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FACTORS SUCH AS PSYCHOSOCIAL SUPPORT, ANXIETY, AND HEALTHCARE FACILITIES INFLUENCE THE CHOICE OF BIRTHPLACE WITH SELF-EFFICACY AS A MODERATING VARIABLE

Faktor Dukungan Psikososial, Kecemasan dan Fasilitas Kesehatan Memengaruhi Pilihan Tempat Bersalin dengan Efikasi Moderasi

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ABSTRAK

Pemilihan tempat persalinan merupakan keputusan penting bagi ibu hamil yang dipengaruhi oleh faktor internal dan eksternal, seperti dukungan psikososial, kondisi psikologis, dan persepsi terhadap fasilitas layanan kesehatan. Penelitian ini bertujuan menganalisis pengaruh dukungan psikososial, kecemasan, dan fasilitas layanan kesehatan terhadap keputusan ibu hamil memilih tempat persalinan, serta menguji peran self-efficacy sebagai variabel moderasi. Penelitian menggunakan pendekatan kuantitatif dengan desain cross-sectional pada 100 ibu hamil trimester ketiga yang aktif memeriksakan kehamilan di wilayah kerja Puskesmas Poasia (40 responden), Mokoau (33 responden), dan Lepo-lepo (27 responden). Sampel ditentukan dengan metode Proportional Stratified Random Sampling. Instrumen penelitian berupa kuesioner skala Likert lima poin, dianalisis menggunakan SmartPLS 4 dengan pendekatan PLS-SEM. Hasil menunjukkan dukungan psikososial (p=0,000) dan kecemasan (p=0,000) berpengaruh signifikan, sedangkan persepsi fasilitas (p=0,102) dan self-efficacy (p=0,266) tidak berpengaruh, baik langsung maupun sebagai moderasi. Simpulan, keputusan pemilihan tempat persalinan lebih ditentukan oleh dukungan sosial dan kondisi psikologis dibanding faktor fasilitas atau kepercayaan diri.

***Kata kunci**: dukungan psikososial, fasilitas kesehatan, kecemasan, self-efficacy, tempat persalinan*

ABSTRACT

The choice of delivery location is an important decision for pregnant women, influenced by both internal and external factors such as psychosocial support, psychological condition, and perceptions of healthcare facilities. This study aims to analyze the influence of psychosocial support, anxiety, and healthcare facilities on pregnant women's decisions regarding delivery location, as well as to examine the role of self-efficacy as a moderating variable. A quantitative approach with a cross-sectional design was employed, involving 100 third-trimester pregnant women who regularly attended prenatal check-ups within the working areas of Poasia Health Center (40 respondents), Mokoau Health Center (33 respondents), and Lepo-lepo Health Center (27 respondents). The sample was determined using the purposive sampling technique. Data were collected through a five-point Likert scale questionnaire and analyzed using SmartPLS 4 with a PLS-SEM approach. The results revealed that psychosocial support (p = 0.000) and anxiety (p = 0.000) had significant effects, whereas perceptions of healthcare facilities (p = 0.102) and self-efficacy (p = 0.266) had no significant influence, either directly or as a moderating variable. In conclusion, the choice of delivery location is more strongly determined by social support and psychological conditions than by facility-related factors or individual self-confidence.

Keywords: anxiety, healthcare facilities, place of delivery, psychosocial support, self-efficacy

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INTRODUCTION

Maternal health is a key indicator of the quality of a country's healthcare system.[1] In Indonesia, the maternal mortality rate (MMR) remains high and poses a significant challenge.[2] The 2020 Population Census reported an MMR of 189 per 100,000 live births, which alarmingly increased to 252 per 100,000 live births according to the 2023 Indonesian Health Survey (SKI).[2] This figure places Indonesia as having the second-highest MMR in ASEAN after Timor Leste, still far from the Sustainable Development Goals (SDGs) target of fewer than 70 per 100,000 live births by 2030.[3]

One primary cause of high MMR is delayed treatment for pregnancy and childbirth complications.[4] The three delays theory identifies that delays may occur in recognizing danger signs and deciding to seek care, reaching a healthcare facility, and receiving appropriate treatment at the facility.[5] According to the Ministry of Health (2022), 31% of delays occur at primary healthcare facilities (FKTP), where referrals are often made only after the mother is in a critical condition. This underscores the need to improve capacity and referral systems at FKTPs.

