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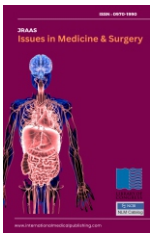

Research Article

Section: Public Health & Medical Education

A Community-Driven Analysis of Home Delivery Preference among Tribal Families in Bhimpur Block, Madhya Pradesh

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HIGHLIGHTS

- Home delivery remains prevalent.
- Cultural traditions influence childbirth.
- Trust in traditional attendants.
- Elders dominate delivery decisions.
- Decentralized culturally responsive interventions.

Key Words:
Home delivery
Tribal communities
Institutional delivery
Elder decision-making
Maternal health
Bhimpur Block
Traditional birth attendants

ABSTRACT

Introduction: Despite the expansion of institutional maternal health services in India, home delivery remains prevalent among tribal communities. Socio-cultural traditions, geographical isolation, economic constraints, and trust in traditional birth attendants continue to influence childbirth practices. Understanding these factors is essential for designing culturally responsive maternal health interventions. **Aim & Objectives:** The study aimed to analyze the socio-cultural, geographical, economic, and trust-based factors influencing the preference for home delivery among tribal communities in the Bhimpur Block of Betul district, Madhya Pradesh. The objectives included assessing awareness of government maternal health schemes, access to health facilities, and the role of elders and traditional dais in childbirth decision-making. **Materials & Methods:** A cross-sectional descriptive study design was adopted. Purposive sampling was used to select 200 tribal elders from the villages of Guruwa, Pipariya, and Kasmarkhandi. Data was collected through face-to-face interviews using structured and semi-structured questionnaires. Descriptive statistics were employed for quantitative analysis, while thematic analysis was used for qualitative responses. **Results:** The findings revealed that 66% of respondents preferred home delivery. Cultural practices significantly influenced this preference (66%), along with a high level of trust in traditional dais (81%). Elders played a dominant role in childbirth decisions (90%). Awareness of ambulance services (82%) and the Janani Suraksha Yojana (64%) was moderate; however, only 29% were aware of a nearby delivery facility, and 61% perceived health facilities as geographically distant. **Conclusion:** The study concludes that the preference for home delivery is shaped by deeply rooted cultural norms, financial insecurity, limited accessibility, and trust-based relationships rather than mere personal choice. Culturally sensitive, decentralized maternal health strategies are essential to improve institutional delivery uptake in tribal regions.

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INTRODUCTION

Home delivery, defined as childbirth occurring outside formal health facilities and typically assisted by traditional birth attendants or family members, remains common among many tribal communities in developing countries [1,23]. Despite improvements in maternal and child healthcare infrastructure, institutional delivery rates among tribal populations continue to lag behind national averages [7,26]. This persistent preference for home delivery reflects a complex interaction of cultural beliefs, social organization, accessibility barriers, economic constraints, and reliance on traditional care systems rather than a single determining factor [11,23].

A community-based perspective places tribal families at the center of analysis, recognizing them as active decision-makers shaped by collective knowledge, lived experience, and entrenched social norms [23]. Cultural beliefs and value systems play a central role in sustaining home delivery practices. Pregnancy and childbirth are often perceived as natural life events rather than medical conditions requiring institutional management [4]. Many tribal groups maintain childbirth rituals, dietary rules, and postnatal practices that are difficult to observe within hospital settings [3].

Traditional birth attendants, usually elderly women with experience passed down through generations, are trusted community figures who provide emotional reassurance, spiritual support, and personalized care [15,23]. Their role extends beyond delivery assistance to reinforcing cultural identity and community cohesion. In contrast, health facilities may be perceived as unfamiliar, impersonal, or culturally alien, intensifying fears related to medical procedures and unfamiliar equipment, which further reinforces preference for home births [6,14].

Geographical isolation and limited physical access to health institutions strongly influence delivery preferences in tribal regions. Settlements are often located in remote, hilly, forested, or poorly serviced areas with inadequate road connectivity and unreliable transport [11,21]. Seasonal barriers such as monsoon rains, flooding, forest routes, and river crossings further compound access difficulties [21]. In the absence of emergency transport, home delivery often becomes a necessity rather than a choice [11,12].

