RESEARCH ARTICLE

Continuing Role of Traditional Birth Attendants and Home Delivery Determinants in Palawan, Philippines: A Mixed-Methods Study

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Abstract

Background: Despite policies promoting facility births, home deliveries attended by traditional birth attendants (TBAs/hilot) persist in rural Philippines. We examined determinants of home delivery and the continuing role of TBAs in Palawan.

Methods: We used a convergent mixed-methods design: a survey of 48 postpartum mothers and 48 in-depth interviews (45–90 minutes). The survey captured socio-demographics, delivery histories, and preferences; interviews explored decision-making, experiences with TBAs and facilities, and barriers to care. Descriptive statistics summarized quantitative patterns; inductive thematic analysis generated qualitative themes. Findings were integrated via a joint-display matrix to produce meta-inferences.

Results: Respondents reported 141 lifetime deliveries; 85.8% (121/141) occurred at home and 81.0% (98/121) of home births were TBA-attended. Three-quarters lived >1 km from the nearest facility, and 89.6% had monthly household income below the provincial poverty threshold. Over half (54.2%) planned their most recent birth at home and 81.3% intended to deliver at home again. Qualitatively, mothers valued TBAs' accessibility, flexible/low payment, and relational care. Facilities were associated with indirect costs, distance, scolding, invasive procedures, and loss of dignity; decisions were commonly joint with partners/elders, reflecting relational autonomy.

Conclusions: Home birth in Palawan represents a constrained preference shaped by structural barriers (poverty, distance), cultural trust in TBAs, and relational decision-making. Safety messaging alone is insufficient without respectful, affordable, and accessible facility care. Policy actions should: (1) reduce non-fee costs (transport/food; maternity waiting homes), (2) institutionalize Respectful Maternity Care, and (3) integrate TBAs as trained community referral partners within UHC.

Keywords: *Home birth; traditional birth attendants; respectful maternity care; mixed-methods; Philippines; Palawan*

Introduction

Maternal mortality remains a persistent public health challenge in the Philippines, reflecting the intersection of poverty, geography, and social inequities that limit women's access to skilled care during childbirth (PSA, 2023; WHO, 2021; WHO-SEARO, 2023). The social value of this study lies in targeting determinants that plausibly affect maternal and neonatal mortality through increased skilled birth attendance and respectful facility care; we discuss program levers (transport subsidies, waiting homes, TBA integration, RMC) with direct relevance to these indicators.

Globally, safe motherhood initiatives emphasize facility-based delivery as a cornerstone of maternal survival (World Health Organization [WHO], 2021, 2022). Yet, three decades after the articulation of the "Three Delays" model—delays in deciding to seek care, reaching a facility, and receiving appropriate treatment—these barriers persist in low- and middle-income countries (Thaddeus & Maine, 1994). Recent syntheses indicate that financial hardship, poor infrastructure, and

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entrenched sociocultural norms continue to limit women's access to skilled birth attendants, even where services are formally available (Islam et al., 2020; Gebre et al., 2022; Baten et al., 2025). This persistence underscores that maternal health is not merely a matter of service provision but of social justice and system responsiveness.

In the Philippine context, women's childbirth choices are negotiated within complex networks of cultural trust, household decision-making, and institutional experience. Traditional Birth Attendants (TBAs) remain deeply embedded in these social worlds, valued for their accessibility, affordability, and emotional support (Choi et al., 2025; Modillas et al., 2024). Their continued presence challenges biomedical assumptions that formal facilities are inherently preferred, revealing instead that cultural familiarity and relational care often outweigh perceived clinical safety (Kassie et al., 2022; WHO-SEARO, 2023). Simultaneously, women's fear of mistreatment, exposure, and coercive medical interventions within health facilities further deter institutional care (Bohren et al., 2015; Ong & Magno, 2021).

This study examined the intersecting structural, cultural, and relational factors that shape childbirth decisions among postpartum mothers in Palawan. Specifically, it explored why home birth remains a preferred option and how traditional birth attendants (TBAs) sustain their central role in maternal care. Using a convergent mixed-methods design, the study aimed not only to show the contextual determinants of home delivery but also to generate actionable evidence for policy reforms consistent with the WHO's Ending Preventable Maternal Mortality (EPMM) agenda and the Philippine Universal Health Care (UHC) framework.

