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RESEARCH

Limitations to institutional delivery among Ashaninka mothers of the Peruvian Amazon

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ABSTRACT

INTRODUCTION According to the World Health Organization (WHO), 2.8 million mothers and newborns die each year from preventable causes, highlighting inequalities in access to quality healthcare services. The study describes the factors that limit institutional childbirth among Ashaninka mothers in the Peruvian Amazon.

METHODS The research was descriptive, using a questionnaire administered to 152 Ashaninka mothers from five communities in Río Tambo.

RESULTS Most Ashaninka mothers who gave birth at home were between 25 and 29 years old, lived with their partners, came from the Koterini Tarzo community, were Catholic, had incomplete secondary education, were housewives, and had a paternal income of less than or equal to 1000 PEN. They chose home birth for cultural reasons such as privacy, tradition, and economics, preferring traditional birth attendants because of their cultural acceptance and experience. Cultural practices included the burial of the placenta, the use of herbs such as "piri piri," and vertical births. The perception of inadequate facilities and the prevalence of cesarean sections limit the acceptance of institutional childbirth. Added to this is a preference for female healthcare personnel, a lack of information about health procedures, and the prohibition of cultural practices.

CONCLUSIONS There is a need to reform the maternal care model in Indigenous contexts, involving healthcare personnel, policymakers, and local authorities to create culturally relevant and accessible services. It is suggested that an intercultural approach be integrated into professional training and that traditional medicine be combined with the healthcare system. Future studies should evaluate the impact of these interventions on maternal and perinatal outcomes in Indigenous communities.

KEYWORDS Mothers, Home Childbirth, Cultural Factors, Sociodemographic Factors, Midwifery

INTRODUCTION

Home birth is a potential risk to the health of both mother and child and poses a threat to reducing maternal mortality rates. The third Sustainable Development Goal (SDG) aims to reduce maternal mortality to 64 per 100 000 live births by 2030. It also states that all women have the right to quality care during pregnancy, childbirth, and the postpartum period. In this context, it is essential that all births occur in a healthcare facility and be attended by qualified healthcare professionals [1].

The Pan American Health Organization (PAHO) has implemented a plan to accelerate the reduction of maternal mortality and severe morbidity. As a result, it has managed to continue the downward trend in maternal mortality, as evidenced by an 18.1% decrease in the maternal morbidity ratio between 2010 and 2015. As part of this plan, an indicator for monitoring extremely severe maternal morbidity was created. It is used to monitor serious complications that occur during pregnancy, childbirth, or the postpartum period and that almost result in the death of the mother, without actually doing so. This indicator has the logistical advantage that the event occurs in a health facility, and if it occurs outside the health center, it could result in maternal death. This is why it is important to work with institutions [2].

In Peru, indigenous and Afro-descendant women are more vulnerable to maternal mortality. This situation is due to multiple limitations in accessing quality care, including the geographical remoteness of their communities, a lack of

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MAIN MESSAGES

- The choice of birthplace among Asháninka mothers in the Peruvian Amazon is influenced by factors that limit access to institutional childbirth, resulting in healthcare inequalities.
- The research provides a unique perspective on the cultural, sociodemographic, and institutional barriers to healthcare access faced by women living in indigenous communities.
- The research was descriptive, and the sample was convenience-based, which may limit the generalizability of the results to other populations.
- Critical factors limiting institutional childbirth were described, highlighting the need for specific interventions to improve prenatal care and access to safe deliveries.

economic resources, and communication difficulties resulting from the use of indigenous languages [3].

According to the 2022 Demographic and Family Health Survey [4], there was a notable decrease in the maternal mortality rate between 1990 and 1996, with 265 maternal deaths per 100 000 live births, as well as in the period from 2004 to 2010, with 93 maternal deaths per 100 000 live births. This represents a 64.9% decrease between these periods [4].

On the other hand, the National Center for Epidemiology, Prevention, and Disease Control reports that in Peru during 2022, there were 291 maternal deaths, a favorable decrease compared to 2020 and 2021, when there were 439 and 493 maternal deaths, respectively. However, of the total deaths that occurred in 2022, 17.9% (represented by 52 maternal deaths) occurred during home births [5].