Economic vulnerability constitutes another major determinant of delivery choice. Even where free maternal healthcare services exist, hidden costs related to transportation, medications, food, accommodation, and loss of wages discourage institutional delivery [1,18]. For households dependent on daily wage labor or subsistence livelihoods, home delivery is perceived as economically predictable and less disruptive [16,17].

Trust in the healthcare system critically shapes delivery decisions. Historical experiences of discrimination, language barriers, lack of cultural sensitivity, and fear of disrespectful behavior contribute to mistrust of formal health facilities [6,7]. Women may fear isolation, unwanted medical interventions, or inadequate communication during childbirth [14,15]. Conversely, traditional birth attendants share language, values, and belief systems with the community, fostering emotional safety and trust [23,25].

Gender relations and household decision-making structures further influence delivery preferences. In many tribal societies, decisions regarding place of delivery are made by husbands, elders, or mothers-in-law rather than pregnant women themselves [5,26]. Limited female autonomy, lower literacy levels, and restricted mobility further constrain women's ability to seek institutional care independently [5].

Government initiatives such as Janani Suraksha Yojana, mobile health units, and community health workers have sought to promote institutional deliveries among tribal populations [3,18]. However, their impact remains uneven due to top-down approaches that often overlook local realities [8,9]. Community-driven strategies, including culturally adapted birthing facilities, integration of traditional birth attendants into referral systems, and recruitment of tribal women as healthcare providers, have been suggested as more sustainable approaches [13].

Despite extensive literature identifying cultural beliefs, economic constraints, limited access, and gendered decision-making as determinants of home delivery, critical gaps remain. Most studies rely on large-scale surveys or facility-based data and focus primarily on women, overlooking the decisive role of elders, traditional authority structures, and localized environmental barriers [11,24]. Empirical research examining trust-based interactions between traditional dais, ASHAs, and formal healthcare providers at the village level is limited [2,13]. This study addresses these gaps through an elder-based, village-level, trust-oriented analysis of home delivery practices in the tribal setting of Bhimpur Block.

Research Objectives

- To explore and understand the perceptions, beliefs and decision-making patterns of elder community members regarding home versus institutional deliveries in the tribal-dominated villages of Guruwa, Pipariya and Kasmarkhandi in the Chillior of Bhimpur Block, Betual district.
- To identify the sociocultural and behavioural determinants that contributes to the continued preference for home deliveries in the study area.
- To assess the influence of geographical challenges, settlement patterns and infrastructural limitations on the accessibility and utilization of institutional delivery services.
- To evaluate community awareness and perceptions regarding available health services, including 108 ambulance services, ASHA/ANM support and government maternal health schemes.
- To document the level of trust placed in traditional birth attendants, ASHAs and formal healthcare providers during childbirth.

- To gather suggestions from community elders on feasible and culturally acceptable interventions to improve institutional delivery uptake in tribal settings. delivery uptake in tribal settings.

MATERIAL & METHODS

The study design in the study is descriptive cross-sectional, which was used to measure the sociocultural, behavioral, and geographical determinants of home delivery practices in the tribal dominated villages of Guruwa, Pipariya, and Kasmarkhandi under the Chillior sub-sector of Bhimpur Block, Betul district, Madhya Pradesh; with a topography of hilly forested land, hamlets scattered across, poor accessibility, and mainly the Gond and Korku tribal population with limited access to health facilities. The study sample included 200 members of the elder community ranging in age between 45 years and more and sampled using purposive sampling methods with an endeavor made to ensure equal representation of both the genders. Permanent residence in the chosen villages, authority to make decisions, and informed consent were inclusion criteria, and the exclusion criteria were elders with communication barriers, cognitive impairment, and temporary residents. The study employed face-to-face interviews to collect the necessary data using a structured and semi-structured questionnaire that involved cultural beliefs, childbirth practice, childbirth safety perceptions, awareness of government schemes (JSY, JSSK), access to health services, trust of health workers, and recommendations to enhance it; the questionnaire was developed in straightforward language and translated to local dialect where necessary. Interviews are conduct in the privacy of households or communities by trained field investigators who are conversant with the local culture but in a 20-30 minutes one-on-one interaction. The ethical principles such as voluntary participation, informed consent, confidentiality and respect to cultural norms were adhered to strictly. Data are verified as complete daily and analyzed through descriptive statistics and thematic analysis of qualitative responses and comparisons made between relevant villages where possible.

