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Understanding Home Delivery Preferences: The Role of Socio-Economic and Cultural Factors in Marsabit County, Kenya

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ABSTRACT

Home deliveries, defined as childbirth occurring outside hospital settings without the assistance of skilled healthcare providers, remain common in some regions despite substantial efforts to improve maternity and newborn health services. This study aimed to assess the influence of cultural factors on the preference for home deliveries in rural Marsabit County, Kenya. A descriptive cross-sectional mixed-methods design was employed, with 396 women participating in quantitative surveys and additional qualitative data gathered from 10 interviews and 2 focus group discussions. Quantitative data were processed using descriptive statistics and logistic regression, while qualitative data were thematically coded. The analysis revealed that the point prevalence of home deliveries among women of reproductive age in Marsabit County was 64.65% (n = 256, 95% *CI* [59.81%, 69.49%]), with 189 (55.26%) of those who had ever delivered at home reporting between 1 and 3 home deliveries. Additionally, 291 (94.17%) of home deliveries were attended by traditional birth attendants (TBAs), highlighting the significant role TBAs play in maternal health in this community. Cultural beliefs and family influence significantly shaped delivery choices, with family cultural influence reducing the likelihood of choosing a healthcare facility for delivery (OR = 0.47, 95% CI: [0.19, 0.81], p = 0.009). Socio-economic conditions, including higher education levels (OR = 1.854, p < 0.001) and stable employment (OR = 2.776, p = 0.007), were strongly associated with an increased likelihood of facility-based deliveries. The study concluded that an integrated approach addressing cultural and socio-economic factors are crucial for promoting safer delivery practices. Recommendations include integrating TBAs into the formal healthcare system and enhancing communication strategies to build trust in government health programs.

Key words: *Social-economic, Cultural Factors, Home Deliveries, Marsabit County, Kenya*

Introduction

The prevalence of home deliveries in rural Marsabit County, Kenya, remains a major public health concern, despite national efforts to reduce maternal mortality and promote skilled birth attendance. Globally, maternal mortality remains unacceptably high, with an estimated 295,000 maternal deaths in 2017, the majority occurring in low- and middle-income countries, particularly sub-Saharan Africa (WHO, 2019). Home deliveries, often without the presence of skilled health professionals, contribute significantly to adverse maternal and neonatal outcomes (WHO, 2014). In 2014, Kenya's maternal mortality ratio (MMR) stood at 495 per 100,000 live births, with Marsabit County showing alarmingly higher figures at 1,127 per 100,000 (KDHS, 2022; WHO, 2019). These disparities highlight systemic inequalities and point to barriers in accessing quality maternal healthcare in marginalized counties like Marsabit.

Marsabit County has long been challenged by geographical isolation, poor infrastructure, and health workforce shortages, with only one doctor per 63,825 residents and one nurse per 1,868 (Policy Strategy and Health Plan, 2016). The health system's limitations severely undermine efforts to provide timely and effective obstetric care. Consequently, in 2017, only 44.4% of deliveries occurred in health facilities, although this marked an improvement from 29.2% in 2013 (KDHS, 2022; MoH, 2018). Factors such as cultural norms, economic constraints, long distances to health facilities, and limited knowledge of available government initiatives significantly shape maternal care-seeking behaviors (Njuguna et al., 2017; Njuki et al., 2015).

The Kenyan government has introduced several policy interventions, including the Linda Mama initiative, free maternity care in public hospitals, maternal waiting homes, and performance-based financing to improve maternal outcomes (Njuki et al., 2015; Mulinge, 2017). However, the persistent preference for home births in Marsabit County suggests these initiatives have not sufficiently addressed context-specific barriers. Cultural traditions, such as reliance on traditional birth attendants, and perceived inadequacies of health facilities continue to drive the choice for home delivery.

This study seeks to explore the prevalence and determinants of home deliveries among women of reproductive age in rural Marsabit. The objectives include determining the current prevalence of home births and examining the influence of cultural, socio-economic, health facility-related, and

knowledge-based factors on delivery choices. The findings aim to provide actionable insights for county and national health policymakers to design more effective, culturally sensitive maternal health programs.

By addressing the root causes of home deliveries in this high-risk region, the study aspires to contribute to the broader global and national goal of reducing maternal and neonatal mortality. It will not only help fill a critical knowledge gap but also support the formulation of targeted interventions that align with Kenya's Vision 2030 and the Sustainable Development Goals, particularly SDG 3 on good health and well-being. Ultimately, improving access to skilled birth attendance in Marsabit and similar regions is essential for safeguarding maternal and child health across Kenya.

