Original Article

Exploring Women's Reasons for Choosing Home Birth with the Help of Their Untrained Family Members: A Qualitative Research

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Abstract

Background: Home births with the help of untrained family members continue to be women's preference in Indonesia. However, the practice has received very little attention. The purpose of this study was to explore women's reasons for choosing home births with the help of their untrained family members.

Methods: This study used an exploratory-descriptive qualitative research approach and was conducted from April 2020 to March 2021 in Riau Province, Indonesia. A total of 22 respondents determined by data saturation was recruited using purposive and snowball samplings. The respondents consisted of 12 women who had at least one planned home birth with the help of their untrained family members, and 10 untrained relatives who had an experience in intentionally assisting their family member's home birth. Data were collected through semi-structured telephone interviews. Nvivo version 11 software was used for data analysis using the Graneheim and Lundman's content analysis.

Results: 13 categories and 4 themes emerged. The themes were living with fallacious beliefs in unassisted home childbirths, feeling of socially alienated from the surrounding communities, dealing with limited access to healthcare services, and escaping from childbirth-related stressors.

Conclusion: Home birth with the help of untrained family members takes place because of not only limited access to healthcare services, but also women's personal beliefs, values, and needs. Designing culturally sensitive health education, ensuring culturally competent healthcare workers and services, overcoming healthcare access barriers, and improving the community's pregnancy and childbirth literacies are fundamental in reducing unassisted home births and promoting facility childbirths.

Keywords: Home childbirth, Birth setting, Traditional birth attendant, Qualitative

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Introduction

Maternal mortality remains a public health issue and a central focus of public health efforts and policies in Indonesia.[1] Despite its Maternal Mortality Ratio (MMR) remarkable decline, the country did not successfully meet the 2015 Millennium Development Goal 5, which targeted the MMR reduction to 102 deaths per 100,000 live births. According to the latest Indonesian Health Profile, instead of declining, maternal deaths that occurred before, during, and after childbirth kept climbing. Besides COVID-19, haemorrhage, gestational hypertension, and infection were the major causes of maternal deaths.[2]

One of the strategies of Indonesian government to achieve the MMR relevant target of the Sustainable Development Goals by 2030 is to encourage all pregnant women to give birth only with the assistance of skilled birth attendants (SBAs) in a healthcare facility.[1, 2] To ensure that all pregnant women, especially those in rural areas of the country, have facility childbirth, the government makes public health centres, auxiliary health centres, and village birth facilities including village midwives available. The government equips these healthcare centres with residential facilities for midwives and their families, so that women can access 24-hour-maternal services.[3] A pregnant woman who has signed up for a national health insurance program may access these healthcare centres for free, or else pay for a relatively small amount of out-of-pocket money.[4] In addition, the government ensures that a midwife and traditional birth attendant (TBA) partnership program continues to take place in order to prevent a pregnant woman from giving birth with a TBA.[5]

The percentage of facility childbirth in the country has always surpassed its annual national target. Nonetheless, disparity continues to happen between different provinces and areas. Planned childbirth, especially in rural areas of these provinces, persistently takes place at an out of institution without an SBA. The practice, widely known as unassisted childbirth or freebirth, happens either with the assistance of TBA - an old, untrained yet experienced, trusted local woman -, without any assistance, or with the help of untrained family members (UFM). However, the country fails to record the rates of perinatal and maternal outcomes of unassisted childbirths assisted by the aforementioned childbirth methods due to its covert nature and weak vital registration systems.[2]

The unassisted childbirth has been not only a public health issue in Indonesia, but also a challenge to the World Health Organization (WHO) African Region, the WHO Eastern Mediterranean Region, and few WHO South-East Asia Region countries where the proportion of births attended by SBAs was low.[6-8] Studies in the regions had recorded wide-ranging reasons for home births with the assistance of TBA. Some reasons were traditional view, religious misconception, and road condition in Bangladesh;[9] physical and socioeconomic barrier, socio-cultural norm, attitude toward TBA and health services in Zambia;[10] and SBA's interaction, attitude, and ability in Ghana.[11] Studies in Indonesia had also explored the reasons for unassisted childbirths attended by a TBA, nationally called *Dukun Bayi, Dukun Beranak* or *Paraji*. The most cited research conducted in West Java Province reported that the reasons for the TBA-assisted home births included trust and tradition, access to services, and users' perception of SBA's knowledge and skill.[12]