RESULTS

Map of Bheemur (Bhimpur) block (2024) showing health facilities, sub-centers, administrative boundaries, and access routes, highlighting healthcare coverage and accessibility for maternal and child services (**Figure 1**).

Demographic Characteristics of Respondents

The demographic proDile of the respondents is shown in Table 1. The average age was 58.4 years, with the majority falling within the 51–60 age group (39%). Most respondents were male (60%), and more than half were illiterate (58%). As expected in this region, Gond (81%) and Korku (15%) tribes formed the dominant groups (**Table 1**).

Delivery Preferences and Beliefs

A strong preference for home delivery was observed among the respondents. Two-thirds (66%) preferred childbirth at home, while only 34% supported institutional delivery. More than half (55%) believed that home delivery is safer or more traditional (**Table 2**).

Cross-Tabulation: Delivery Preference by Gender

Both male and female elders showed high preference for home delivery, although female elders showed slightly stronger preference (**Table 3**).

Awareness of Health Services and Infrastructure

All respondents (100%) reported having accessible roads to the health center. Awareness of the 108-ambulance service was high (82%), yet 61% felt the nearest facility was too far, and only 29% knew of any nearby functional delivery point (**Table 4**).

Geographic and Seasonal Accessibility

Field observations showed that several hamlets in Guruwa, Pipariya, and Kasmarkhandi remain difDicult to access, especially during monsoon due to:

- River overDlow
- Muddy or broken pathways
- Forested patches
- Lack of transport options at night

This contributed significantly to the reliance on home deliveries despite road availability.

Reasons for Preference for Home Delivery

Respondents were allowed to select multiple reasons. Cultural norms (66%) and lack of nearby facilities (57%) were the most cited reasons. Unexpected onset of labor at night (49%) and habituated beliefs (43%) were also significant contributors (**Table 5**).

Trust in Healthcare Providers

Trust patterns show the highest confidence in traditional dais (81%), followed by ASHA workers (72%). Trust in ANMs and PHC/CHC doctors were moderate to low (**Table 6**).

Decision-Making Patterns in Place of Delivery

The majority of childbirth decisions were made by male elders (49%) and senior women such as mothers-in-law (41%). Only 3% reported that the pregnant woman herself made the decision (**Table 7**).

Suggestions Provided by Community Elders

Respondents proposed culturally feasible and practical interventions. The most common suggestion was establishing a delivery room within the village (**Table 8**). **Table 9** presents the level of awareness and utilization of key government maternal health schemes among the tribal elders. **Table 10** illustrates the perceptions of tribal elders regarding the advantages of institutional delivery. The findings reveal a mixed and often ambivalent understanding of the benefits associated with childbirth in health facilities. **Table 11** presents the perceived disadvantages of institutional delivery as reported by tribal eld-

ers in the study area. The findings highlight multiple interrelated social, cultural, economic, and structural concerns that discourage the utilization of health facilities for childbirth. **Table 12** summarizes the level of knowledge among tribal elders regarding the presence and role of local health workers and available maternal health services in their villages. The findings reveal variable awareness, with notable gaps that affect timely utilization of institutional care. **Table 13** describes the experiences of community members with past childbirth events and how these experiences shape current delivery preferences in the tribal villages studied. The findings indicate that past delivery outcomes play a critical role in reinforcing attitudes toward home or institutional childbirth. **Table 14** examines how the timing and onset of labor affect decisions regarding the place of delivery among tribal communities. The findings indicate that labor-related factors significantly influence whether childbirth occurs at home or in a health facility. **Table 15** indicates that home delivery is driven by limited female autonomy, financial constraints, household responsibilities, traditional beliefs, and inadequate birth preparedness. **Table 16** shows communities trust traditional birth attendants more than formal healthcare due to familiarity, cultural alignment, and perceived support, while fear and mistrust reduce confidence in institutions. **Table 17** lists elders' suggestions: improved facility access, transport, awareness of institutional delivery, respectful care, and household support during childbirth. **Table 18** presents a composite index summarizing key factors influencing home delivery, integrating household, community, cultural, and health system determinants to highlight overall barriers and facilitators for institutional delivery. Barriers influencing delivery location, showing frequencies and percentages of household, cultural, and healthcare-related factors **(Figure 2)**. Levels of trust in various sources of delivery-related advice among the community **(Figure 3)**. Community-recommended measures to enhance institutional delivery uptake **(Figure 4)**.