Methodology

Study Design

We used a convergent mixed-methods design to examine determinants of home delivery and the continuing role of traditional birth attendants (hilot) among mothers in Palawan, Philippines. Quantitative and qualitative data were collected and analyzed concurrently with equal priority to provide breadth and depth on the social, cultural, and structural factors shaping childbirth decisions. The quantitative strand described the prevalence and distribution of delivery choices and related characteristics, while the qualitative strand explored the contextual and experiential meanings behind those choices. Findings were integrated at interpretation using a joint-display to align statistical patterns with narrative evidence and to generate meta-inferences that strengthened explanatory power and validity.

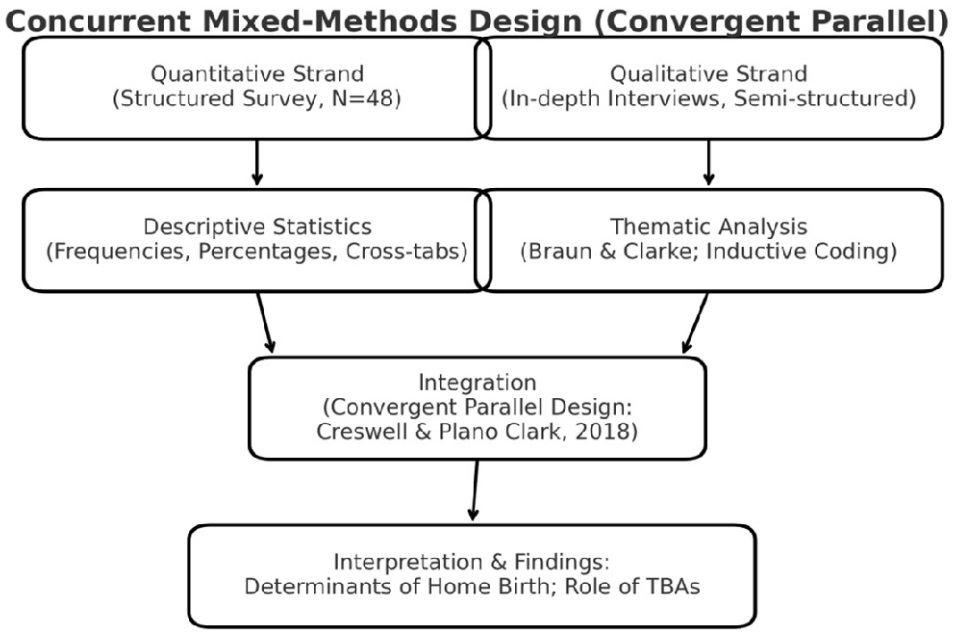

Figure 1. *Themes and policy implications*

A conceptual linkage of four empirically derived themes—(1) structural barriers, (2) trust and reliance on TBAs, (3) perceptions of facility-based care, and (4) decision-making networks—to corresponding system-level policy responses (financial and geographic support; TBA integration; respectful maternity care; family/community engagement).

Study setting

The study was conducted in a selected barangay of Palawan, a province in Region IV-B (MIMAROPA), Philippines. Palawan's topography includes remote and island communities where access to health facilities remains challenging. The province has a diverse cultural population, including both Tagalog and Indigenous communities such as the Tagbanua and Palaw'an peoples. Despite the implementation of the Philippine Safe Motherhood Program, home deliveries persist in many areas of Palawan, making it an appropriate setting for this investigation.

Study participants and sampling

Participants were 48 postpartum mothers recruited through purposive sampling with assistance from barangay health workers (BHWs). Inclusion criteria were: (1) residency in the study area; (2) at least one home or facility delivery within the previous two years; and (3) willingness to complete both the survey and in-depth interview. A sample of N=48 was sufficient to achieve descriptive saturation for the quantitative strand and thematic saturation for the qualitative strand. Across these respondents, mothers reported 141 lifetime deliveries; 121 occurred at home, and among those home deliveries, 98 were attended by traditional birth attendants (TBAs; *hilot*).

Data Collection

Data were collected between February 10 and April 30, 2021, using two complementary tools: a structured questionnaire and an in-depth interview (IDI) guide. Each participant completed both in one session lasting approximately 60–90 minutes.

Quantitative strand: The questionnaire (developed in English, translated into the local dialect, and back-translated) was pilot-tested with five mothers outside the study sample; minor revisions improved clarity and cultural appropriateness. It captured socio-demographics, delivery histories, reasons for home delivery, and reliance on TBAs.