While the reasons for unassisted childbirths with the attendance of TBA in Indonesia had been clear, there was no qualitative study that shed light on the women's motivations for having freebirths with the help of their UFM, which let the practice continue to exist. We only found a study with a strong underpinning methodology that unexpectedly found that freebirths with the help of relatives were not uncommon among indigenous local women of Dani ethnic group in rural areas of Jaya Wijaya District, Papua Province, Eastern part

of Indonesia.[13] This study, therefore, aimed to fill the gap by exploring the Indonesian women's reasons for choosing home births with the attendance of their sole UFM despite the availability of maternity services in the country. The study findings would add evidence to help inform policymakers in Indonesia and in other countries where such a phenomenon is existent to make effective and proper interventions.

Materials and Methods

This study which was conducted from April 2020 to March 2021 used an exploratory-descriptive qualitative design. The study took place in Riau Province, Indonesia. The province was selected because it not only failed to achieve the target of a national strategic plan for facility childbirth and experienced persistent increase in maternal deaths, but also had groups of ethnic women who were known to still practice the unassisted home births with the help of their relatives. Out of 10 regencies and two cities in Riau Province, Kampar, Pelalawan, Rokan Hilir, and Siak were four regencies selected for their failure to achieve the facility childbirth target at the time this study was being conducted.[14]

The respondents of this research were women who had at least one planned vaginal home birth with the help of their sole UFM within three years prior to the data collection. Our exclusion criteria were women who had cryptic pregnancies and preterm births that led to unintentional freebirths, and women who planned unassisted home births but were transferred to professional assistances. To better understand why women intentionally chose home births with their UFM's help, we also excluded those women who intentionally gave birth at home when the COVID-19 pandemic spread and sparked facility childbirth fear among women.[15] We recruited relatives who had at least a one-time experience in assisting their family members' home birth intentionally, never had a childbirth assistance training, and were not considered TBAs.

Due to freebirth data unavailability, we started the recruitment process using purposive sampling by contacting the midwives in four studied regencies for information about women whose home births were assisted by their UFM. From the midwives, we only received information about six women who had freebirths but once had visited them for either due date information or post-partum vitamin request. We then contacted and recruited the women who fulfilled our criteria. Using snowball sampling, we found this hard-to-reach population by asking the recruited women to voluntarily connect us with their UFM who had helped them with the home birth(s), and with their relatives, neighbours, and friends who had similar home birth experiences. We recruited the women's connections who fulfilled our study criteria. The sampling continued until we reached data saturation.

Due to a COVID-19 lock-down policy in the country, we collected data through telephone interviews. All interviews were conducted by the first two of five authors (NK, E, YS, MN, FE) who were health science faculty members in health higher education institutions in Riau Province, were interested in women's health, and had experience in qualitative study. The interview used a semi-structured topic guide developed and written in the Indonesian language by all authors. The interview topic guide trustworthiness was tested by NK and YS among three women and two UFM in Pekanbaru city where such a phenomenon also took place. All authors revised the interview topic guide based on the pilot test results (Table 1).

Each telephone interview lasted from 70 to 90 minutes and were audio recorded. As we found that not all the recruited respondents could speak Indonesian but their local language (the Nias Language), we had a professional translator help us translate the interviews but made the respondents aware of the translator's presence. E, YS, MN, FE, assisted by our students, transcribed all Indonesian language interview recordings