Data from the Indonesian Ministry of Health (2022) indicates that approximately 31% of delays occur at the first-level health facility, where health workers often refer only after an emergency arises. This highlights a critical need to enhance FKTP capacity and referral systems.

Beyond service system factors, the mental health of pregnant women is an often-overlooked concern. The WHO (2022) reported that 10% to 13% of pregnant women globally experience mental health disorders like anxiety and depression.[6] In Indonesia, 15.2% of pregnant women experience moderate to severe anxiety, which can trigger complications such as gestational hypertension, preeclampsia, preterm birth, and even maternal death.[7] Anxiety is often triggered by unwanted pregnancies, maternal age being too young or too old, and economic pressures.

Unwanted pregnancy itself is a significant issue. The National Population and Family Planning Board (BKKBN) (2022) reported that 17.5% of pregnancies in Indonesia are classified as unwanted.[8] Pregnancies at ages below 20 or above 35 carry a 2–3 times higher risk of complications compared to the ideal age range.[9] Economic hardship, particularly among low-income families, exacerbates the psychological condition of pregnant women and hinders access to optimal healthcare services.[10]

Psychosocial support from husbands, families, and the community plays an essential role in maintaining the mental stability of pregnant women.[11] Emotional, informational, and instrumental support has been shown to reduce anxiety and increase maternal confidence in facing childbirth.[12] However, only about 15% of community health centers (puskesmas) in Indonesia have clinical psychologists (Ministry of Health, 2023), resulting in uneven access to mental health services for pregnant women.[13]

The availability and quality of healthcare facilities also influence mothers' choice of delivery location.[15] Cases of mothers giving birth in vehicles or at home due to delays in reaching facilities or the unavailability of healthcare workers remain common, especially in remote areas.[16] This highlights serious issues in referral systems, infrastructure, and healthcare workforce availability at the primary care level.

The availability and quality of healthcare facilities also influence mothers' choice of delivery location.[15] Cases of mothers giving birth in vehicles or at home due to delays in reaching facilities or the unavailability of healthcare workers remain common, especially in remote areas

Self-efficacy, or a mother's confidence in her ability to manage pregnancy and childbirth, is another important factor. According to Bandura, individuals with high self-efficacy are more confident,

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better able to control anxiety, and more likely to make adaptive decisions.[14] Pregnant women with high self-efficacy are mentally better prepared and more proactive in accessing healthcare services, including choosing a safe delivery location.[15]

Data from the Poasia, Mokoau, and Lepo-lepo community health centers in Kendari City show an increase in the number of women in their third trimester over the past three years: 275 in 2022, 288 in 2023, and 300 in 2024. This upward trend emphasizes the need to monitor and study the factors influencing mothers' choices of delivery location, particularly in areas with high coverage of antenatal services.[16]

Based on these conditions, it can be concluded that maternal decisions regarding delivery location are influenced not only by physical or medical factors but also by psychological and social factors. This study aims to comprehensively analyze the influence of psychosocial support, anxiety, and healthcare facility availability on pregnant women's decisions in choosing delivery locations, with self-efficacy as a moderating variable.

METHODS

This study employed a quantitative approach with a cross-sectional design to analyze the influence of psychosocial support, anxiety, and healthcare facilities on pregnant women's decisions in choosing a place of delivery, with self-efficacy as a moderating variable. Primary data were collected using a structured questionnaire developed based on relevant theoretical indicators.