Likewise, the National Institute of Health reported that in 2019, there were seven cases of maternal deaths in indigenous communities and another five in 2020 in the same communities [6].

According to data provided by the World Bank, the estimated maternal mortality rate per 100 000 live births in Peru was 69 in 2020 [7].

A study conducted in 2020 showed that, by geographical region, the maternal mortality ratio was highest in the jungle region of Peru (195.12). Similarly, according to place of birth, home births showed an alarming mortality ratio of 1754.83 maternal deaths in the period from 2015 to 2019 [8]. Therefore, institutional childbirth is key to reducing the maternal mortality rate. Considering that there were 44 recorded cases of maternal deaths in the Asháninka native communities of the Río Tambo district between 2011 and 2021, this study could help identify the factors associated with the decision between institutional and home childbirth [6].

According to the National Institute of Health and the 2022 Demographic and Family Health Survey [4], despite a significant decrease in the maternal mortality rate compared to the 1990s and an increase in institutional births in urban and rural areas, the reality is very different for the indigenous peoples of our country. These communities suffer from extreme poverty. The Ashaninka indigenous communities are no exception, as they have to cross the Tambo River to travel and access institutionalized health care [4].

According to evidence from Peru, although the proportion of home births has been declining, the situation is different in the country's rural areas. This type of birth is more frequent in rural regions, which is characteristic of environments where there are marked economic gaps and social inequalities [9]. For this reason, the overall objective of this research is to describe the factors that limit institutional childbirth among Ashaninka mothers in the Peruvian Amazon.

METHODS

This is a descriptive study, following the guidelines of the STrengthening the Reporting of OBservational studies in Epidemiology (STROBE) guidelines. In July 2023, a team of six people (one graduate and five obstetrics teachers) began this research. A survey with a simple selection questionnaire was used, administered by the authors in the native language to mothers from Ashaninka communities in the Río Tambo district, Satipo, Junín, Peru. The questionnaire was administered from July 14th to September 14th, 2023, with prior authorization from the President of the Central Ashaninka of Río Tambo. One week was spent in each community, conducting door-to-door surveys with the support of community leaders.

The instrument, assessed as reliable using Cronbach's α (0.902) [10], included four sections. These include sociodemographic factors (9 items), cultural factors (4 items), and institutional factors (6 items) for the independent variables, as well as one item for the dependent variable (institutional or home birth attendance), totaling 19 questions.

The instrument was validated by three expert obstetricians using the midpoint distance method (1.2) [11], confirming its suitability for research. It was then translated into Ashaninka by a certified interpreter from the Ministry of Culture to ensure that there would be no language barriers. The survey was administered in Ashaninka to mothers who were not fluent in Spanish.

The universe included 250 mothers from five communities in the Río Tambo district (Mazaroveni, Koriteni Tarzo, Shimavenzo, Santavancori, and Puerto Ocopa), with 50 mothers per community. A sample of 152 cases was included, selected for convenience due to geographical barriers.

The inclusion criteria were mothers who were multiparous or primiparous, had given birth within the last four years up to September 2023, and were aged between 15 and 39

years. The exclusion criteria were women with pre-existing medical complications or circumstances that contraindicated institutional delivery.

The study's target factors are considered mediators that enable or restrict the ability to cope with adversities related to other categories of health determinants [12]. Factors related to the choice of birthplace include sociodemographic, cultural, and institutional aspects.

The survey data were organized in a database using Statistical Package for the Social Sciences (SPSS) version 27. Absolute and relative frequencies were calculated. Additionally, these data were presented in graphs and tables to facilitate better understanding [13].

This study was approved by the Institutional Ethics Committee of the Jorge Basadre Grohmann National University of Tacna, Peru, using a certificate dated June 13, 2023 (Code 2023-027-CEIUNJBG).