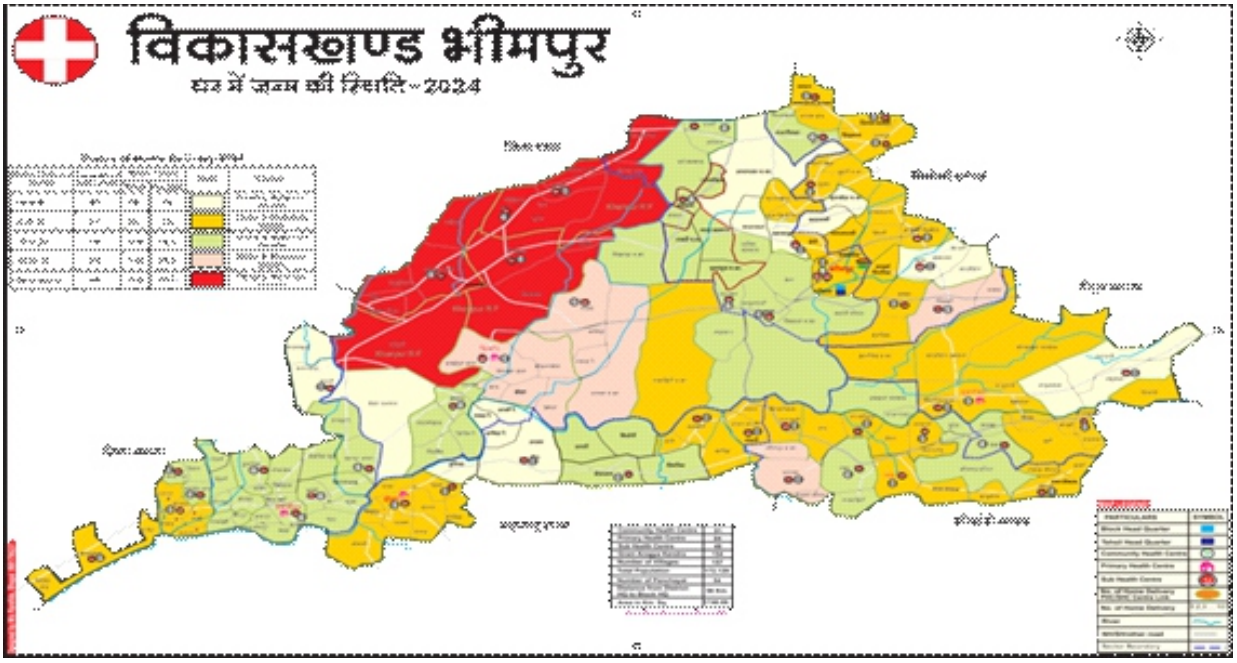

Figure 1: Administrative and health infrastructure map of the Bheemur (Bhimpur) block (2024).

Table 1: Demographic Profile of Respondents (n = 200)

Variable	Category	Frequency	Percentage
Age Group	45–50 years	46	23%
	51–60 years	78	39%
	61–70 years	54	27%
	>70 years	22	11%
Gender	Male	120	60%
	Female	80	40%
Literacy	Literate	84	42%
	Illiterate	116	58%
Tribal Group	Gond	162	81%
	Korku	30	15%
	Others	8	4%

Table 2: Delivery Preferences and Beliefs

Preference/Belief	% Respondents
Prefer home delivery	66%
Prefer institutional delivery	34%
Believe home is safer/traditional	55%