Qualitative strand: In-depth, face-to-face interviews were conducted in the local language (45–90 minutes) using a semi-structured guide. With consent, interviews were audio-recorded, supplemented by field notes, and transcribed verbatim. Throughout fieldwork, researchers kept reflexive journals to document assumptions and decision points; field notes captured contextual observations (setting, non-verbal cues, interruptions). When feasible, surveys and IDIs were completed in a single visit; otherwise within one week.

Trustworthiness and Rigor

Methodological rigor was ensured across both quantitative and qualitative components. For the quantitative strand, structured survey instruments and systematic cross-checking of responses established consistency and reliability of data entry and analysis.

For the qualitative strand, credibility was strengthened through member checking and peer debriefing, which validated emerging interpretations. Dependability and confirmability were maintained through an audit trail and reflexive journaling, minimizing researcher bias. Transferability was enhanced by providing thick descriptions of the study context and participants, allowing readers to assess applicability to similar rural LMIC settings.

Together, these strategies ensured methodological coherence, transparency, and alignment with standards for rigor in mixed-methods health research (Creswell & Plano Clark, 2018; Nowell et al., 2017).

Ethical Considerations

Although no formal institutional review board approval was available at the time, the study followed the Philippine National Ethical Guidelines for Health and Health-Related Research (2022) and the principles of the Declaration of Helsinki (2013). Community authorization was secured through barangay health centers, and written informed consent was obtained in the local language. For one participant identified as Tagbanua, the researchers observed cultural protocols consistent with the Indigenous Peoples' Rights Act (RA 8371). In addition, the Indigenous Cultural Community (ICC) in the manuscript was not named and the researchers did not collect group-identifying location details to avoid deductive disclosure. Where research involves identifiable ICCs or community-level activities, Free and Prior Informed Consent (FPIC) and coordination with NCIP may be required; therefore, this study remained at the level of individual interviews with standard informed consent.

Data analysis and integration

Quantitative strand. Survey data were reviewed and cross-checked prior to entry, then analyzed in IBM SPSS Statistics v26. We computed descriptive statistics (frequencies, percentages, and cross-tabulations) to summarize respondents' socio-demographic characteristics, delivery practices, and preferences.

Qualitative strand. Interviews were transcribed verbatim in the language used and translated into English. We conducted inductive thematic analysis following the six-phase framework of Braun and Clarke (2006), using NVivo 12 Plus for coding and

retrieval. Two trained qualitative coders independently performed open coding; a codebook was iteratively refined to ensure clarity and conceptual alignment. To establish reliability, we assessed intercoder agreement on a random subset of transcripts using Cohen's κ, achieving κ = 0.82 (substantial agreement; Landis & Koch, 1977). Discrepancies were resolved in adjudication meetings facilitated by the principal investigator, with decisions logged to maintain an audit trail; finalized codes were then applied uniformly across transcripts. Illustrative quotations were selected to keep women's voices central.

Integration. We used a convergent mixed-methods approach: quantitative and qualitative datasets were analyzed independently and then merged at the interpretation stage via a joint-display matrix that aligned (1) statistical patterns (QUAN), (2) qualitative themes and exemplars (QUAL), and (3) meta-inferences and policy implications. This procedure connected "who delivers where, with whom, and why" to "how structural, cultural, and relational factors shape choices," yielding conclusions that are both statistically grounded and contextually rich. An overview of integrated findings is presented in Table 1 (joint display).

Table 1. *Joint Display of Integrated Findings: Determinants of Home Delivery among Mothers in Palawan (N = 48)*