Methodology

This study utilized an explanatory sequential mixed-methods design to investigate factors influencing home deliveries in rural Marsabit County, Kenya. Quantitative data were collected using structured questionnaires administered to 408 women of reproductive age (15 - 49 years) who had delivered within the last six months. The qualitative component, involving in-depth interviews and focus group discussions, was conducted with ten purposively selected key informants - community health workers, cultural elders, and traditional birth attendants.

The research was conducted in Saku and North Horr sub-counties, with participants selected through a stratified random sampling approach. The sample size was determined using Yamane’s formula and adjusted for non-response. Ethical considerations guided inclusion and exclusion criteria, focusing on cognitively capable women within the defined age and residency parameters.

Data collection instruments included mobile-based Kobo Toolbox for the quantitative surveys and semi-structured guides for qualitative interviews. Operationalization of variables combined demographic categories and Likert-scale responses to assess cultural, socio-economic, and healthcare-related influences. The integration of both data types provided a comprehensive understanding of the determinants shaping maternal health decisions in Marsabit, with findings aimed at informing policy and healthcare interventions.

Results

The analysis revealed that all respondents, 396 (100%), had children, 84.6% of respondents were married, 73.48% had no formal education, and 88.13% were not employed and most 40.4% were muslims. See Table 1.

Table 1. Respondents Socio-Demographic Variables

Variable	Particulars	Frequency	Percentage
Age Group	10-19	20	5.26
	20-29	144	37.89
	30-39	158	41.58
	40-49	74	18.69
Marital Status	Married	335	84.6
	Widowed	33	8.33
	Divorced	19	4.8
	Single	9	2.27
Highest Education Level	None	291	73.48
	Primary	72	18.18
	Secondary	20	5.05
	College	13	3.28
Occupational Status	Unemployed	349	88.13
	Self Employed	44	11.11
	Salaried Employed	3	0.76
Religion	Muslim	160	40.4
	Catholic	122	30.81
	Other Religion	110	27.78

Variable	Particulars	Frequency	Percentage
	Protestant	4	1.01
Household Monthly Income	<10,000	376	94.95
	11000-20000	20	5.05
Total		396	100

Prevalence of Home Delivery

The majority of women (64.65%) delivered at home, while only 35.35% delivered at a health facility. Among respondents, 78.03% had delivered at home at least once, with 55.26% having had 1-3 home deliveries, and 32.16% reporting 4–6 home deliveries. A smaller group (2.92%) reported 7-9 home deliveries. A high proportion (94.17%) of home deliveries were attended by TBAs. Most respondents (81.57%) acknowledged that delivering in a healthcare facility reduces the risk of complications, although 18.43% did not share this belief. See Table 2.

Table 2: Distribution of Place of Last Delivery, Frequency of Home Deliveries, and Perceptions on Skilled Birth Attendance among Respondents

Variable	Particulars	Frequency	Percentage
Place of last delivery	Home	256	64.65
	Health Facility	140	35.35
Number of home deliveries if you have ever delivered at home	0	87	21.97
	1-3	189	55.26
	4-6	110	32.16
	7-9	10	2.92
TBA attendance	Yes	291	94.17
	No	18	4.62
Delivering in a healthcare facility reduces the risk of complications	Yes	323	81.57
	No	73	18.43

Note: *The "Number of Home Deliveries" and "TBA Attendance" statistics refer to respondents who have ever delivered at home, regardless of their most recent delivery location. Therefore, while some respondents may have delivered at a healthcare facility recently, these figures reflect their overall history of home deliveries. Additionally, the "TBA Attendance" variable specifically applies to those who have experienced home deliveries and indicates whether a traditional birth attendant assisted during those births. This means most women have had at least one home delivery in their childbirth history and that most have also been served by a TBA at least once in the past. The percentages for "TBA Attendance" are calculated only for the women who had at least a history of home delivery.*

Influence of Socio-economic Factors on Home Deliveries

The logistic regression analysis of socio-economic variables revealed several significant predictors of health facility usage for childbirth. Highest Education Level was a particularly strong determinant, with the analysis showing that women with higher educational attainment were significantly more likely to choose a health facility for delivery (OR = 1.854, 95% CI [1.360, 2.528], $p < 0.0001$). This finding aligns with existing literature suggesting that education empowers women with knowledge about the benefits of professional healthcare, increasing their propensity to seek out institutional care during childbirth. The positive correlation between education and health facility delivery highlights the critical role that educational interventions can play in improving maternal health outcomes in this population.