The study population consisted of all third-trimester pregnant women in the working areas of Poasia, Mokoau, and Lepo-lepo Community Health Centers. Samples were selected using a purposive sampling technique with the following inclusion criteria: gestational age ≥ 28 weeks, registered and actively attending antenatal care, ability to read and write, and willingness to participate as respondents. A total of 100 respondents were determined using the SEM-PLS approach and proportionally distributed across locations, namely Poasia (40 respondents), Mokoau (33 respondents), and Lepo-lepo (27 respondents).

The independent variables in this study were psychosocial support, anxiety, and healthcare facilities, with self-efficacy as the moderating variable and the decision on the place of delivery as the dependent variable. The research instrument was a questionnaire using a five-point Likert scale: 5 = strongly agree, 4 = agree, 3 = neutral, 2 = disagree, and 1 = strongly disagree. For positive statements, scoring was applied directly, while for negative statements, reverse scoring was used.

Data were analyzed using SmartPLS version 4 with the PLS-SEM method, which included evaluation of the outer model (validity and reliability) and the inner model (relationships between variables and moderation effects). The analysis criteria applied were factor loadings > 0.7 and AVE > 0.5.

This study was approved by the Health Research Ethics Committee with Ethical Clearance Number: 522/EC/KEPK/2024. Prior to data collection, all respondents received an informed consent form containing information on the purpose of the study, research procedures, participants' rights to refuse or withdraw at any time, and assurances of data confidentiality. Respondents who agreed and signed the consent form were included in the study.

The research was conducted from September to November 2025 in the working areas of Poasia, Mokoau, and Lepo-lepo Community Health Centers, Kendari City, Indonesia.

RESULT

The majority of third-trimester pregnant women were aged 20–35 years (85%), had a secondary to higher education level, and 50% were housewives. Most were in their first or second pregnancy, indicating limited experience and a greater need for support. A total of 70% lived less than 1 km from a health facility, reflecting good physical access; however, psychosocial

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factors and perceptions of service quality still had a significant influence on the choice of delivery place.

Convergent Validity

Convergent validity assesses the consistency of indicators in measuring the same construct and is considered good if the outer loading value is greater than 0.50. In this study, the test was conducted through outer model analysis using SmartPLS 4 to evaluate the quality of construct measurement (Figure 1).

Table 1. Characteristics of Third-Trimester Pregnant Women Respondents in Poasia, Mokoau, and Lepo-lepo Health Centers, 2024

Variables	Category	n	%
Age Respondents (year)	< 20	5	5%
	20–35	85	85%
	> 35	10	10%
Elementary	Elementary School	5	5%
	Junior high school	15	15%
	Senior high school	45	45%
	Diploma	20	20%
	Bachelor	15	15%
Current Employment or Occupation	Housewife	50	50%
	Government employees	10	10%
	Employee Private	20	20%
	Self-employed	18	18%
	Other	2	2%
Parity	First	40	40%
	Second	35	35%
	Third or more	25	25%
Distance from Home to Nearest Health Facilities	< 1 km	70	70%
	1–5 km	28	28%
	> 5 km	2	2%

