Original Article

Factors Influencing Home Deliveries in Kerala: A Focused Ethnographic Study in Malappuram District

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Abstract

Introduction: The main objective of this study is to understand the factors that influence home deliveries in Kerala, particularly in regions where institutional care is widely accessible but underutilised.

Materials and methods: A focused ethnographic approach was used in this study. Participants were selected using the information obtained from the health department. In-depth interviews were held with the women who had home deliveries in the past three years. Key informant interviews were conducted with stakeholders and focus group discussions were used for ASHAs and Anganwadi workers.

Results: Traditional beliefs, peer influences, patriarchal decision-making, shyness and embarrassment, fear of hospitals, media exploitation, along with the availability of traditional birth attendants and encouragement from certain unqualified professionals all contribute to home deliveries.

Conclusions: There is a need to encourage community participation and create and implement policies to protect the rights of mothers and their unborn children. This will help in ensuring safe delivery and delivery practices.

Key words: Home deliveries, Traditional birth attendants, Women's autonomy, Kerala

Introduction

The measures adopted for achieving SDG 3 and the Global Strategy for Women, Children, and Adolescent Health (2016-2030) and also the framework for Ending Preventable Maternal Mortality (2015-2030) are helping to increase "the proportion of births attended by skilled health personnel (SDG indicator 3.1.2)[1-3]. Despite such initiatives, studies show that in middle- and low-income countries, many home deliveries happen without a skilled health worker[4]. India's Reproductive, Maternal, Newborn, Child, and Adolescent (RMNCH+A) strategy by the Ministry of Health and Family Welfare provides a comprehensive approach to child survival and safe motherhood, and it also ensures 'continuum care'[5]. For one third of India's population, consisting of women and preschool children, "any neglect or delay

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in care can adversely affect the wanted outcome"[6]. Despite the initiation of Janani Suraksha Yojana (JSY) in 2005, a conditional cash transfer program (CCT) under the National Health Mission by the Government of India aimed at reducing maternal mortality rates through the promotion of institutional deliveries, a substantial number of deliveries continue to take place at home in India[7]. According to the Health Management Information System (HMIS), 1,067,470 home deliveries were reported in 2020-21 and 922,637 in 2021-22[8]. In many places women still preferred home for delivery due to a lack of skilled birth attendants, especially at the grassroots level[9]. Seeking and access to health care by women influenced by several other factors in India, such as household socioeconomic status, geographic regions, education level, inadequate health facilities, cultural and traditional factors, household dynamics etc[10-13]. Even though the government launched certain programs to tackle the out-of-pocket expenditure (OOPE) such as Janani Shishu Suraksha Karyakram (JSSK), we are still trailing behind.

According to 'Gender Statistics in Kerala,' a report prepared by the Department of Economics and Statistics, Kerala witnessed 740 home deliveries during the year 2017-2018, and this report shows that the prevalence of home deliveries was higher in Malappuram district compared to other districts, and Malappuram topped the chart (with 254), followed by Wayanad (151 cases)[14]. Unravelling the factors and understanding the dynamics behind the phenomenon would have profound significance for the improvement of the RMNCH+A Strategy and for the policy as well.

The broad objective of the study is to identify the factors influencing home deliveries in Kerala and also assess the accessibility and utilisation of comprehensive antenatal, postnatal, and neonatal care for mother and child with the purpose of specifically exploring their role in this phenomenon.

Methodology

Study design and setting

A qualitative study using a focused ethnographic approach was conducted in the Thanalur Panchayath, Malappuram district, Kerala covering women and stakeholders in relation to home deliveries.

Study population and sample size

Women who had delivered at home and willing to participate were included in the study. Participants were selected purposively based on the information regarding home deliveries obtained from the ASHAs. Apart from the women, key informants as stakeholders were also interviewed. They include doctors and health workers, ASHA workers from the Family Health Centre, elected representatives, Anganwadi workers, ICDS supervisors, and CDPO (Child Development Project Officer).In total, 42 in-depth interviews were conducted with the participants in addition to informal conversations with a number of women, and 10 key informant interviews. Apart from this, focus group discussions were held with 20 ASHAs and 14 Anganwadi workers.