Theme	Quantitative Findings	Qualitative Findings	Integrated Interpretation (Meta-Inferences)
1. Structural Barriers: Poverty, Distance, and Information	• 89.6% of mothers below poverty line • 75% lived >1 km from nearest facility • 54.2% had not completed secondary education	Women described financial constraints, poor roads, and lack of transport as major deterrents to facility births. *"Even if I want to go to the hospital, we have no money for fare."* (P7)	Home delivery is a constrained preference, a rational adaptation to structural inequities. Poverty, geography, and hidden costs restrict access, consistent with findings across rural LMICs.
2. Trust and Reliance on Traditional Birth Attendants (TBAs)	• 81.0% of deliveries attended by TBAs • 81.3% planned home delivery for next birth	TBAs were trusted for accessibility, emotional comfort, and flexible payment. *"Ang hilot madaling tawagin at pwedeng utangin muna ang pambayad."* (P9)	TBAs embody relational care grounded in community trust. Their integration into local health systems is essential to bridge cultural and institutional gaps.
3. Perceptions of Facility-Based Care: Safety versus Dignity	• 29.2% had ever delivered in a facility • 54.2% planned last delivery at home • 81.3% intended to deliver at home again	Hospitals perceived as safe yet emotionally unsafe due to fear of scolding, exposure, and painful procedures. *"At the hospital, they shout at you. At home, my TBA comforts me."* (P28)	Women navigate a safety–dignity trade-off. Trust and dignity shape care-seeking more than biomedical safety alone. Facility reforms must institutionalize Respectful Maternity Care (RMC).
4. Relational Decision-Making: Household Gatekeeping and Norms	• Decision-maker: joint (39.6%), mother alone (29.2%), elder (2.1%)	Husbands control resources; elders uphold tradition; women negotiate choices. *"Kung may pera si asawa, baka sa ospital."* (P14) *"Nanay ko ang nagsabi na sa bahay na lang ako manganak."* (P13)	Decision-making is relational, shaped by gender, kinship, and cultural norms. Maternal autonomy is negotiated rather than absolute. Community interventions should engage men and elders.
Synthesis: Intersecting Determinants of Home Delivery	—	—	Home delivery reflects structural vulnerability, cultural rationality, and relational agency. Effective interventions must combine poverty alleviation, TBA integration, RMC implementation, and family-inclusive decision-m

Table 2. *Demographic Profile of Respondents (N = 48)*

Characteristics	Frequency (n)	Percentage (%)
Age		
15–19	9	18.8
20–24	13	27.1
25–29	12	25.0
30–34	6	12.5
35–39	7	14.6
40–44	1	2.1
Marital Status		
Single	3	6.3
Married	9	18.8
Cohabitant	36	75.0
Ethnicity		
Tagalog	29	60.4
Bisaya	7	14.6
Cuyunin	6	12.5
Muslim	3	6.3
Tagbanua	1	2.1
Ilonggo	1	2.1
Agutaynon	1	2.1
Education		
Elementary (incomplete)	5	10.4
High school (incomplete)	19	39.6
High school graduate	16	33.3
College (incomplete)	6	12.5
Vocational course	2	4.2
Monthly Income		
< ₱10,481.00	43	89.6
₱10,481–20,962	5	10.4
Number of Children		
1	12	25.0
2	15	31.3
3	7	14.6
4	5	10.4
5	3	6.3
6	3	6.3
7	1	2.1
8	1	2.1
10	1	2.1
Total:	**141**	
Distance from Facility		
< 1,000 m	12	25.0
1,001–2,000 m	23	47.9
2,001–3,000 m	13	27.1
Prenatal Visits		
None	6	12.5
1	4	8.3
2	5	10.4
3	10	20.8
4	14	29.2
≥5	9	18.8

This joint display demonstrates how integration at the theme level connected statistical trends with lived realities, producing meta-inferences unattainable through single-strand analysis. It shows that mothers' reliance on Traditional Birth Attendants (TBAs) and preference for home birth stem not from cultural resistance but from structural vulnerability and relational decision-making within families and communities.

The following narratives elaboration of each theme—structural barriers, trust in TBAs, facility perceptions, and relational decisions—expands on these integrated insights, situating them within existing evidence and policy discourse.

Results and Discussion

The convergent mixed-methods analysis yielded four interrelated themes that illuminated the multidimensional factors that had shaped women's childbirth decisions in Palawan. Quantitative results mapped the prevalence and distribution of determinants, while qualitative narratives deepened understanding of the structural, cultural, and relational contexts underlying home deliveries. Table 2 presents the demographic characteristics of the participants, providing contextual background for interpreting the integrated results.

Theme 1: Structural barriers—poverty, distance, and information

Women's preference for home birth in Palawan emerged as a rational adaptation to intersecting structural constraints—poverty, limited education, and geographic inaccessibility—that restricted access to facility-based care. Quantitative data showed that 89.6% of mothers lived below the provincial poverty threshold, and three-fourths resided more than one kilometer from the nearest birthing facility, while over half (54.2%) had not completed secondary education.