Table 1: The interview topic guide

I. For women whose home births were attended by their untrained family members
● Explain about your experience with your home birth (s)!
● What did childbirth mean to you?
● What were your reasons to give birth at home?
● Probing: Why not at a healthcare facility?
● Please explain about your feeling when your childbirth process was being assisted solely by your untrained family members?
● Explain why you chose your untrained family members to help you with the childbirth process at home!
● Explain what you did when/if complicated childbirth process took place during your home birth process!
II. For untrained family members
● Explain why your wife/daughter-in-law/sister-in-law gave birth at home? Probing: Why not at a healthcare facility!
● What were your reasons for attending your wife/daughter-in-law/sister-in-law's home birth(s)?
● How did you help the childbirth process of your wife/daughter-in-law/sister-in-law at home?
● Explain about your feeling throughout whole childbirth process of your wife/daughter-in-law/sister-in-law that you were attending without the presence of skilled birth attendant!
● Explain about any issues or challenges that you encountered when helping your wife/daughter-in-law/sister-in-law's home birth process and how you solved them?

as soon as the interviews were complete. Likewise, the translator helped transcribe the local language interview recordings and translated them into the Indonesian Language. Supervised by NK, the translator double checked the transcripts for their translation accuracy. Only the Indonesian language versioned transcripts were analysed.

We analysed the data through Nvivo version 11 software using Graneheim and Lundman's content analysis.[16] The initial step was to gain a general understanding by reading and re-reading the transcribed interview texts. After this step, we divided up the texts into meaning units and coded the condensed meaning units consistently using a codebook developed and agreed by all authors. Based on the similarities and differences in their contents and contexts, we grouped the codes into subcategories and then grouped the subcategories into categories. Having cross-checked and approved the categories, we continued the analysis by developing the themes.

To assure the rigor of the study, we used the Lincoln and Guba qualitative research trustworthiness.[17] A periodical peer-debriefing with authors and university colleagues to discuss research procedures, challenges, and findings was held to establish credibility. Once the analysis was done, a member checking was conducted by having five respondents (three women and two UFM) read and give feedback to a copy of the research write-up. Transferability was promoted by using the same data collection methods and materials in four studied locations. Dependability was established by keeping a research audit trail in all study stages in which the co-authors were involved in cross-checking and approving the developed sub-categories, categories, and themes. Confirmability was achieved by having our university colleagues with experience and expertise in qualitative study supervise and give reactions throughout the study stages. We also assured that all researchers were being reflexive throughout the research process by writing down thoughts, beliefs, assumptions, and feelings in a reflexive journal. Worth noting, none of the researchers had an out-of-the system birthing experience.

The ethical approval was obtained from the Ethics Committee of Nursing and Health Research, Faculty of Nursing, University of Riau, Riau Province, Indonesia, number 36/UN.19.5.1.8/KEPK.FKp/2020. Before starting each telephone interview, we explained the study objective, data collection method, risk and benefit, anonymity, confidentiality, and including the respondents' rights to withdraw from the study at any time they wished even after signing the informed consent. All agreed respondents gave a verbal informed consent. The

translator signed a confidentiality agreement.

Results

We interviewed a total of 22 respondents that comprised 12 women and 10 UFM. The 10 UFM were five husbands, three mothers-in-law, one father-in-law, and one sister-in-law. Our study respondents were of Nias ethnic group who inter-provincially migrated from rural

Table 2: Demographic characteristics of the participants

	Participant code	Participant type	Residence	Ethnicity	Education level	Health insurance	Numbers of childbirth		Numbers of family's home birth(s) assisted
							Home births	Facility childbirths	
Women who had home childbirths	P1	Woman	Pelalawan	Nias	No formal education	No	2		
	P2	Woman	Siak	Nias	No formal education	No	5		
	P3	Woman	Kampar	Nias	No formal education	No	3		
	P4	Woman	Pelalawan	Nias	No formal education	No	3		
	P5	Woman	Rokan Hilir	Nias	No formal education	No	3		
	P6	Woman	Kampar	Nias	No formal education	No	2		
	P7	Woman	Siak	Nias	No formal education	No	1	1	
	P8	Woman	Siak	Nias	No formal education	Yes	3		
	P9	Woman	Pelalawan	Nias	Elementary school	No	7		
	P10	Woman	Siak	Nias	Elementary school	No	4		
	P11	Woman	Rokan Hilir	Nias	No formal education	No	1		
	P12	Woman	Pelalawan	Nias	No formal education	No	4		
Untrained family members	P13	Husband	Pelalawan	Nias	Elementary school	No			4
	P14	Mother-in-law	Rokan Hilir	Nias	No formal education	No	8		15
	P15	Husband	Siak	Nias	No formal education	Yes			3
	P16	Husband	Kampar	Nias	No formal education	No			4
	P17	Sister-in-law	Rokan Hilir	Nias	Elementary school	No	5		1
	P18	Husband	Siak	Nias	No formal education	No			3
	P19	Father-in-law	Pelalawan	Nias	No formal education	No			2
	P20	Husband	Rokan Hilir	Nias	Elementary school	No			1
	P21	Mother-in-law	Siak	Nias	No formal education	No	6		12
	P22	Mother-in-law	Pelalawan	Nias	No formal education	No	4		7