Data collection

The fieldwork was undertaken from August to November 2024 after obtaining permission from the District Medical Officer (DMO) Malappuram. In-depth interviews and conversations with the women and key informant interviews were conducted on a one-to-one basis using an interview guide. Such a focused approach helped in finding out the factors which influence home deliveries. Apart from this, we also conducted focus group discussions with female health workers and anganwadi workers. Verbal informed consent was obtained before the interviews. House-to-house interviews were carried out in Malayalam (the local language) by the principal investigator.

Data analysis

Thematic analysis was used after transcription and translation. Data was analysed manually, and the JBI critical appraisal checklist for qualitative research was used to find the congruence between research objectives and the findings[15].

Ethical clearance and consent to participate

The protocol was submitted to the Institutional Ethics Committee of Ananthapuri Hospitals and Research Institute for approval and ethical clearance obtained from the IEC (IEC NUMBER: AHRI/EC/206/Jan2024).

Consent was obtained before the interviews. Study objectives were clearly explained to the participants, and the interview schedules were filled without any identifier of the participants. No compulsion was there for the respondents to participate in this study. The prevailing pattern in Malappuram indicated that home deliveries were occurring in specific areas, known to everyone. Health workers routinely visit the area and interact with them, and we visited the houses in that area with their help, ensuring minimal risk for the respondent.

Results

Four major themes developed from the analysis include: (1) socio-demographic factors, (2) psychosocial factors, (3) socio-cultural factors, and (4) health system factors.

1 Socio-demographic factors

1.1 Area of living

Majority of the women who gave birth at home live in the same neighbourhood which may also influence future mothers to continue this tendency. Some women are hesitant to contact the outside world beyond their immediate family or neighbours and living in such a location would lead to continuing such a trend.

1.2 Age and parity

Women gained confidence for home delivery after multiple deliveries and an increase in age. In some areas, multiparous women prefer home delivery. But surprisingly, many primiparous women also choose home to give birth to their child.

Many factors, such as socioeconomic status, education, and caste, which are often reported to influence home deliveries in other studies, do not appear to have any significant relevance in our context.

2. Socio-cultural factors

2.1 Traditional beliefs

Some people believe in traditional constraints, conservative views, and strict norms to uphold their beliefs.

"A native mother travelled from a developed foreign country to give birth to her baby at home, then returned. Two years later, she arrived for another home delivery. She had strong convictions, but she received all immunizations and visited the hospital as needed." (ASHA worker, FGD)

2.2 Gender hierarchy and autonomy in decision-making

Autonomy is regarded as critical for decision-making especially for selecting, seeking, and using health care services.

"When I was taking a gender class at *Devdhar School, one girl presented her thoughts on how a girl should behave. That incident made me realise that patriarchal society has an impact on the younger generation as well. We had an argument there, and I tried to convey the myths and misconceptions instilled by her family members, but she refused to accept them. Look, even in the modern era, these types of people influence and oppress the growing younger generation. This would always have an impact on home delivery, vaccine resistance, and seeking medical treatment."* (Elected representative, retired teacher)

2.2.1 Decision-making power in accessing health care

Females are suppressed in many houses. In some households, women suffered as a result but the majority of them did not consider it as a major issue.

"In some houses women are not permitted to leave their house alone. If they wish to travel somewhere, they will accompany their spouse. Father is the leader of the house, and he makes the decision, which everyone follows." (Anganwadi worker, FGD)

2.2.2 Decision-making power regarding choice of place of delivery

Some women can select where they give birth, but majority do not. Main decision-makers are fathers.

"My father makes decisions regarding me. I will not say a single word against him. My second child died five hours after I gave birth. He has bluish discolouration all over the body; we attempted to save him. But it was his fate."(36-year-old woman, IDI).