Qualitative narratives deepened these findings, illustrating how indirect costs, transport difficulties,

Note. *N = 48 postpartum mothers who participated in the survey and in-depth interviews. Percentages are based on total respondents. Some variables may not total 100% due to rounding or multiple responses.*

and poor infrastructure shaped childbirth decisions. As one mother shared, *"Even if I want to go to the hospital, we have no money for the tricycle fare and food while staying there"* (P7). Another explained, *"Kailangan ko maglakad ng mga kalahating kilometro kahit sobrang sakit na ng tiyan ko"* (*I had to walk half a kilometer even though I was already in pain*) (P23). Limited schooling further reduced awareness of maternal risks, reinforcing dependence on elders and traditional birth attendants. One young mother reflected, *"Hindi ko alam kung anong gagawin nung sumakit na tiyan ko. Umasa na lang ako sa hilot"* (*I didn't know what to do when labor pains started. I just relied on the TBA*) (P11).

Together, these findings indicated that home delivery is a constrained preference rather than a deliberate rejection of institutional care. Poverty and distance intersected to limit women's autonomy, while inadequate education narrowed their ability to make informed decisions. This aligned with global evidence that social inequities and spatial barriers—rather than cultural resistance—drive persistent reliance on home births (Yaya et al., 2018; Thaddeus & Maine, 1994; Gabrysch & Campbell, 2009).

Policy implication. Addressing these structural barriers requires **multi-level interventions**: transport subsidies, maternity waiting homes near birthing centers, and expanded *PhilHealth* or UHC benefits that cover not only hospital fees but also indirect costs. Community education and empowerment programs must likewise enhance women's capacity to recognize risk and advocate for safe, facility-based childbirth.

Theme 2: Trust and reliance on traditional birth attendants (TBAs)

Traditional Birth Attendants remained central to childbirth in Palawan, reflecting deep community trust, accessibility, and cultural embeddedness. Quantitative findings showed that 81.0% of home deliveries were attended by TBAs, and over four in five respondents (81.3%) expressed intent to deliver at home again, underscoring TBAs' enduring influence in maternal care (Table 3).

Qualitative narratives revealed that TBAs' presence in the community, flexibility in payment, and compassionate approach made them indispensable to mothers navigating poverty and distance. As one woman shared, *"Ang mga hilot madaling tawagin at pwedeng utangin muna ang pambayad"* (*The hilot is easy to call and even allows deferred payment*) (P9). Another added, *"She massages me, prays with me, and tells me not to be afraid"* (P32). Their availability and emotional reassurance contrasted sharply with the perceived impersonality and inaccessibility of health facilities. Mothers valued TBAs not only for affordability but also for preserving dignity, privacy, and relational care—qualities women felt were often missing in hospital settings.

Table 3. *Home Deliveries and Attendants (N = 121 home deliveries)*

Variable	Frequency (n)	Percentage (%)
Number of Children Delivered at Home		
1 (18 mothers)	18	13.7
2 (13 mothers)	26	19.8
3 (8 mothers)	24	18.3
4 (2 mothers)	8	6.1
5 (2 mothers)	10	7.6
6 (3 mothers)	18	13.7
8 (1 mother)	8	6.1
9 (1 mother)	9	6.9
Attendant During Delivery		
Traditional Birth Attendant (TBA)	98	81.0
Midwife	23	19.0

Note. Respondents reported 141 lifetime deliveries; 121 were home deliveries (85.8%). Among home deliveries, 98 (81.0%) were attended by traditional birth attendants (TBAs/hilot) and 23 (19.0%) by midwives. Percentages are based on the relevant denominators.

While some mothers recognized TBAs' limitations in managing obstetric complications—*"Suhi ang bata at namatay pa ito. Ayaw ko na mangyari ulit 'yun"* (*The baby was breech and died. I never want that to happen again*) (P21)—their trust remained grounded in longstanding social ties and shared cultural values. This paradox reflects what scholars describe as relational trust: the prioritization of emotional safety and familiarity over purely clinical security (Dynes et al., 2013; Sialubanje et al., 2015; Kassie et al., 2022).

These findings echoed evidence across Asia and sub-Saharan Africa that TBAs persist as first responders and cultural intermediaries bridging the gap between home and institutional care (Campbell & Graham, 2006; Sibley et al., 2014). Rather than being phased out, TBAs can be repositioned as community-based partners in safe delivery—trained in early risk recognition, equipped with standardized referral tools, and formally linked to rural health units.

