., placenta return home for burial) where medically safe to bridge trust gaps.

Community engagement

Organize ANC outreach sessions involving male partners to emphasize shared decision-making and the importance of skilled attendance.

Economics and finance

Upgrade health facilities in Ntenjeru North to address stock-outs, emphasizing proper health service management where drugs are stocked according to their need.

Establish maternity waiting homes near facilities to accommodate women from remote villages.

Future research

Expand sample sizes and employ quantitative surveys to generalize findings across Kayunga District.

Investigate the safety/efficacy of traditional practices (e.g., herbal use) to inform integration strategies.

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List of abbreviations
ANC – Antenatal Care
CFPH/TBA – Cultural and Familial Preference at Home/Traditional Birth Attendant
HBM – Health Belief Model
LAC – Low Awareness of Complications
MD – Male Dominance
MOH – Ministry of Health
PAHC – Perceived Advantage of Hospital Care
PATC – Perceived Advantage of Traditional Birth Attendant/Home Care
PW – Pregnant Woman
RMC – Respectful Maternity Care
TBA – Traditional Birth Attendant
UBOS – Uganda Bureau of Statistics
UDHS – Uganda Demographic and Health Survey
UNICEF – United Nations International Children's Emergency Fund
VHT – Village Health Team
WHO – World Health Organization

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Conflict of interest.
There is no conflict of interest.

Availability of data.
Data used in this study are available upon request from the corresponding author.

Author's contribution.
YSK designed the study, conducted data collection, cleaned and analyzed data, and drafted the manuscript.
DN supervised all stages of the study from the conceptualization of the topic to manuscript writing and submission.

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