3. Psychosocial factors

3.1 Shyness and embarrassment

Many women reported feeling shy and embarrassed during their institutional deliveries which further led them to choose home deliveries. Women faced lack of privacy and discomfort in many health care settings. This conflicted with their cultural beliefs, encouraging women to deliver at home where they feel more comfortable.

"Why should I expose my body to someone who is completely unfamiliar to me? Even during pregnancy, the ossathi (Traditional Birth Attendant) would almost cover my body and arrange curtains to cover any exposed areas." (23 years old, IDI)

3.2 Peer influence

Another key factor for this trend is peer group impacts. The information concerning home delivery was passed down from one individual to another. Influence from friends and families contributed to home deliveries.

"My school friends shared their home delivery experiences in our WhatsApp group. They recommended and encouraged me to perform delivery at home." (21 years old, primiparous, IDI)

3.3 Fear of hospitals

The fear of hospitals and fear created as a result of wrong knowledge led them to give birth at home. The women feared being alone as well as undergoing surgery. Many women want to give birth without medical interventions such as pain medication, labour induction, forceps, or other types of equipment.

4. Health system factors

4.1 Disrespect

Some women at both public and private facilities stated unhappiness with the level of interpersonal care provided, particularly with the contempt shown by nurses and other health providers. Many women reported being scolded and shouted at. Some of them discussed the non-consented care they had received from the previous deliveries. The repeated per vaginal examinations without consent made them uneasy about institutional delivery. A few of them also reported neglect by health staffs during institutional deliveries. Women who delivered at home explained that the presence of family members such as the women's mother and husband is vital because their closeness provides psychological support.

4.2 Lack of trust in health system and no antenatal care visits

None of the mothers visited the antenatal care clinic at least once. Some of them took supplements like iron and folic acid from ASHAs. However, they were not ready to visit the subcentre. A few of them took vaccination after many rounds of counselling. One health staff revealed:

"Many of them refused to inform us about their pregnancy. In many situations, we learnt only after five or six months. As a result, it is quite difficult for us to offer them counselling, routine check-ups, supplements, and vaccination." (Health care provider)

Majority of the providers suggested that unqualified personnel from different backgrounds, including alternative practitioners and quacks, facilitate home delivery and they mislead the people and nurture an anti-institutional attitude in the society along with the availability of traditional birth attendants who promote home deliveries. They propagated that delivery should be conducted in a natural way.

"Our ancestors gave birth to their children at home. Then why should we go to the hospital? Either it is a hospital or it is home; we must go through the same pain and must take the same effort; then why should we choose a hospital instead of a home?"(25 years old, IDI)

4.3 Mass media exposure

The younger generation in Thanalur who use social media blindly lacks trust in institutional delivery due to misleading information. According to information gathered from health workers, there are WhatsApp groups to propagate anti-institutional sentiments.

"I have seen a lot of home birth videos on YouTube. When I read the comments below the videos, I understood that delivering a baby in a tranquil environment like home provides more comfort than a hospital."(19 years old, IDI)

Discussion

Despite significant advancements in maternal healthcare, many women in our study area still opt—or are compelled—to give birth at home. Our study undertaken in Thanalur Panchayath in Malappuram District shows that there are several factors that sustain such a practice despite the availability, accessibility, and affordability of care.

Our study findings indicate that the traditional beliefs do contribute to home deliveries. In India, a qualitative study conducted in rural Meghalaya stated that the prevailing traditional beliefs, along with superstitious concepts, contribute to home deliveries[10].

We found that shyness and embarrassment are other important factors that lead to home deliveries among pregnant women. A study conducted in Delhi revealed that women felt embarrassed and uneasy being around unfamiliar people during such a vulnerable moment. The lack of privacy, along with the absence of a family member for support in the institutional setting, contrasted with the safe and secure environment they had at home during childbirth[16]. Fear also influences the choice of delivery. A study conducted in Vadodara, Gujarat, finds that the fear of being alone in unfamiliar surroundings and the fear of surgical interventions influence women to deliver their babies at home[11].