RESULTS

The sample consisted of individuals aged between 25 and 29. The majority of mothers were cohabiting. In terms of community of origin, they came mainly from Santavancori, Puerto Ocopa, Shimavenzo, Mazarovoni, and Koterini Tarzo in similar proportions. The most common level of education was incomplete secondary education. Most participants were engaged in agricultural activities, followed by housework, and to a lesser extent, retail work. Regarding monthly income, it is most concentrated in amounts of less than or equal to PEN 1000. Home births predominated, followed by institutional births. The sociodemographic and obstetric characteristics are shown in Table 1.

Sociodemographic factors that may limit institutional childbirth among Ashaninka mothers include age, with home births being most common among women aged 20 to 24. Marital status was also relevant, with most women living with their partners and opting for home births. The community of origin, especially Koterini Tarzo, as well as the Catholic religion, also influenced this preference. In terms of education, most mothers, especially those with incomplete secondary education, chose home birth. The father's occupation in agriculture and educational level, mainly incomplete secondary education, also showed a preference for home birth. Finally, those with incomes less than or equal to PEN 1000 tended to prefer it, as shown in Table 2.

Regarding cultural factors, mothers mentioned that they preferred home births for privacy, reliability, family tradition, family presence and support, fidelity to their husbands, and economic constraints. Regarding the assistance of traditional birth attendants, they emphasized that they are accepted in the community, are experienced, instruct the mother, speak the Ashaninka language, and are available to the mother. Practices during domestic childbirth that limit institutional childbirth include burial of the placenta, family gatherings to pray, participation of women who perform steam treatments, traditional dances, vertical childbirth wearing a cushma garment, and consumption of local herbs such as "piri piri."

Table 1. Sociodemographic and obstetric characteristics of Ashaninka mothers surveyed (n = 152).

Characteristics		N	%
Age	15 to 19 years old	38	25.0
	20 to 24 years old	37	24.3
	25 to 29 years old	45	29.6
	30 to 34 years old	21	13.8
	35 to 39 years old	11	7.2
Marital status	Married	7	4.6
	Cohabiting	144	94.7
	Widowed	1	0.7
Community of origin	Mazarovoni	30	19.7
	Koterini Tarzo	30	19.7
	Santavancori	31	20.4
	Shimavenzo	30	19.7
	Puerto Ocopa	31	20.4
Educational level	Incomplete primary education	22	14.5
	Complete primary education	35	23.0
	Incomplete secondary education	86	56.6
	Complete secondary education	9	5.9
Ocupation	Housewife	61	40.1
	Employee/dependent	1	0.7
	Farmer	90	59.2
Monthly income	Less than or equal to 1000 PEN	151	99.3
	Greater than 1000 PEN	1	0.7
Birthplace	Home-based	95	62.5
	Institutional	57	37.5
Total		**152**	**100.0**

PEN: Peruvian nuevos soles; Source: Prepared by the authors based on study data.

Table 2. Sociodemographic factors according to birthplace (n = 152).

Factors		Home birth		Institutional birth	
		n	%	n	%
Age	15 to 19 years old	21	55.3	17	44.7
	20 to 24 years old	28	75.7	9	24.3
	25 to 29 years old	26	57.8	19	42.2
	30 to 34 years old	14	66.7	7	33.3
	35 to 39 years old	6	54.5	5	45.5
Marital status	Married	3	42.9	4	57.1
	Cohabiting	91	63.2	53	36.8
	Widowed	1	100.0	0	0.0
Community of origin	Mazarovoni	17	56.7	13	43.3
	Koterini Tarzo	25	83.3	5	16.7
	Santavancori	13	41.9	18	58.1
	Shimavenzo	18	60.0	12	40.0
	Puerto Ocopa	22	71.0	9	29.0
Religion	Catholic	89	62.2	54	37.8
	Evangelical	5	100.0	0	0.0
	Christian	1	25.0	3	75.0
Mother's level of education	Incomplete primary education	15	68.2	7	31.8
	Complete primary education	22	62.9	13	37.1
	Incomplete secondary education	53	61.6	33	38.4
	Complete secondary education	5	55.6	4	44.4
Occupation	Housewife	38	62.3	23	37.7
	Employee/dependent	1	100.0	0	0.0
	Farmer	56	62.2	34	37.8
Father's level of education	Incomplete primary education	8	80.0	2	20.0
	Complete primary education	8	47.1	9	52.9
	Incomplete secondary education	77	62.6	46	37.4
	Complete secondary education	2	100.0	0	0.0
Father's monthly income	Less than or equal to 1000 PEN	97	62.3	57	37.7
	Greater than 1000 PEN	1	100.0	0	0.0
Total				**37.50**	

PEN: Peruvian nuevos soles; Source: Prepared by the authors based on the study database.