Policy implication. Maternal health programs should focus on integration, not exclusion. Structured collaboration between TBAs and midwives—through referral protocols, documentation systems, and supportive supervision—can align cultural trust with biomedical safety, ensuring that no mother's choice for comfort becomes a risk for survival.

Theme 3. Perceptions of facility-based care: safety versus dignity

Quantitative data showed that only 29.2% of mothers had ever delivered in a health facility, while 54.2% planned to give birth at home and 81.3% intended to do so again (Tables 4 and 5). Despite national campaigns for institutional delivery, hospitals were widely perceived as distant, intimidating, and emotionally unsafe spaces.

Qualitative narratives revealed a persistent ambivalence toward facility-based care. Hospitals were recognized for clinical safety yet feared for experiences of disrespect and loss of privacy. Several mothers recalled being scolded or exposed during examinations: *"Takot ako sa dugo at sa karayom… Takot sa I.E. at ayaw ko na nakaladlad ang maselang parte ng aking katawan"* (I'm afraid of blood and needles… of internal exams and being exposed) (P8). Another shared, *"At the hospital, they shout at you. At home, my TBA comforts me"* (P28). Such accounts showed that emotional harm and indignity often outweigh perceived medical safety, echoing evidence across Southeast Asia and sub-Saharan Africa where mistreatment and lack of respect deter facility use (Bowser & Hill, 2010; Bohren et al., 2015; Ong & Magno, 2021).

Table 4. *Experience of Facility-Based Birth (N = 48)*

Variable	Frequency (n)	Percentage (%)
Experience of Facility-Based Birth		
Hospital	14	29.2
Birthing Home	0	0.0
None	34	70.8
Planned for Home Delivery		
Yes	26	54.2
No	22	45.8
Decision-maker for Home Delivery		
Wife (alone)	14	29.2
Couple (joint)	19	39.6
Parents/Elders	1	2.1
Not planned	14	29.2
Plans to Deliver at Home Again		
Yes	39	81.3
No	9	18.7

Note. N = 48 postpartum mothers. Data represent each respondent's most recent delivery experience. Percentages are calculated from valid responses per item; totals may not equal 100% due to rounding.

Table 5. *Outcomes of Home Deliveries (N = 48 mothers)*

Outcome	Frequency (n)	Rank
Normal maternal health	44	1
Normal newborn health	44	1
Perineal tearing, not repaired	7	3
Child died	3	4
Hemorrhage, transferred to hospital	2	5
Retained placenta, transferred to hospital	1	6
Retained placenta fragments, transferred	1	6
Baby did not cry immediately, transferred	1	6
Baby turned yellow (jaundice), transferred	1	6
Mother fainted after delivery	1	6
No attendant available, cord cut by other	1	6

Note. N = 48 mothers reporting outcomes of home deliveries. Frequencies reflect self-reported experiences, with some respondents indicating multiple outcomes per birth. Ranking is based on frequency of occurrence.

Some women acknowledged hospitals' lifesaving capacity—*"Sa ospital na ako manganak sa sunod para safe"* (P16)—yet persistent costs, distance, and mistrust tempered this willingness. Perceived *normal* outcomes from prior home births reinforced reliance on TBAs: *"Normal lang ang panganganak ko… kaya mas kampante ako sa hilot kaysa ospital"* (P17). Even reports of untreated tears or infant loss did not fully erode this trust, illustrating how familiarity and emotional safety outweigh biomedical risk (Bohren et al., 2020; Amorim & Machado, 2018).

Overall, women faced a safety–dignity trade-off: hospitals offered emergency security but risked shame and verbal abuse, while home births promised comfort, privacy, and respect. This tension exposed a critical deficit in Respectful Maternity Care (RMC), care that values autonomy, informed consent, and compassionate communication. Without addressing relational and affective needs, campaigns promoting institutional delivery risk entrenched mistrust.

Policy implication. To earn women's trust, RMC must be institutionalized within Philippine maternal-health practice. Training for midwives and hospital staff should emphasize culturally sensitive, patient-centered communication, consistent with global RMC frameworks (White Ribbon Alliance, 2011; WHO, 2018). Structural reforms such as private birthing cubicles, companion-of-choice policies, and postpartum debriefing, can align clinical safety with emotional dignity. Integrating these reforms with strengthened referral systems and community education can transform hospitals into trusted spaces of safe and dignified birth.