Table 3: Delivery Preference by Genders

Delivery Preference	Male Elders (n=120)	Female Elders (n=80)	Total (%)
Prefer home delivery	74	58	66%
Prefer institutional delivery	46	22	34%

Table 4: Awareness and Accessibility

Indicator	Yes (%)	No (%)
Road accessible throughout the year	100	0
Awareness of 108 ambulance	82	18
Facility considered too far	61	39
Knowledge of nearby delivery facility	29	71

Table 5: Reasons for Home Delivery (Multiple Responses)

Reason	% Respondents
Cultural/traditional norm	66%
No nearby delivery facility	57%
Labor starts suddenly or at night	49%
"We have always done it this way"	43%
Fear or mistrust of hospitals	21%
Belief that ASHA can manage at home	18%

Table 6: Trust Levels in Health Providers

Provider Type	High Trust (%)	Moderate (%)	Low (%)
Traditional Dai	81	14	5
ASHA Worker	72	20	8
ANM	48	33	19

Table 7: Decision-Makers in Delivery Location

Decision Maker	Percentage (%)
Male elder	49%
Senior woman (mother-in-law)	41%
Husband –wife jointly	7%
Pregnant woman herself	3%

Table 8: Suggestions for Improving Delivery Practices

Suggestion	Mentions
Village-level delivery room	83
More community awareness meetings	66
Incentives for institutional delivery	43
Respect dai and ASHA but promote facility births	37
More 9th-month home checkups	31

Table 9: Awareness and Utilization of Maternal Health Schemes (JSY/JSSK)

Indicator	Yes (%)	No (%)
Heard about JSY (Janani Suraksha Yojana)	64%	36%
Know JSY provides financial benefit	41%	59%
Heard about JSSK (Free delivery + transport)	37%	63%
Aware that institutional delivery is free	53%	47%
Believes schemes are easy to avail	29%	71%

Table 10: Perception of Institutional Delivery Advantages

Perceived Advantage	Frequency (n=200)	Percentage (%)
Availability of trained staff	88	44%
Better management of complications	102	51%
Clean environment	64	32%
Access to emergency transport	57	28%
Availability of medicines/injections	76	38%
No advantage seen	58	29%

Table 11: Perceived Disadvantages of Institutional Delivery

Reason for Avoidance	Frequency	Percentage (%)
Facility too far	122	61%
Fear of staff behavior	42	21%
Belief hospital delivery is unnecessary	96	48%
Lack of familiarity with hospitals	84	42%
Costs associated with travel or stay	73	36%
Fear of interventions (e.g., injections, surgery)	28	14%

Table 12: Knowledge of Local Health Workers and Services

Item	Yes (%)	No (%)
Know the ASHA of their village	94%	6%
Know the ANM responsible for their area	71%	29%
Know where the Sub Health Centre (SHC) is located	52%	48%
Have interacted with Anganwadi worker	87%	13%
Know the PHC location	63%	37%

Table 13: Community Members' Experience With Past Deliveries

Experience Reported	Yes (%)	No (%)
Household s have had 1 home delivery in last 2 years	72%	28%
Household had past complications in home delivery	19%	81%
Households used 108 ambulances previously	31%	69%
Household had at least one institutional delivery	48%	52%
Prefer to repeat experience	67%	33%

Table 14: Timing and Onset of Labor That Influence's Delivery Location

Timing of Labor	Frequency	Percentage (%)
Labor started at night	98	49%
Labor progressed too quickly	62	31%
Labor occurred during monsoon	34	17%
Family felt hospital too far during labor	89	45%

Table 15: Household Level Barriers Contributing to Home Delivery

Barrier	Frequency	Percentage (%)
No immediate decision-maker present	38	19%
Delay in arranging vehicle	87	43%
Family preference for dai	115	57%
Elders discouraged going to facility	96	48%
Financial burden due to travel	73	36%

Table 16: Community Trust in Traditional Systems vs. Formal Healthcare

Source of Healthcare Advice	High Trust (%)	Moderate Trust (%)	Low Trust (%)
Herbal healers	68%	22%	10%
Family elders' advice	92%	7%	1%
PHC/CHC	36%	40%	24%
Sub Health Centre	41%	35%	24%