In addition, beliefs that limited institutional childbirth included the perception of inconvenient facilities and the idea that all births are by cesarean section (Table 3).

The health factors that limited institutional delivery among Ashaninka mothers are related to accessibility and trust in healthcare personnel (Table 4). Regarding accessibility, the primary obstacles identified were distance to healthcare facilities, inadequate transportation, and reliance on waterways. In terms of trust, mothers preferred female personnel and expressed insecurity with young personnel or those who did not speak their language (Table 5). During institutional delivery, mothers mentioned the lack of explanations, prohibition of customs, discrimination, fear of medical procedures, lack of supplies, and obstetric violence as limiting experiences. In contrast, those who opted for home birth faced complications that required emergency medical care, as shown in Table 6.

DISCUSSION

This study describes the factors that limit institutional childbirth among Ashaninka mothers in the Peruvian Amazon, such as sociodemographic, cultural, and institutional factors. Traditional beliefs and a preference for trusted midwives, together with the cultural inadequacy of health services and poor treatment in healthcare facilities, emerge as the main obstacles faced by these mothers when choosing home birth.

Apolaya and Herrera [14] point out that speaking languages other than Quechua and living in a city between 1000 and 3000 meters above sea level influences the preference for home birth. Guerrero and Becerra [15], in a qualitative phenomenological study on the experiences of institutional childbirth among women in rural settings, describe the need for emotional and physical support as one of the resulting categories, which indirectly coincides with the results of our study. These authors mention discomfort with vaginal touch and lack of communication from healthcare personnel toward mothers as obstacles to the acceptance of institutional childbirth. These aspects are consistent with our study, which describes lack of communication as a specific limitation for Ashaninka mothers. Apolaya and Herrera [14] identify the importance of the obstetrician in institutional childbirth care. This point coincides with our study, which reveals that obstetric complications not managed by traditional midwives are a factor that leads Ashaninka mothers to seek care at healthcare centers.

This study has some methodological limitations. The descriptive design does not allow for the establishment of causal relationships between the factors described and

the choice of birthplace. In addition, convenience sampling, conditioned by geographical and logistical barriers inherent to the Amazon context, may have introduced selection biases and limited the representativeness of the sample. Data collection was conducted by the authors themselves with the support of community leaders, which facilitated access but could also have influenced responses due to social desirability. Despite these limitations, the study lays the foundation for future research with more robust and representative methodologies.

The implications for clinical practice are clear: public health programs must incorporate an intercultural approach that recognizes and respects the traditional practices of indigenous communities. This includes training health personnel in practices such as vertical childbirth and integrating traditional midwives into the formal health system. Creating spaces that facilitate family participation and respect for local customs could enhance the acceptance of institutional healthcare services.

Table 3. Cultural factors by birthplace (n = 152).