Occupational Status also emerged as an important factor, with self-employed and salaried women showing a higher likelihood of delivering in a health facility compared to their unemployed counterparts (OR = 2.776, 95% CI [1.319, 5.841], $p = 0.007$). This suggests that financial stability and access to resources, which are often tied to employment, enhance women's ability to afford and access healthcare services. On the other hand, Religion was negatively associated with the use of health facilities, with a significant odds ratio indicating that certain religious beliefs or practices may deter women from opting for institutional delivery (OR = 0.488, 95% CI [0.386, 0.618], $p < 0.0001$). This finding underscores the complex interplay between cultural and socio-economic factors in shaping healthcare decisions, suggesting that efforts to improve maternal health in this context must also address cultural and religious barriers to healthcare access.

Table 3: Influence of Socio-economic Factors on Home Deliveries

Variable	Coefficient	Odds Ratio	OR Lower CI	OR Upper CI	P-value
Const	-2.7798	0.0621	0.0113	0.3393	0.0013
Marital Status	0.2240	1.2511	0.9015	1.7363	0.1803
Highest Education Level	0.6176	1.8545	1.3604	2.5280	0.0001
Occupational status	1.0208	2.7755	1.3188	5.8415	0.0072
Religion	-0.7167	0.4883	0.3860	0.6178	0.0000
Household monthly income	0.2542	1.2894	0.4063	4.0926	0.6662

Economic constraints were a significant factor influencing the decision to opt for home deliveries in Marsabit County, with prohibitive costs associated with hospital deliveries, particularly transportation expenses, leading many families to choose home deliveries as a more economical option. Education emerged as a crucial factor, as women with higher education levels were more likely to opt for hospital deliveries, being more aware of the risks and benefits of medical care. Additionally, the lack of stable employment played a significant role, with those without regular jobs or steady incomes finding it difficult to afford the associated costs of hospital deliveries, further reinforcing the preference for home-based childbirth.

Participants consistently highlighted the prohibitive costs associated with hospital deliveries, particularly transportation expenses. For many families, the cost of hiring a vehicle to reach the nearest healthcare facility was simply unaffordable, leading them to choose home deliveries as a more economical option. For instance, one participant mentioned,

"… *Transport costs to the hospital are high, and even though the services are supposed to be free, there are still things you have to pay for…*" (P4).

This sentiment was echoed by others who stated,

"… *When times are tough, it's hard to afford anything extra, like the cost of going to a hospital…*" (P10),

"… *Many families can't afford the cost of transport to the hospital, so they choose to deliver at home instead …* " (P7).

These financial barriers were particularly acute in large families or those with unstable incomes, further entrenching the preference for home deliveries.

Education emerged as a crucial factor in determining the choice of delivery location. Participants noted that women with higher levels of education were more likely to opt for hospital deliveries, as they were more aware of the risks associated with childbirth and the benefits of medical care. As one participant stated,

"… *Women who have gone to school are more likely to choose a hospital delivery because they understand the risks involved with childbirth…*" (P4).

Similarly, another participant observed,

"… *Those who have gone to school know more about the risks of childbirth and are more likely to go to the hospital to deliver …*" (FGD3).

This trend highlights the role of education in shaping health-seeking behaviors and the importance of increasing educational opportunities for women in these communities to encourage safer delivery practices.

The lack of stable employment also played a significant role in influencing home delivery decisions. Participants pointed out that those with regular jobs or steady incomes could afford the associated costs of hospital deliveries, while those without employment found it difficult to access such care.

"… *Those with regular jobs or a steady income can afford the costs associated with a hospital delivery…*," explained one participant (P5).

This disparity in access was further emphasized in the focus group discussions, where participants noted that

"… *Without a steady income, it's difficult to afford the costs associated with a hospital delivery, so home delivery is the only option for many…*" (FGD3).

The economic vulnerability of these communities, exacerbated by irregular employment, thus emerged as a critical barrier to accessing formal healthcare services for childbirth.

Influence of Cultural Practices on the Choice of Home Deliveries

The data reveal complex cultural dynamics influencing the choice of childbirth location among women in the community. A slight majority (52.02%) indicated that their own cultural beliefs consistently influence their decision to opt for home childbirth. However, fewer women (43.69%) acknowledged similar influence from their husbands' beliefs, and 43.43% cited family beliefs as influential. Community norms appear to be divided, with 46.97% agreeing that home deliveries are prioritized over hospital births, while 45.71% disagreed.