Finally, this ambivalence toward facility delivery is inseparable from household and community dynamics. Perceptions of hospitals as unwelcoming shape family negotiations over cost, distance, and tradition, often reinforcing home-birth preferences. In this moral and relational context, trust and dignity are collective concerns, setting the stage for the following theme on how childbirth choices are embedded within kinship, financial realities, and social norms.

Theme 4: Relational Decision-Making, Household Gatekeeping, and Norms

Childbirth decisions in rural Palawan were rarely made by women alone but instead negotiated within family, marital, and community networks, reflecting the deeply relational nature of reproductive choices. Quantitative findings showed that 39.6% of decisions were made jointly with husbands, 29.2% by mothers alone, and 2.1% under the influence of elders, a pattern consistent with the collective decision-making typical of rural households (refer to Table 4).

Qualitative accounts revealed that financial capacity, social expectations, and gendered roles shaped these negotiations. Husbands' control over resources often determined access to

institutional care: *"Kung may pera si asawa, baka sa ospital. Pero kung wala, sa bahay na lang"* (*If my husband has money, maybe in the hospital; if not, then at home*) (P14). This dynamic illustrated how economic precarity intersects with patriarchal decision-making, aligning with studies across LMICs where men's financial authority often mediates women's health choices (Story & Burgard, 2012).

Elders, particularly mothers and mothers-in-law, were also decisive voices. Their experiential authority framed childbirth as a routine, domestic event best managed at home: *"Nanay ko ang nagsabi na sa bahay na lang ako manganak, tulad ng dati"* (*My mother told me to give birth at home, just like before*) (P13). Such intergenerational influence reflected the persistence of cultural norms that normalize home births, echoing findings from South Asia and sub-Saharan Africa (Kabakian-Khasholian et al., 2017; Yaya et al., 2018).

Despite these constraints, some women demonstrated negotiated agency, asserting partial control within social expectations. *"Ako ang nagdesisyon kasi katawan ko ito, pero siyempre kailangan din sumang-ayon si asawa"* (*I made the decision because it's my body, but of course my husband also needed to agree*) (P30). This illustrated what feminist scholars term relational autonomy, a form of agency exercised through relationships rather than in isolation (Kabeer, 1999; Mackenzie & Stoljar, 2000).

At the community level, social norms further reinforced home births as the expected practice. *"Lahat ng kapitbahay ko sa hilot lang nanganak, kaya normal na din para sa akin"* (*All my neighbors gave birth with the TBA, so it felt normal for me too*) (P21). Such **peer conformity** sustained the perception of home delivery as safe and ordinary, echoing evidence that collective norms strongly shape maternal behaviors (Campbell & Graham, 2006; Dynes et al., 2013).

Women's autonomy in childbirth decisions is best understood as *relational and negotiated*, influenced by household hierarchies, economic dependence, and social norms. These dynamics highlighted that health-seeking behaviors are moral and social choices as much as medical ones.

Policy implication. To shift childbirth practices toward safer options, interventions must extend beyond women alone. Maternal health programs should engage husbands as partners, include elders as allies, and mobilize communities to transform norms around safe and respectful facility-based care. Strategies such as couple counseling, male involvement in birth planning, and women's peer groups can foster shared responsibility for maternal health and promote informed, collective decision-making.

Synthesis and Implications

Across the four themes, the integrated analysis revealed that home delivery among mothers in Palawan is not a simple matter of personal preference but the result of intersecting structural, cultural, and relational determinants. Quantitative data showed patterns of persistent poverty, low education, and limited facility access, while qualitative narratives exposed the affective and social dimensions that underlie these statistics—trust in traditional birth attendants (TBAs), fear of mistreatment in facilities, and the moral weight of family and community expectations.

This underscored how women's childbirth choices emerge within conditions of structural vulnerability (economic hardship and geographic isolation), cultural rationality (valuing dignity and familiarity), and relational agency (negotiating with family and community gatekeepers). When viewed together, these findings complicated biomedical framings of "noncompliance," suggesting that home birth is often a constrained but rational strategy within unequal systems of care.