Source: Processed data, 2025

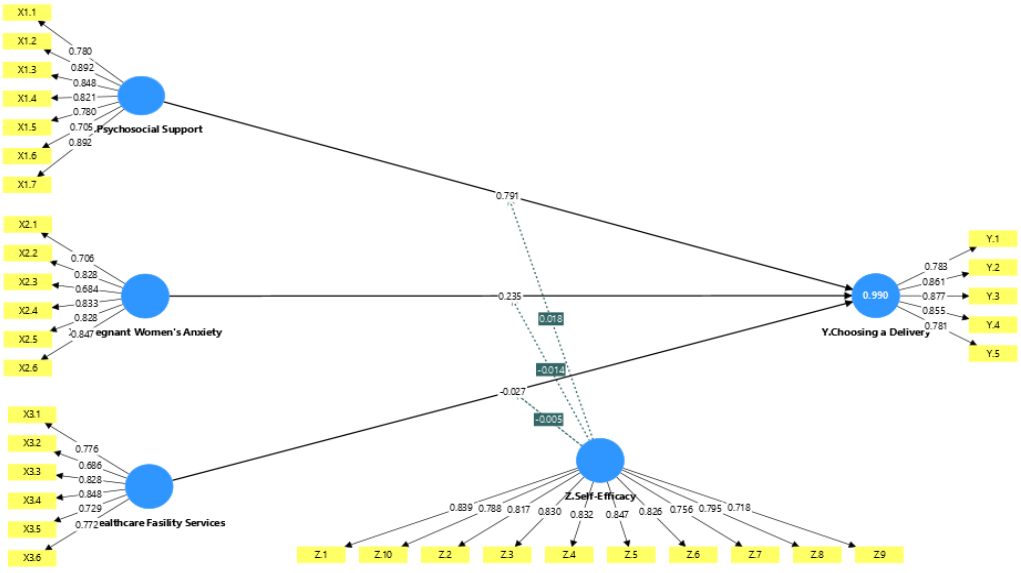

Figure 1. Analysis Using SmartPLS 4

Figure 1 shows that psychosocial support strongly and positively influences delivery decisions (0.791), while pregnant women's anxiety has a negative effect (–0.235). Healthcare facility services have a weak indirect effect through self-efficacy

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(–0.027). Although self-efficacy has a small positive contribution (0.099), its moderating effect is minimal, as indicated by very low interaction coefficients (0.018; –0.014; –0.005). This suggests its role in strengthening the influence of other variables is limited.

Significance Test (*Bootstrapping*)

Hypothesis testing is based on t-statistics and p-values obtained through bootstrapping, which uses repeated sample replication. An alternative hypothesis (Ha) is accepted if the t-statistic exceeds 1.96 and/or the p-value is below 0.05, indicating a significant relationship; otherwise, the null hypothesis (Ho) is accepted.

Table 4. Results of T Statistics

	Original Sample (O)	T Statistics	P Values
X1. Psychosocial Support → Y. Choosing a Delivery	0.791	27,268	0.000
X2. Pregnant Women's Anxiety → Y. Choosing a Delivery	0.235	8.111	0.000
X3. Healthcare Facility Services → Y. Choosing a Delivery	-0.027	1,634	0.102
Z. Self-Efficacy → Y. Choosing a Delivery	-0.018	1.113	0.266
Z × X1 → Y. Choosing a Delivery (Moderation by Self-Efficacy)	0.018	0.432	0.666
Z × X2 → Y. Choosing a Delivery (Moderation by Self-Efficacy)	-0.014	0.301	0.763
Z × X3 → Y. Choosing a Delivery (Moderation by Self-Efficacy)	-0.005	0.365	0.715

Source: Processed data, 2025

Table 4 shows that psychosocial support (0.791; p=.000”) and pregnant women’s anxiety (0.235; p=.000”) significantly influence delivery location decisions, with psychosocial support having the strongest effect. Healthcare facility services (–0.027; p = 0.102) and self-efficacy (–0.018; p = 0.266) show no significant impact. All moderating effects of self-efficacy are also insignificant, indicating that it does not alter the influence of other variables on decision-making.

DISCUSSION

1. Support the Psychosocial for Pregnant Mothers in Choose Place Childbirth Process

This study found that psychosocial support strongly influences pregnant women’s choice of delivery place, with a coefficient of 0.791, T-statistic 27.268, and p-value 0.000, explaining 79.1% of decision variation. Greater support increases the likelihood of choosing safe and affordable facilities. Psychosocial support—emotional, informational, instrumental, and appreciation—reduces anxiety, builds confidence, and serves as a cue to action in the Health Belief Model, reinforcing perceived benefits and lowering barriers to accessing delivery services. This finding aligns with prior research that low social support reduces facility-based births. Emotional companions during pregnancy foster positive birth experiences and greater health service use, underscoring that social support is an essential part of maternal and child healthcare, particularly where access to information and services is limited.[17]

In Indonesia’s communal culture, delivery choices are strongly shaped by husbands, families, and community leaders, highlighting the need for maternal health programs to involve these networks in education and counseling. Strengthening social capacity through prenatal classes, home visits, health cadres, and community leaders can complement structural supports like Jampersal and BPJS, fostering collective behaviors that encourage safe, facility-based childbirth.