Table 17: Suggested Improvements by Elders – Expanded List

Suggested Intervention	Frequency
Delivery room at village	83
Awareness meetings	66
Incentives for institutional delivery	43
Strengthen ASHA & ANM visits	52
Respect dai but involve in facility referrals	37

Table 18: Summary Composite Index of Determinants

Determinant Category	Strength of Influence	Interpretation
Cultural traditions	Very High	Strongest predictor of home delivery preference
Distance to facility	High	Perceived as major barrier
Trust in dai	Very High	Drives preference for home births
Awareness of schemes	Moderate	Awareness does not ensure facility use
Geographical barriers	High	Seasonal issues intensify risk
Influence of elders	Very High	Elders heavily determine birth location
Availability of facility	Low	Few know nearest functional delivery point

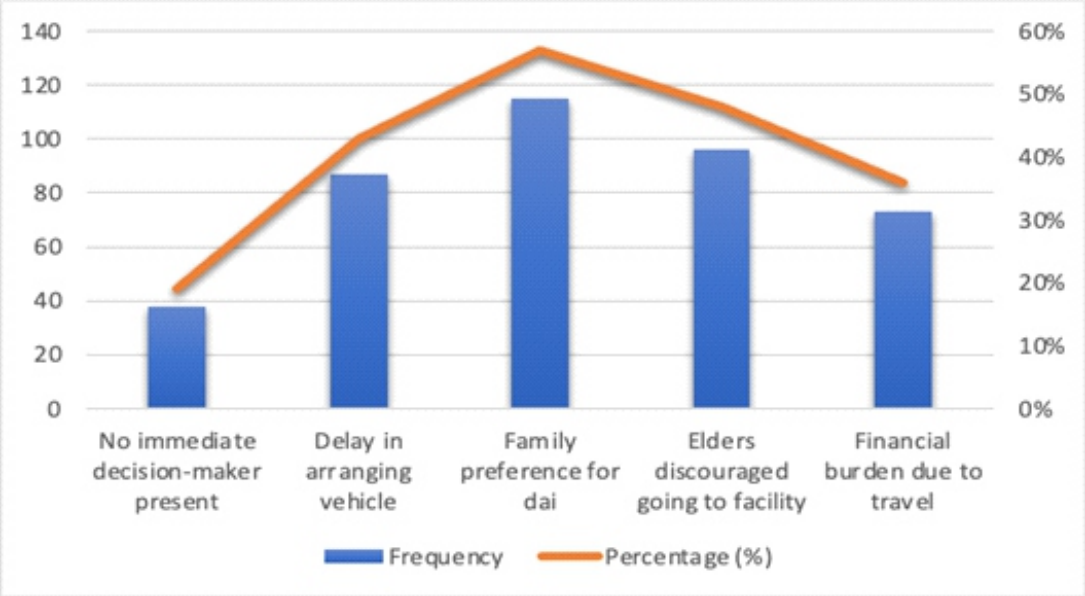

Figure 2: Barriers affecting delivery location choice, showing frequencies and percentages of key influencing factors.