Through the convergent mixed-methods design, meta-inferences were generated that link empirical evidence to actionable levers: poverty-targeted subsidies, maternity waiting homes, TBA integration and referral mechanisms, respectful maternity care (RMC) protocols, and family-centered health promotion. These integrated insights demonstrated that effective maternal health policy in the Philippines must operate not only at the clinical level but also at the **social, cultural, and structural levels** that shape women's lived experiences of childbirth.

Conclusion and Recommendations

Guided by a convergent mixed-methods approach, this study illuminated the structural, cultural, and relational determinants of childbirth decisions among mothers in Palawan, specifically, why home birth persists and how Traditional Birth Attendants (TBAs) continue to occupy a central role in maternal care. The integration of quantitative and qualitative strands revealed that women's choices are shaped less by ignorance than by constrained access, cultural trust, and relational dynamics within households and communities.

Findings demonstrated that structural barriers such as poverty, distance from health facilities, and transportation costs, continue to limit women's access to institutional delivery. Beyond these material constraints, the enduring trust in TBAs reflected their social embeddedness: they are accessible, affordable, and provide care that preserves women's sense of dignity and emotional safety. Conversely, experiences and fears of disrespect, invasive examinations, and lack of privacy in facilities

reinforced hesitancy toward hospital-based childbirth. Decisions about place of delivery also emerge as relational, often negotiated with husbands or elders whose approval and financial support are crucial.

These findings highlighted that maternal health behaviors cannot be reduced to individual preference or knowledge gaps. Instead, they are situated within a web of structural vulnerability and cultural meaning. Thus, policy responses must address both the supply side (availability, accessibility, and quality of facility-based services) and the demand side (social trust, family decision-making, and community engagement).

To advance maternal health equity in Palawan and similar contexts, four interlinked strategies were recommended:

Strengthen community–facility linkages by integrating trained TBAs into local health networks through referral and supervision mechanisms under the Universal Health Care framework.

Enhance respectful maternity care (RMC) practices by institutionalizing privacy standards, informed consent, and postpartum debriefing to rebuild trust in facility-based delivery.

Address geographic and economic inequities through transportation subsidies, maternity waiting homes, and expanded midwife deployment in remote barangays.

Promote relational decision-making and empowerment by engaging husbands, families, and community elders in maternal health education and advocacy.

The study underscored that reducing home births and preventable maternal deaths required not only infrastructural investments but also sociocultural sensitivity and relational accountability. By recognizing TBAs as allies, respecting women's agency, and dismantling systemic barriers, maternal health programs can more effectively align with the WHO's *Ending Preventable Maternal Mortality (EPMM)* agenda and the country's commitment to *Universal Health Care,* ensuring that every mother in Palawan, and across the Philippines, delivers safely, with dignity, and without fear.

Limitations

This study had several limitations. First, recall bias may have affected participants' reports of past childbirth experiences, particularly among mothers with multiple previous deliveries. Second, the small sample size (N = 48) was designed for descriptive depth and not for inferential analysis; thus, findings should be interpreted as indicative rather than generalizable. Third, data collection during the COVID-19 pandemic (February–April 2021) may have influenced both service availability and mothers' care-seeking patterns, potentially amplifying home-delivery prevalence. Fourth, because the study was conducted in selected barangays of Palawan, transferability to other geographic or cultural contexts should be made with caution. Finally, self-reported data on distance, income, and delivery outcomes may have been affected by reporting error or social desirability bias, though reflexive journaling and field-note triangulation were used to enhance credibility.

Reflexivity

As a nurse-midwife and researcher with prior engagement in rural maternal health, I recognized that my positionality shaped both data collection and interpretation. My background facilitated rapport with mothers and community health workers but also risked framing their choices through institutional expectations. To address this, I maintained a reflexive journal to record assumptions, reactions, and analytic decisions throughout the study.

Guided by Benner's Novice-to-Expert framework, I situated myself as an emerging yet self-aware researcher whose partial outsider status allowed openness to women's lived experiences. Conscious of power imbalances, given my educational privilege and the participants' economic vulnerability, I conducted interviews in local dialects, within familiar home settings, and allowed narratives to unfold naturally.

Integrating participants' voices alongside quantitative data was a deliberate reflexive act, ensuring that women's experiences remained central. This stance balanced professional insight with humility, fostering interpretations grounded not only in health system perspectives but in the authenticity of mothers' realities.

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"To practice ethically is to recognize the shared humanity that binds caregiver and patient."