areas of North Sumatera to remote rural areas of its neighbouring province, Riau, from 1 to 11 years ago. While a great number of women lived in nuclear family households, a few lived as extended families with their parent(s)-in-law with patrilineal kinship system (family's line of male descent). Women and their families lived in small wooden huts and communal amenities located in the middle of secluded plantation areas. Most of the respondents were casual laborers who moved from one area or province to another for a better job. The characteristics of the participants are presented in Table 2. The data analysis generated 539 condensed meaning units from the transcribed interview texts, 178 codes, 43 subcategories, 13 categories and four themes. The categories and themes extracted from the data are presented in Table 3.

1. Living with Fallacious Beliefs in Unassisted Home Childbirths

Our study findings revealed that to our respondents freebirth with the help of UFM was a tradition. The respondents' consistent exposure to such a practice had instilled positive beliefs that made home childbirth their top-notch preference. The assimilation of this tradition into the studied community members, however, was not accompanied by the exposure of childbirth-related health education.

1.a. Unassisted Home Birth Is a Long-rooted Practice

In the community to which our respondents belonged, childbirth normally took place at home with the assistance of untrained birth attendants, including UFM. Such a practice had been passed across generations. Although the women were given freedom to make their own decision, most family members would give consideration and encourage the women to choose home birth. One participant stated: *"In my hometown, women gave birth at their homes with the assistance of local TBAs or women of the house…My mother, my sisters, and my aunties gave birth at home with the help of their mothers-in-law. We all did. I opted for it too and they supported me."* (P8)

1.b. Developed Positive Beliefs in Unassisted Home Birth

Encouraged by their family members' experiences, the respondents grew up believing that childbirth was a normal physiological process every pregnant woman would have to go through. Childbirth complication was considered normal and manageable by the family members, which did not require a hospital transfer. Death occurring during the process was part of destiny to accept. The respondents were ensured that home, among other places, was the safest place to give birth, and their UFM, among other birth attendants, were the most appropriate birth attendants to rely on. Giving birth in a health facility would only put childbirth in risk.

A respondent mentioned: *"Childbirth process was no different from one woman to another. It was a normal process…There was no urgency to give birth with a midwife at*

Table 3: Categories and themes generated from the data

Categories	Themes
● Unassisted home birth is a long-rooted practice ● Developed positive beliefs in unassisted home birth ● Negative beliefs toward safe motherhood programs due to inadequate exposure	Living with fallacious beliefs in unassisted home childbirths
● Language barrier ● Religion-influenced childbirth ritual difference ● Childbirth-related traditional practice difference	Feeling of socially alienated from surrounding communities
● Distance ● Poor road condition ● Transportation ● Health insurance	Dealing with limited access to healthcare services
● Security, comfort, and convenience ● Privacy ● Private moment	Escaping from childbirth-related stressors

a health centre… Sometimes, it was not an easy childbirth, but our family members were usually able to manage it. If something bad happened during the home birth that led to death of either mother or baby, it must have been destiny. What can we do, we only had to accept our fates" (P22).

1.c. Negative Beliefs Toward Safe Motherhood Programs Due to Inadequate Exposure

No respondent was exposed to adequate health education on pregnancy, childbirth, and postpartum. They did not see it as a necessity. Two women randomly visited a private practice midwife once in their first pregnancies and did so merely to answer their curiosities about their due dates. No one made a visit to a healthcare provider in their subsequent pregnancies and childbirths. A respondent mentioned: *"As far as I was concerned, my family never had prenatal care during pregnancy. I never had it either as I felt completely fine, and so did my babies. When I had a question about pregnancy or childbirth, I asked my mother-in-law or mother. They were experienced"* (P4).