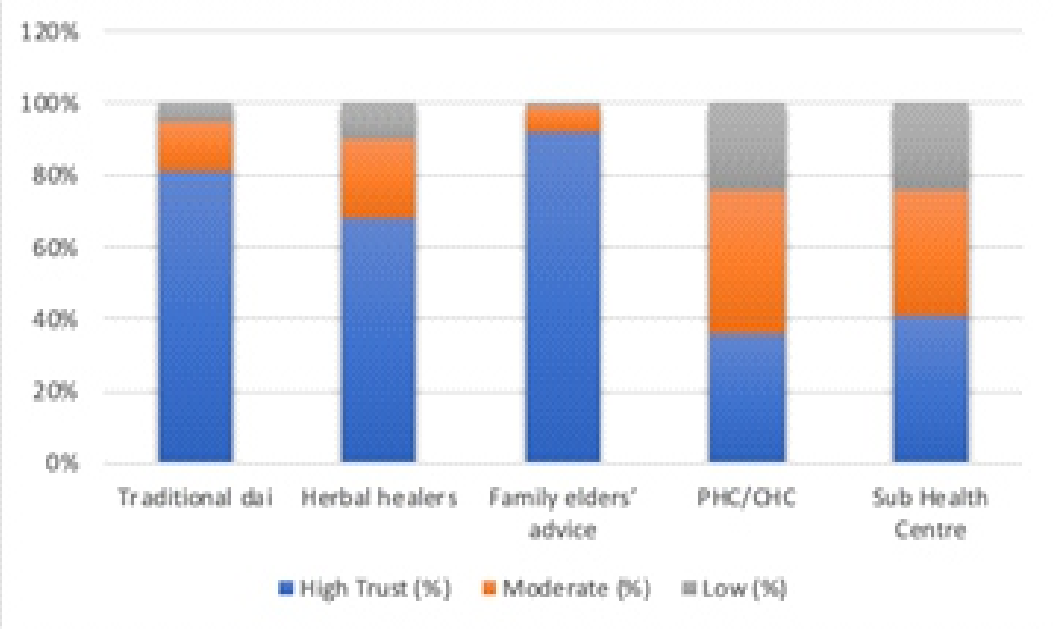

Figure 3: Trust levels in sources of delivery-related advice.

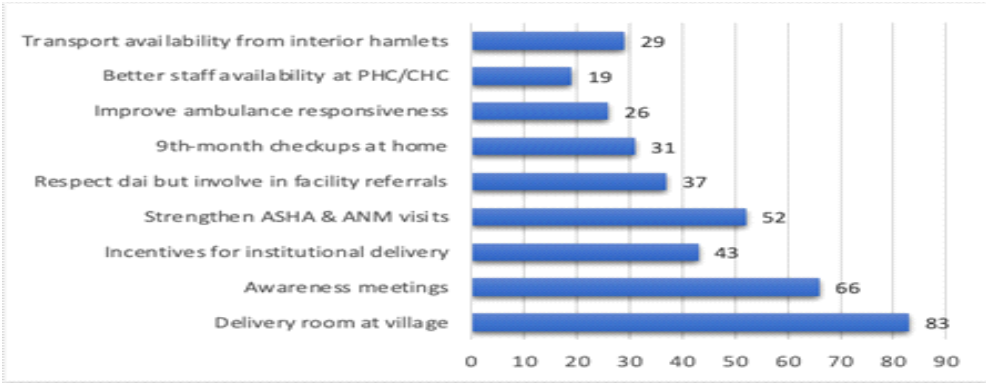

Figure 4: Community-suggested measures to improve institutional delivery.

DISCUSSION

The findings of this community-based study demonstrate that preference for home delivery in the tribal villages of Bhimpur Block is deeply embedded in cultural norms, authority structures, and collective experience rather than lack of awareness alone. A substantial proportion of elders favored home delivery and perceived it as safer and more appropriate, consistent with earlier studies among indigenous populations [22,23]. The limited proportion of women independently deciding their place of delivery highlights the dominant influence of elders and male authority in reproductive decision-making, corroborating findings from other tribal regions of India [5,26].

Geographical and environmental barriers emerged as critical structural factors reinforcing dependence on home delivery. Perceived distance to health facilities, lack of awareness of functional delivery centers, seasonal flooding, forest routes, and absence of night transport were commonly reported deterrents. These findings align with evidence that poor physical accessibility and inadequate infrastructure exacerbate maternal health risks among tribal populations [20,21,24].

Economic considerations continued to play a decisive role despite awareness of free maternal healthcare schemes. Concerns regarding hidden costs, transport, food, accommodation, and wage loss limited the effectiveness of incentive-based programs such as JSY [18,19]. Similar financial barriers have been documented in rural and tribal settings, where economic insecurity undermines utilization of skilled birth attendance [16,17].

Trust emerged as the most influential non-material determinant. High trust in traditional birth attendants and family elders contrasted sharply with low confidence in public health facilities. Fear of staff behavior, unfamiliar environments, and medical interventions discouraged institutional delivery, consistent with studies emphasizing the importance of interpersonal trust and respectful maternity care [2,6].