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2. Anxiety Pregnant Women to Decision Pregnant Women in Choosing the Place of Childbirth

The analysis reveals that maternal anxiety significantly affects delivery place decisions (coef. = 0.235, T = 8.111, p = 0.000), explaining 23.5% of variation. Although weaker than psychosocial support, anxiety remains influential, shaped by perceptions of childbirth risks. Depending on its source, anxiety can either encourage facility-based deliveries or push mothers toward home births and traditional attendants. Prior studies confirm that high anxiety may lead to elective procedures or avoidance of hospitals, with social, cultural, and informational factors amplifying these effects, particularly in rural areas.[18]

Anxiety affects not only the choice of delivery location but also pregnancy complications, pain perception during labor, and satisfaction with care. Integrating psychological support into antenatal services is therefore essential. This can be achieved through prenatal classes, support groups, partner involvement, and improved health communication. Such interventions enhance maternal mental health, reduce anxiety, and encourage safer and more planned childbirth decisions.

From a policy standpoint, integrating mental health services into maternal healthcare is critical. Routine anxiety screening during antenatal care would allow early detection and intervention. Strengthening psychosocial support through community health workers, education programs, and culturally appropriate strategies can address anxiety effectively. These findings underscore the need for maternal health programs to address both the physical and emotional well-being of mothers. Further research is needed to identify the most prevalent types of anxiety and the most effective intervention strategies in diverse cultural contexts across Indonesia.

3. Facility Service Health to the Decision Pregnant Women in Choosing a Place of Childbirth

Path analysis showed that health service facilities (X3) had no significant effect on delivery location decisions (coefficient 0.027, T = 1.634, p = 0.102). This indicates that perceptions of facilities do not significantly influence childbirth choices, contrary to common assumptions. The slight negative coefficient suggests that better facility perceptions do not always translate into their use, with social or emotional factors playing a stronger role. In line with Andersen's Behavioral Model, facilities as "enabling factors" appear less influential here than personal and social determinants.

A possible explanation is that physical facilities alone are insufficient if not paired with positive interpersonal experiences. Even well-equipped and clean facilities may be overlooked if service quality, such as communication, privacy, or staff friendliness, is lacking. In rural areas, where infrastructure is often limited, mothers may place higher value on proximity, familiarity, and trust in traditional birth attendants rather than physical amenities.

These findings align with other research showing that delivery location preferences are often shaped more by cultural values, community recommendations, and prior personal experiences than by objective assessments of facility quality. This suggests that improving service infrastructure without addressing patient perceptions and experiences may have a limited impact. A holistic approach that includes empathy, respect, and patient-centered care is essential.[19]

Policy implications include the need for targeted education to increase awareness of the importance of medical facilities for safe childbirth. Antenatal classes and counseling should emphasize the role of standardized services in reducing delivery risks. Overall, health service facilities are not a

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dominant factor in this study's context, highlighting the importance of improving not just physical infrastructure, but also the relational and cultural aspects of care. Further research should explore which facility attributes most influence maternal decision-making.

4. Self-efficacy towards Decision-Making for a Pregnant Mother to Choose a Place of Childbirth

The path analysis results show that the self-efficacy variable (Z) does not have a significant influence on pregnant women's decisions regarding the place of delivery (Y). This is indicated by a coefficient value of 0.018, a T-statistic of 1.113 (below the critical value of 1.96), and a p-value of 0.266, which is well above the 0.05 significance threshold. Statistically, this means there is no convincing relationship between pregnant women's self-confidence and their choice of delivery location.