Factors		Home birth		Institutional birth	
		n	%	n	%
Reasons for giving birth at home					
Privacy and reliability	Yes	95	62.5	57	37.5
	No	0	0.0	0	0.0
Family tradition	Yes	95	62.5	57	37.5
	No	0	0.0	0	0.0
Family presence and support	Yes	92	96.8	3	3.2
	No	3	5.3	54	94.7
Sign of fidelity to husband	Yes	35	97.2	1	2.8
	No	60	51.7	56	48.3
Financial constraints	Yes	89	96.7	3	3.3
	No	6	10.0	54	90.0
Reasons for preferring traditional birth attendants					
They are accepted in the community	Yes	95	62.5	57	37.5
	No	0	0.0	0	0.0
They have experience and are capable of handling childbirth	Yes	95	77.2	28	22.8
	No	0	0.0	0	100.0
They educate the mother	Yes	95	62.5	57	37.5
	No	0	0.0	0	0.0
They speak the Ashaninka language	Yes	95	62.5	57	37.5
	No	0	0.0	0	0.0
They are available to care for the mother	Yes	95	62.5	57	37.5
	No	0	0.0	0	0.0
Practices during home birth					
Burial of the placenta	Yes	95	66.4	48	33.6
	No	0	0.0	0	100.0
Family gathering to pray	Yes	41	97.6	1	2.4
	No	54	49.1	56	50.9
Use of cotton on the newborn's forehead	Yes	0	0.0	0	0.0
	No	95	62.5	57	37.5
Participation of a woman who steams	Yes	95	68.8	43	31.2
	No	0	0.0	14	100.0
Traditional dance	Yes	48	98.0	1	2.0
	No	47	45.6	56	54.4
Vertical birth wearing a cushma garment	Yes	95	62.5	57	37.5
	No	0	0.0	0	0.0
Consumption of local herbs called "piri piri"	Yes	95	62.5	57	37.5
	No	0	0.0	0	0.0
Beliefs about institutional childbirth					
The facilities are inconvenient for cultural traditions	Yes	95	62.5	57	37.5
	No	0	0.0	0	0.0
Children born in hospitals are weaker	Yes	16	94.1	1	5.9
	No	79	58.5	56	41.5
Hospital childbirth is more painful	Yes	27	96.4	1	3.6
	No	68	54.8	56	45.2
All deliveries are by C-section	Yes	56	98.2	1	1.8
	No	39	41.1	56	58.9
Partners are not allowed to accompany the mother during delivery	Yes	0	0.0	0	0.0
	No	95	62.5	57	37.5

Source: Prepared by the authors based on study data.

Table 4. Institutional factors according to birthplace (n = 152).

Factors		Home birth		Institutional birth	
		n	%	n	%
Accessibility					
Distance to healthcare facility	Less than 1 hour	29	96.7	1	3.3
	1 to 2 hours	30	100.0	0	0.0
	2 to 3 hours	36	58.1	26	41.9
	More than 3 hours	0	0.0	30	100.0
Availability of transportation to healthcare facility	Private vehicle	19	95.0	1	5.0
	Waterway	61	98.4	1	1.6
	Public transportation	15	53.6	13	46.4
	Walking	0	0.0	15	100.0
	Motorcycle	0	62.5	27	37.5
Type of road to healthcare facility	Unpaved roads	0	0.0	40	100.0
	River	95	84.8	17	15.2
Trust in healthcare personnel					
Preference for female staff in childbirth care	Security and trust	93	94.9	5	5.1
	No men allowed without permission from the couple	2	5.4	35	94.6
	The gender of the staff is not important	0	0.0	17	100.0

Source: Prepared by the authors based on study data.

Table 5. Patients' experiences during institutional childbirth (n = 57).

Experiences	Response	Institutional birth	
		n	%
The healthcare facility has young healthcare personnel, such as practitioners/serumists, whom I consider inexperienced.	No	43	75.4
	Yes	14	24.6
Healthcare personnel do not speak the Ashaninka language, resulting in poor communication.	No	49	87.5
	Yes	7	12.5
You do not receive adequate explanations before medical procedures or treatment.	No	12	21.1
	Yes	45	78.9
Healthcare personnel persuade me or prohibit my customs.	No	9	15.8
	Yes	48	84.2
I have felt discriminated against.	No	54	94.7
	Yes	3	5.3
I consider vaginal touching to be a sign of violence.	No	46	80.7
	Yes	11	19.3
Fear of episiotomy.	No	33	57.9
	Yes	24	42.1
Refusal of perineal washing and/or shaving.	No	54	94.7
	Yes	3	5.3
Refusal of the horizontal position for childbirth.	No	57	100.0
	Yes	0	0.0
Falta de insumos para atención del parto.	No	35	61.4
	Yes	22	38.6
Obstetric violence: mistreatment during childbirth (shouting, pulling on the legs or hands, insults)	No	51	89.5
	Yes	6	10.5
The feeling of coldness and lack of warmth from the healthcare professional during childbirth.	No	49	86.0
	Yes	8	14.0
I had a complication during or after childbirth: postpartum hemorrhage, preeclampsia, infection, retained placenta, retained placental tissue, among others.	No	54	94.7
	Yes	3	5.3

Source: Prepared by the authors based on study data.