2. Feeling of Socially Alienated from the Surrounding Communities

Our study findings revealed that the migrations had led to socially alienated feeling from the surrounding communities. Apart from being minority and living in secluded areas, the respondents felt that they were different from the local communities for some fundamental aspects, mainly language and religion. The feeling resulted in the women's dependence on family members, disconnection, and disinclination to seek the local communities' help with the childbirth process, not to mention the local TBAs and health workers.

2. a. Language Barrier

The study showed that the respondents spoke the Nias language, while the surrounding communities in which they resided spoke their local language, mainly Ocu and Melayu language. Very few respondents could speak the Indonesian language. A respondent mentioned: *"We had a completely different language. They did not understand us and vice versa…What if we needed something during the childbirth process, like water to drink? What if they got annoyed if we did not understand and do their instructions during the childbirth process?"* (P17).

2.b. Religion-influenced Childbirth Ritual Difference

All respondents were non-Muslims who lived in a Muslim-majority community even country, which possessed different influence and approach to childbirth process. A respondent asserted: *"They would say something like 'Bismillah' to start the childbirth process. We had our way too to perform. We were afraid that if they helped us with the home birth, it would put us in an uncomfortable situation"* (P15).

2.c. Childbirth-related Traditional Practice Difference

The respondents we studied had different traditional childbirth practices, including a method to prepare and bury the placenta. The respondents were hesitant if the local attendants would want to follow the practice when assisting them with the childbirth process. A participant mentioned: *"In our culture, we believed that after its birth kakak anak (placenta) would return to the mother's belly. If it were not properly taken care of, the next pregnancy would likely have an issue. Thus, before its burial, kakak anak must be birthed, bathed, washed with soap, dried by a towel, powdered, lubricated by eucalyptus oil, and wrapped by a new white fabric. None of the people here was familiar with our traditional practice, but our family"* (P9).

Because of the differences they had with the local communities, the women preferred their family members as their sole birth attendants. Among family members whom the women preferred was mother-in-law, considered the most experienced. However,

when a mother-in-law was no longer alive or unreachable, a husband would be the option. In a situation where a husband felt hesitant to help with the home birth and there was no other female family member around, a father-in-law would take the lead. A father-in-law who assisted a home birth was usually a widower who lived at the same house with his pregnant daughter-in-law and married son. Regardless of the birth attendant, during the childbirth process the women were in a passive role, i.e., pushing the baby out in a birth position of their preference. Conversely, the birth attendant took an active role in conducting a whole home birth process starting from preparing the birthing tool to burying the placenta.

A respondent said: *"It was the time for me to give birth and for my husband to see the planned home birth. I trusted my experienced father-in-law. He understood my needs…We shared the same custom and value. Together with my husband, he was there to welcome my baby's head by his hands. I did not need to feel embarrassed. I had considered him my own father"* (P11).

3. Dealing with Limited Access to Healthcare Services

Distance, poor road condition, lack of transport, and health insurance had made access to healthcare services more difficult and the practice to continue.

3.a. Distance

A third respondent reported that there was no health centre or midwife in the areas where they lived. They had to travel to a nearby village if they needed to have professional assistance. A respondent stated: *"To reach the nearest auxiliary health centre, we had to drive to the seaport for at least one hour, cross the harbour by a rental boat for another 1.5 hours, and take another five minutes. It was too far to reach"* (P7).

3.b. Poor Road Condition

Respondents lived in remote rural areas in which poor roads were always a challenge. Roads were hilly, potholes, covered by sand or brown clay, which was slippery and impassable due to rain. In some areas, there was only a narrow unpaved foot pathway in between unoccupied jungle or weeds, which was dark and unsafe. A participant mentioned: *"The street was potholes, slick, gloom, and dangerous. When it was the due date, there was no way I gave birth somewhere else or had someone else come here to help me give birth"* (P6).