The negative coefficient of – 0.018 suggests a very weak and insignificant relationship, both practically and theoretically, between self-efficacy and delivery location choice. In the context of this study, higher self-efficacy does not necessarily encourage pregnant women to choose a particular delivery place, and it may not influence at all. This finding is notable, as Bandura's self-efficacy theory states that individuals with high confidence in their abilities tend to make more rational and focused decisions. In many health studies, self-efficacy is linked to positive medical decision-making behaviors, including during pregnancy. However, the present results deviate from these theoretical expectations.

One possible explanation is that, in many communities, especially in Indonesia, the decision of where to give birth is often not solely in the hands of the pregnant woman. Decisions are frequently shaped by the husband, parents, community leaders, or local customs, meaning that individual self-confidence may not be strong enough to determine the final choice. In some cases, women with high self-efficacy may even feel more capable of giving birth outside health facilities if they believe in their natural ability to do so, potentially explaining the slightly negative coefficient. They may feel confident in their physical strength without the need for medical intervention, which in certain contexts can lead to non-health facility choices.

Previous studies have produced mixed findings. For instance, one study found that high self-efficacy encourages mothers to better prepare for childbirth and more often choose medical facilities. Conversely, another study revealed that decisions on delivery location are more influenced by access, cost, and perceived service quality than by individual self-efficacy. In this context, other variables such as social support, anxiety, and prior experiences seem to play a more dominant role. Therefore, public health interventions that focus solely on improving self-efficacy, without accounting for social and cultural contexts, are unlikely to be effective. Education and counseling programs should involve husbands, families, and community leaders so that delivery decisions can be made collectively, but still based on accurate health information.[20]

These findings highlight the need for a holistic approach to supporting pregnant women. While personal empowerment remains important, the social environment and access to health services must also be strengthened to support maternal decision-making. Public policies that promote multi-stakeholder involvement in pregnancy and childbirth support are essential to addressing these complexities. In conclusion, this study finds that self-efficacy does not significantly influence pregnant women's choice of delivery location, suggesting that stronger social and structural factors drive these decisions. Further research is needed to explore the role of self-efficacy alongside

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other mediating variables that may shape maternal health behaviors.

5. Self-Efficacy Moderates The Influence of Support Psychosocial to the Decision Pregnant Women in Choose Place of Childbirth

The analysis results indicate that self-efficacy does not moderate the relationship between psychosocial support and pregnant women's decisions in choosing a place of delivery. This is reflected by the very small interaction coefficient (0.018), a T-statistic of 0.432 well below the critical value of 1.96, and a p-value of 0.666, exceeding the 0.05 significance threshold. Statistically, this means self-efficacy neither strengthens nor weakens the influence of psychosocial support on delivery location decisions.

Theoretically, women with higher self-efficacy were expected to respond more effectively to psychosocial support in choosing delivery locations. However, findings show that psychosocial support influences decisions independently of self-confidence. The negligible interaction coefficient indicates that social support is a strong direct predictor, especially in collectivistic cultures like Indonesia, where family and community norms often override individual factors. Prior studies also suggest that while self-efficacy may moderate decisions in individualistic contexts, in socially driven settings such as childbirth choices in Indonesia, even confident women defer to family or health workers, making social support a stand-alone determinant.[21]

From a practical perspective, these findings suggest that interventions to promote the use of health facilities for childbirth should focus on strengthening direct social support rather than relying on changes in individual self-efficacy. Education programs, maternal health campaigns, and prenatal classes should be community- and family-oriented. Increasing self-efficacy alone is unlikely to have a meaningful impact unless accompanied by robust social support networks. Counseling should therefore actively involve partners, family members, and community leaders.