Community-suggested measures, including village-level delivery facilities, strengthened ASHA and ANM services, & respectful integration of traditional birth attendants into referral systems, highlight the need for decentralized and culturally sensitive healthcare models [13]. Overall, the findings support a shift from top-down policy implementation toward community based, trust oriented maternal health interventions in tribal areas [8,9].

CONCLUSION

The study conclusively shows that the unique preference of tribal families in the Bhimpur Block to deliver their babies at home is entrenched in tribal cultures, high levels of trust of traditional birth attendants and elders, gendered modes of decision making, geographical isolation, and the perceived economic constraints instead of sheer ignorance. Although the level of awareness regarding the use of ambulance services is high, and the extent of knowledge about the government programs like the JSY and JSSK is partial, the distance to facilities, seasons, fear of being subjected to hospital procedures and distrust of regular healthcare providers have limited institutional deliveries. The traditional practices are further strengthened by the fact that elders have a dominating influence on decisions made by pregnant women and the very low autonomy of the latter. Generally, the results confirm that this situation with home delivery is not an issue of choice but a tricky combination of socio-cultural, infrastructural, economic, and trust-based factors that need community-sensitive and decentralized policy interventions.

This study has several weaknesses such as a cross-sectional nature, use of self-reported information, and sampling of elders exclusively, and also it is constrained to three villages, limiting the ability to make causal inference and apply the results to other tribal areas. However, the results have a powerful policy implication, such as the necessity of culturally respectful maternal health interventions, village-based delivery services, enhanced last-mile transportation, enhanced ASHA/ANM services, and a systematic engagement of traditional dais in referral networks. The findings also emphasize the need to target the elderly and men in the awareness programs and not just the pregnant women. Subsequent studies ought to take longitudinal and mixed-methodologies, incorporate women of reproductive age, compare across tribal blocks, and assess the effects of community-based efforts to transform the delivery practices to safer institutional care.

LIMITATIONS & FUTURE PERSPECTIVES

The study's limitations include a single-centre setting, a relatively small sample size, and a short study duration, which may limit the broader applicability of the results. Future studies should incorporate multicentre designs with larger populations to enhance validity, assess long-term outcomes, and investigate advanced diagnostic and management approaches. Such efforts will improve overall patient care and help minimize complications.

CLINICAL SIGNIFICANCE

The clinical significance of this study lies in its potential to bridge the gap between research findings and practical healthcare applications. It emphasizes the importance of translating scientific observations into meaningful improve-ments in patient care, diagnosis, and treatment outcomes. By highlighting real-world relevance, the study contributes to evidence-based medical practice and supports informed clinical decision-making. Ultimately, the findings aim to enhance patient quality of life, optimize therapeutic strategies, and promote better disease management in clinical settings.

ABBREVIATIONS

JSY: Janani Suraksha Yojana
TBA: Traditional Birth Attendant
ANM: Auxiliary Nurse Midwife
ASHA: Accredited Social Health Activist
MCH: Maternal and Child Health
NRHM: National Rural Health Mission

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AUTHOR CONTRIBUTIONS

All authors significantly contributed to the study conception and design, data acquisition, or data analysis and interpretation. They participated in drafting the manuscript or critically revising it for important intellectual content, consented to its submission to the current journal, provided final approval for the version to be published, and accepted responsibility for all aspects of the work. Additionally, all authors meet the authorship criteria outlined by the International Committee of Medical Journal Editors (ICMJE) guidelines.

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CONFLICT OF INTEREST

Authors declared that there is no conflict of interest.

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All necessary consent & approval was obtained by authors.

CONSENT FOR PUBLICATION

All necessary consent for publication was obtained by authors.

DATA AVAILABILITY

All data generated and analyzed are included within this research article. The datasets utilized and/or analyzed in this study can be obtained from the corresponding author upon a re-asonable request.

USE OF ARTIFICIAL INTELLIGENCE (AI) & LARGE LANGUAGE MODEL (LLM)

The authors confirm that no AI & LLM tools were used in thewriting or editing of the manuscript, and no images were altered or manipulated using AI & LLM.

AUTHOR'S NOTE

This article serves as an important educational tool for the scientific community, offering insights that may inspire future research directions. However, they should not be relied upon independently when making treatment decisions or developing public health policies.

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