3.c. Transportation

All respondents only had a worn-out motorcycle which did not have functional features, including head light and ride pillion. There was no public transport such as bus, taxi, and motorcycle taxi (*Ojek*). A few public health centres were even separated by river and connected by river transportation modes. A respondent stated: *"Our home and public health centre were separated by a river. We needed to pay for a boat to cross the river. Sometimes the boats were not working"* (P10).

3.d. Health Insurance

In addition, almost all women did not have any health insurance. They were not eligible for national health insurance schemes because they did not have national identification cards and family certificates. They even could not show a proof of their current residency essential to help them enrol in national health insurance. In the absence of health insurance, the respondents had to pay out-of-pocket money for a facility childbirth that they could not afford, not to mention additional related expenses. A participant asserted: *"We could not sign up for national health insurance as we could not fulfil the requirement. Thus, if we wanted to give birth in a health centre, we would have to pay for transports, childbirth services, medicines, and additional extra money to buy meals for my husband and children who came with me. It was too much for us"* (P5).

4. Escaping from Childbirth Related-stressors

Two thirds of the women we studied

revealed that pregnancy and childbirth induced various stressors. The stress could even get worse when free births took place in new environments with no complete support system. Having home births with the help of family members gave them relief and privacy.

4.a. Security, Comfort, and Convenience

All respondents asserted that childbirth itself always made them nervous, worried, and anxious. The stressors were felt even more by giving birth in an unfamiliar place and birth attendant. Home births with the help of UFM offered birthing position options and support system availability. A respondent mentioned: *"Childbirth was a matter of life-and-death for my new-born baby and me. As a parent, there was always anxiety around childbirth. All those feelings, when giving birth with the help of my husband or mother-in-law, vanished completely... I could have my children around without feeling worried about leaving them at home… I could do whatever I wanted during my childbirth process. I could exercise different positions that helped ease my labor pain: kneeling and lying down on a bare floor, sitting, and walking here and there"* (P12).

2.b. Privacy

The respondents asserted that childbirth was a process where women's private body parts got exposed to its childbirth assistant. Thus, home birth with the help of UFM was the only way to protect the privacy of their intimate body parts. A participant asserted: *"When we were delivering a baby, we were opening our legs and exposing our vagina to the one helping us. Letting a stranger see it; no way, it was embarrassing. But I was okay with my husband or other family members. We were family after all. They knew me outside and inside"* (P1).

4.c. Private Moment

All our respondents said that childbirth was a private moment. They showed a concern that bad experiences could happen at any time during the childbirth process. Whatever happened was not for stranger's consumption. A respondent mentioned: *"We never knew that probably something during childbirth happened to us. A stranger who helped me with my home birth might share about my home birth experience with others intentionally or unintentionally. It would be embarrassing. My home birth was my own story"* (P14).

Discussion

The objective of this study was to explore reasons for planned home births only with the help of UFM. While three themes reflected the respondents' negative motivations, one theme displayed their positive reason. The three negative reasons were living with fallacious beliefs in unassisted home childbirths, feeling of socially alienated from the surrounding communities, and dealing with limited access to healthcare services. The respondents' positive motive was escaping from childbirth-related stressors.

Our study revealed that home births with the help of UFM had been long-standing practice, particularly of the minority who resided in remote rural areas. As reported by other studies, such a situation was not different from that in other developing world dealing with low facility childbirth and weak dimensions of healthcare access (availability, accessibility, affordability, acceptability).[6-8, 18] Consistent exposure to the practice instilled cultural beliefs, which later influenced women's future childbirth preference, as confirmed by another study and supported by planned behaviour theory.[18, 19] The theory describes that if a woman has a positive attitude about freebirth, believes that social pressure is favourable towards freebirth, and that they have an ability to freebirth, they more likely will do the practice.

Of developed cultural beliefs our respondents had, childbirth was a normal physiological process or life event. Such a belief was, indeed, shared by women in other developing and developed countries who chose

unassisted home births.[20-22] Women from the developed countries, however, would make the decision based on active research about their health risk status, birth options, birth preparations, and emergency action plans from various resources.[21, 23] Women in our study, on the other hand, took their relatives and their relative's experiences as their sources of information and were irrespective to safe motherhood services, which might reflect their low educational background.