Methodologically, the high p-value also suggests that the moderating effect of self-efficacy is weak and inconsistent in this population. Future research could investigate other potential moderators, such as education level, access to health information, or previous childbirth experience, that might more significantly alter the influence of psychosocial support. Overall, this study confirms that in collectivistic, community-based contexts, social factors play a more dominant and independent role than individual psychological traits in shaping pregnant women's health decisions.

6. Self-Efficacy Moderates The Influence of Anxiety on Pregnant Women's Decision Pregnant Women in Choose a Place of Childbirth

The study found that self-efficacy does not moderate the relationship between maternal anxiety and pregnant women's decisions regarding the place of delivery. This is evidenced by an interaction coefficient of -0.014, a T-statistic of 0.301, and a p-value of 0.763, which is far above the 0.05 significance threshold. Statistically, this indicates that the interaction between self-efficacy and anxiety has no significant effect on delivery location decisions.

Theoretically, self-efficacy is expected to mitigate the negative effects of anxiety, as individuals who believe in their abilities tend to manage stress more effectively and make rational decisions. However, these findings suggest that a mother's self-confidence is insufficient to neutralize the impact of anxiety on childbirth decisions. The negative interaction coefficient implies that higher self-efficacy slightly reduces the influence of anxiety, though the effect is negligible and not significant. Thus, high self-confidence does not necessarily weaken the role of anxiety in determining where to give birth.

Literature indicates that self-efficacy as a moderator is effective mainly when

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individuals have substantial control over a situation. In the context of childbirth, decision-making often lies beyond personal control due to social pressure, limited access, and family influence. This aligns with Bandura's view that self-efficacy's impact depends heavily on social and structural contexts. Differences from prior studies showing stronger moderating effects may be attributed to cultural and situational variations, particularly in Indonesia, where childbirth decisions remain strongly influenced by family norms and traditions.[22]

In developing countries, environmental and social factors often outweigh personal psychological influences such as self-efficacy in maternal and child health decisions. This suggests that reducing childbirth-related anxiety should involve addressing both internal and external stressors. Common anxieties, such as fear of pain, complications, or death, cannot be alleviated through self-confidence alone. Holistic strategies should integrate education, family support, and strengthened health worker involvement to create a more supportive environment for mothers.

The practical implication is that psychosocial interventions should not rely solely on boosting self-efficacy but must also target external sources of maternal anxiety. Approaches could include enhanced communication between mothers and healthcare providers, family counseling, and ensuring access to safe and affordable maternity services. Future research should examine other possible moderators, such as partner support, previous childbirth experiences, or maternal knowledge, that may be more effective in influencing the relationship between anxiety and delivery decisions. In the Indonesian context, community-based approaches and strong external support remain key to fostering safer and more informed childbirth choices.

7. Self-Efficacy Moderates The Influence of Facility Service Health On The Decision That Pregnant Women In Choose A Place Of Childbirth

The study found that self-efficacy does not significantly moderate the relationship between perceptions of healthcare facilities and pregnant women's delivery decisions (interaction coefficient = -0.005; T = 0.365; p = 0.715). This indicates no evidence that self-efficacy strengthens or weakens the influence of perceived facility quality. The near-zero coefficient suggests that regardless of a mother's self-efficacy level, her decision remains primarily determined by facility characteristics such as equipment, comfort, and staff availability. Although self-efficacy theoretically supports confident decision-making, in this context, it does not significantly shape responses to facility perceptions.

These findings are consistent with research in developing countries showing that childbirth decisions are driven more by objective facility factors such as access, cost, and availability than by internal psychological traits like self-efficacy. Material constraints cannot be overcome by confidence alone. Other studies also note that mothers' choices are often shaped by prior experiences, community recommendations, and facility reputation, rather than by personal decisiveness. As a result, self-efficacy plays only a minimal moderating role in this relationship.[23]

The limited effect of self-efficacy may also be explained by external constraints that reduce women's autonomy in choosing facilities. Economic, geographic, and cultural factors often restrict available options. In patriarchal settings such as much of Indonesia, childbirth location is often decided collectively by family members, particularly husbands, in-laws, or community leaders reducing the influence of both individual facility perceptions and personal self-efficacy.