For future research, this study suggests several hypotheses that could be explored using more robust and controlled observational methods. For example, it would be valuable to investigate how the intervention of traditional birth attendants in an institutional setting could impact maternal and perinatal health outcomes. Additionally, longitudinal studies could be conducted to evaluate the effects of cultural awareness programs on reducing complications during childbirth.

Finally, although this study was conducted among Ashaninka mothers in the Peruvian Amazon, it offers an invaluable perspective that could be relevant to other indigenous communities in Latin America. The description of factors that

Table 6. Patients' experiences during home birth (n = 95).

Experiences	Response	Home birth	
		n	%
The midwife did not know how to handle a complication during delivery, and I was taken to the healthcare facility as an emergency.	No	0	0.0
	Yes	95	100.0

Source: Prepared by the authors based on study data.

limit birthplace choices may contribute to the formulation of more inclusive, intercultural, and effective public health policies that address the particular needs of these populations.

CONCLUSIONS

This study reveals that the decisions of Ashaninka mothers regarding their birthplace are profoundly influenced by their worldview, social environment, and prior experiences with healthcare services. This highlights the need to rethink the model of maternal and perinatal care in indigenous contexts. This transformation requires the joint commitment of health personnel, policymakers, and community authorities to develop culturally relevant, humanized, and accessible services that foster trust and reduce maternal and infant morbidity and mortality. For this reason, it is recommended that an intercultural approach be incorporated into professional training and that strategies be promoted to integrate traditional medicine into the healthcare system.

As future lines of research, we suggest the development of case-control studies to identify cultural and sociodemographic factors associated with the birthplace, as well as cohort studies to determine the association between intercultural interventions and maternal and perinatal outcomes in indigenous communities.

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Limitantes al parto institucional en madres asháninkas del Amazonas peruano

RESUMEN

INTRODUCCIÓN Según la Organización Mundial de la Salud (OMS), 2,8 millones de madres y neonatos mueren anualmente por causas prevenibles, destacándose desigualdades en el acceso a servicios sanitarios de calidad. El estudio describe los factores que limitan el parto institucional en madres asháninkas del Amazonas peruano.
MÉTODOS La investigación fue descriptiva, utilizando un cuestionario aplicado a 152 madres asháninkas de cinco comunidades en Río Tambo.
RESULTADOS La mayoría de las madres asháninkas con parto domiciliario tenían entre 25 y 29 años, estado civil convivientes, provenían de la comunidad Koterini Tarzo, eran católicas, con educación secundaria incompleta, amas de casa e ingresos paternos menor o igual a 1,000 PEN. Ellas, elegían el parto domiciliario por razones culturales como privacidad, tradición y economía, prefiriendo parteras tradicionales por su aceptación y experiencia. Las prácticas culturales incluían el entierro de la placenta, uso de hierbas como el "piri piri" y partos verticales. La percepción de instalaciones inadecuadas y la prevalencia de cesáreas limitan la aceptación del parto institucional. A ello se suma la preferencia por personal de salud de sexo femenino, la falta de información sobre procedimientos de salud y la prohibición de prácticas culturales.
CONCLUSIONES Existe la necesidad de reformar el modelo de atención materna en contextos indígenas, implicando al personal de salud, los responsables de políticas y las autoridades locales para crear servicios culturalmente relevantes y accesibles. Se sugiere integrar el enfoque intercultural en la formación profesional y combinar la medicina tradicional con el sistema de salud. Futuros estudios deberían evaluar el impacto de estas intervenciones en los indicadores maternos y perinatales en comunidades originarias.