Another reason that kept pushing our respondents to home births with the help of UFM was their social alienated feeling. Being a minority group, having fundamental differences with the locals, and/or living in seclusion in rural areas of the province have let the women feel disconnected from their surrounding societies. Our finding was relevant to an Indian tribe in a separate habitation in rural areas away from the main settlement. Their language that differed from that of other social groups drove them to have unassisted home births.[24] Due to barriers and differences, such as language and communication, the immigrant women felt isolated, feared, and ignored. As a result, the women constantly avoided accessing and utilizing available maternity healthcare services.[25] A narrative review that studied 22 studies in different countries reported that different socio-cultural beliefs and language barriers had hindered migrant and ethnic minority to get involved in maternal care.[26]

Due to their social alienation feelings, the women relied their childbirths merely on their closest relatives. While in some societies, childbirth was a traditionally female domain or task,[27, 28] our study revealed a surprising finding that not only female family members, such as mothers-in-law and sisters-in-law, but depending on situation, male family members, such as husbands and or fathers-in-law, solely or jointly, could also intentionally participate as birth attendants who actively attended a whole home birth process. The involvement of in-laws in freebirths as exposed by our study might explain the patrilineal kinship system the respondents had. Also, our study divulging male partner's role in freebirths was in line with those of the studies in Finland and Nepal, apart from its driving factor, which resulted from emergency.[28, 29] Instead of feeling embarrassed, our respondents felt safe, comfortable, and secure that their home birth assistants were their family members. While some childbearing women in the United Kingdom only wanted female companionship, some women in Kenya did not want to have their family members in their childbirth process.[30, 31]

Our study findings reported that besides distance, road condition, and transportation issues, as also experienced by women in rural areas of the other developing countries,[7-11] the absence of health insurance also caused the women in our study to keep the practice. Supported by a study in Indonesia, poor women without health insurance were more likely to have unassisted home birth.[32] The challenge is that home birth is less integrated in the Indonesian health care system. A woman who chooses home birth must pay a private midwife service out of her pocket money, which was similar to the situation in Finland, Japan, Norway and Spain,[24, 29, 33] and was different from that in Canada, England, and the Netherlands where health insurance covered home births for low-risk pregnancies.[24]

Our study findings reported that a reason for unassisted home birth with relatives was escaping from childbirth-related stressors. Our results were in line with those of other studies that reported lack of privacy and birthing options were the factors that drove freebirths, and to women in Afghanistan, exposing bodies during childbirth was intimidating and embarrassing.[22, 34] Previous negative and traumatic experiences with facility childbirth pushed women in Australia, UK, Poland and Norway, to freebirth.[20, 21, 35, 36] Related to childbirth, women required ideal circumstances to work best, including optimal environment, privacy, relaxation, and active birth positioning.[20, 21]

Our study has limitations. Due to the nature of the sampling method that we used, our respondents turned out to be a homogenous group. As a result, our study findings might not have captured a wide range of women's reasons for choosing freebirths with the help of UFM. Thus, future research should explore unassisted home births in other ethnic groups in such culturally and ethnically diverse country of Indonesia. Nonetheless, our study had strengths as well. To the best of our knowledge, this was the first in Indonesia to explore the reasons for unassisted home births with the help of UFM and to report whom among relatives intentionally attended home births.

Conclusion

Our study shows that unassisted home childbirths with the help of untrained family members take place because of not only limited access to healthcare services, but also women's personal beliefs, values, and needs. As such, reducing unassisted home birth and improving facility childbirth not only require relevant stakeholders' commitment, but also demand women, their families and communities' intention to engage in healthy behaviours on the use of health facility for childbirth. A measure to be taken can be formulating proper and effective safe motherhood-health policies and programs that target, involve, and empower women and their families, not to mention the underserved minority communities in rural areas across the country. The policies and programs may include but not limited to designing culturally sensitive health education, ensuring culturally competent healthcare workers and services, and overcoming healthcare access barriers. Family involvement in childbirth is beneficial and needs support. However, there is a need to set the family's boundary of role in the process. Improving community's pregnancy and childbirth literacy is also essential as it will help the community understands when and where to seek relevant information, as well as how to use the information to make the best decision.

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