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Even confident mothers may have little control over the final decision.

The practical implication is that efforts to enhance maternal self-efficacy alone will not be sufficient unless paired with tangible improvements in the quality and accessibility of health facilities. Policymakers and health providers must ensure that facilities meet high standards and are accessible to all, enabling positive perceptions to meaningfully influence decisions. Given the minimal moderating role of self-efficacy, community-based programs, strengthened primary care systems, and family-focused counseling remain more relevant strategies for increasing the utilization of safe and professional delivery services.

The study found that self-efficacy does not significantly moderate the relationship between perceptions of health facilities and pregnant women's delivery decisions (interaction coefficient -0.005; T = 0.365; p = 0.715). This suggests that regardless of self-efficacy level, decisions are primarily influenced by facility characteristics such as equipment, comfort, and skilled personnel. Consistent with findings from developing countries, childbirth choices are shaped more by access, cost, prior experiences, and community influence than by psychological traits. The limited role of self-efficacy is further explained by external constraints—economic, geographic, and cultural—that reduce women's autonomy, particularly in patriarchal contexts where husbands, in-laws, or community leaders often dominate decision-making.

The practical implication is that efforts to enhance maternal self-efficacy alone will not be sufficient unless paired with tangible improvements in the quality and accessibility of health facilities. Policymakers and health providers must ensure that facilities meet high standards and are accessible to all, enabling positive perceptions to meaningfully influence decisions. Given the minimal moderating role of self-efficacy, community-based programs, strengthened primary care systems, and family-focused counseling remain more relevant strategies for increasing the utilization of safe and professional delivery services.

Limitations of the Study

This study has several limitations that should be considered when interpreting the findings. First, the sample size was relatively small, consisting of only 100 respondents, which may limit the generalizability of the results to pregnant women in Kendari City and across Indonesia. Second, the study area was restricted to three community health centers—Poasia, Mokoau, and Lepo-lepo—therefore the findings should be generalized with caution, particularly to regions with different social, cultural, and healthcare access characteristics. Third, the cross-sectional design only captured relationships between variables at a single point in time, making it unable to explain the dynamic changes in psychological states or decision-making processes from pregnancy to childbirth. Finally, the study focused only on psychosocial support, anxiety, healthcare facilities, and self-efficacy. Other potentially influential factors, such as socioeconomic status, education level, cultural norms, prior childbirth experiences, and interactions with healthcare providers, were not included, even though they may significantly shape pregnant women's decisions regarding delivery location.

Recommendations for Future Research

Future studies should expand sample size and diversity to improve representativeness and generalizability. Multi-site research across different geographic, social, cultural, and healthcare contexts is needed for a broader perspective. Longitudinal designs are recommended to track psychological states, social support, and facility perceptions from pregnancy through childbirth, offering stronger causal insights. Additional variables—

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such as culture, socioeconomic status, prior birth experiences, provider interactions, and media exposure—should be considered. A mixed-methods approach combining quantitative data with qualitative insights (e.g., interviews or FGDs) would further enrich understanding of women's decisions on delivery location.

CONCLUSION

The analysis concludes that psychosocial support and maternal anxiety are the most influential factors in pregnant women's decisions on choosing a place of delivery, with psychosocial support showing the strongest effect (coefficient 0.791, p = 0.000) and anxiety also significant (coefficient 0.235, p = 0.000). Health care facilities, despite their importance for safety and comfort, did not significantly affect decision-making (p = 0.102), and self-efficacy neither directly influenced decisions (coefficient -0.018, p = 0.266) nor moderated the effects of psychosocial support, anxiety, or health facility perceptions. Overall, decisions were more strongly shaped by social and emotional factors than by perceptions of facilities or personal self-confidence.

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