A distinct factor that leads to home deliveries observed in Thanalur is peer influence. While other studies have shown that familial influence leads to home deliveries, in Thanalur, the influence of peer groups, particularly school friends, also plays a significant role. This peer influence is a new factor contributing to the decision to opt for such a method. Many studies have found that familial influence and sometimes familial pressure play a role in pregnant women choosing home deliveries. A situational analysis from urban slums in Delhi revealed that mothers and family members who played a significant role in decision-making commonly preferred home births. They observed that their relatives had experienced positive outcomes with home deliveries[16].

Mothers with higher parity are more likely to choose home deliveries because they develop confidence to give birth at home from the previous delivery, and therefore they perceive delivery as a normal process[12]. However, in our study, many younger primiparous women preferred home deliveries. Mothers in Thanalur living in the same geographical area and locations showed a higher tendency to give birth at home. This could be due to the exchange of information and other societal factors. Area of residence could also be an influencing factor in the choice of the delivery place, particularly between rural and urban settings. A national survey in India found that women living in rural areas were more likely to deliver at home[12].

None of the women who give birth at home visited subcentres for antenatal care clinics. One of the studies conducted in India found that women who attend more than three antenatal care clinics were likely to deliver at an institution compared to women who did not attend antenatal care clinics or women who attended less than three antenatal care visits[11].

Our study found that disrespect, including non-consented care, verbal abuse, prior experiences, and breaches of physical privacy, intimidated women from opting for institutional delivery. A study conducted in rural Uttar Pradesh reported experiences of women being shouted at, verbally abused, and discriminated against based on their societal status[13]. These findings align with existing literature on mistreatment and disrespectful care, providing additional evidence that such experiences, both those prior personal experiences and experiences of others, significantly influence women's decision-making and deter them from seeking care at facilities with skilled birth attendants [13]. Many studies in different settings mentioned about the disrespect and abuse during health facility-based delivery[17-19].

Another significant trend observed in Thanalur is the growing lack of trust in the healthcare system which has fuelled an anti-hospital attitude among many villagers. This mistrust leads them to rely on individuals without formal qualifications in alternative medicine who often spread false information. Increasing negative news about institutional care deepens the mistrust in the healthcare system, particularly among younger generations. This growing scepticism discourages

them from considering institutional delivery and healthcare services.

Our study found that decision-making authority varied across households but the majority were male-dominated. One of the studies from Uttar Pradesh highlights that male involvement is also a crucial factor for enhancing the overall use of RCH and Integrated Child Development Services (ICDS)[20]. Studies have consistently shown that women with access to mass media are significantly more likely to opt for institutional deliveries [12]. However, the positive influence of social media or mass media is not seen in our study. Women, especially the younger generation, blindly rely on the misinformation that circulates through social media, which further exacerbates the situation and results in more people adopting an anti-institutional behaviour. Additionally, patriarchal societal norms often restrict women's access to social and mass media, limiting their exposure to healthcare and their rights. This restriction perpetuates ignorance and prevents women from seeking timely and appropriate healthcare services.

Strengths and limitations

One of the major strengths of the study is that it is one of the unique studies that document the factors that contribute to the prevalence of home deliveries in Kerala. The findings help in getting a deeper insight into this growing trend by examining participants' views, experiences, and practices. It was indeed difficult to complete such a study in the present socio-cultural context in the district and it might require more innovative approaches to undertake a study based on implementation research methodology which could be useful.

Conclusions

It is important to identify the unqualified individuals behind these malpractices and it is necessary to educate women about the complications of such malpractices and to empower them with knowledge about their rights to bodily autonomy and help them to make informed decisions regarding their health and childbirth. Health care must ensure a safe and comfortable environment that respects women's dignity. Promoting accurate health information through trusted digital platforms and through other media with the help of community influencers or leaders is essential for community mobilisation. Policymakers must recognise the rights of mothers and their unborn children in Kerala which include strict regulations that must be enforced to prevent unqualified individuals from conducting unsafe practices.

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Conflicts of interest: Nil

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