Cultural practices such as traditional ceremonies were identified by 54.80% of respondents as reinforcing home delivery preferences. Nonetheless, a substantial majority (65.66%) reported that their religious faith does not directly influence their choice of delivery place, and 63.38% stated that their religion does not encourage adherence to traditional childbirth practices. Regarding the role of elders, opinions were mixed. While 42.93% felt elders see home deliveries as more culturally appropriate, and 39.39% believed elders consider them safer, more respondents disagreed with these notions. Similarly, 40.40% believed elders view home births as less stressful for women.

Views on TBAs also varied. While 54.80% believed TBAs have valuable skills, only 37.63% preferred them over healthcare facilities. Notably, 82.58% respected TBAs for their role, even though fewer (45.20%) found them more trustworthy than healthcare professionals. These findings suggest that while cultural and religious beliefs continue to shape childbirth practices, there is a growing awareness of the benefits of institutional deliveries, tempered by strong traditional respect for TBAs.

Table 3 presents the results of a logistic regression analysis exploring the influence of cultural and religious beliefs, as well as perceptions of traditional birth attendants (TBAs), on home deliveries.

Table 3: Influence of Cultural Practices on Home Deliveries

Label	No	Not Sure	Yes	Coeff.	OR	OR Lower CI	OR Upper CI	P-value
	n(%)	n(%)	n(%)					
Do your cultural beliefs always influence your decision for home childbirth?	174 (43.94)	16 (4.04)	206 (52.02)	-0.0240	0.9763	-0.4431	0.3952	0.9108
Do your husband's cultural beliefs always influence your decision for home childbirth?	211 (53.28)	12 (3.03)	173 (43.69)	-0.1414	0.8681	-0.7084	0.4256	0.6249
Do your family's cultural beliefs have a direct influence on your choice of place of delivery?	209 (52.78)	15 (3.79)	172 (43.43)	-0.7499	0.4724	-1.3134	-0.1863	0.0091
Do community norms always prioritize home deliveries over hospital deliveries in your community?	181 (45.71)	29 (7.32)	186 (46.97)	-0.0541	0.9474	-0.5642	0.4560	0.8355
Do cultural practices often discourage pregnant women from seeking healthcare facility deliveries in your community?	198 (50.00)	28 (7.07)	170 (42.93)	0.5241	1.6890	0.0319	1.0163	0.0369
Are traditional cultural ceremonies associated with childbirth reinforce the preference for home deliveries?	160 (40.40)	19 (4.80)	217 (54.80)	-0.3523	0.7031	-0.7695	0.0649	0.0979
Does your religious faith directly influence your decision for a place of delivery?	260 (65.66)	15 (3.79)	121 (30.56)	0.2681	1.3075	-0.2492	0.7854	0.3098
Do your religious beliefs encourage you to follow traditional practices during childbirth?	251 (63.38)	11 (2.78)	134 (33.84)	-0.6954	0.4989	-1.1872	-0.2035	0.0056
Do elders in your community always believe that home deliveries are more culturally	200 (50.51)	26 (6.57)	170 (42.93)	0.0960	1.1007	-0.3841	0.5760	0.6952

appropriate than hospital deliveries?								
Do elders in your community always believe that home deliveries are safer for women compared to hospital deliveries?	215 (54.29)	25 (6.31)	156 (39.39)	-0.1102	0.8956	-0.6149	0.3944	0.6686
Do elders in your community always believe that home deliveries are less stressful for women compared to hospital deliveries?	206 (52.02)	30 (7.58)	160 (40.40)	0.0667	1.0690	-0.3625	0.4960	0.7606
Do you always believe that traditional birth attendants (TBAs) possess valuable knowledge and skills that make them preferable for childbirth assistance compared to healthcare facilities?	217 (54.80)	30 (7.58)	149 (37.63)	-0.2734	0.7608	-0.6698	0.1230	0.1765
Are TBAs often considered more trustworthy and reliable than healthcare professionals for childbirth assistance in your community?	195 (49.24)	22 (5.56)	179 (45.20)	-0.1161	0.8904	-0.4972	0.2651	0.5506
Are TBAs respected in your community for their role in childbirth?	60 (15.15)	9 (2.27)	327 (82.58)	-0.6452	0.5246	-1.0318	-0.2585	0.0011

Among the variables analyzed, three were found to be statistically significant ($p< 0.05$). The logistic regression analysis identified several significant factors influencing the decision to deliver at home versus a healthcare facility. Respondents whose family's cultural beliefs directly influenced their choice of delivery were less likely to choose a healthcare facility (OR = 0.47, 95% CI: [0.19, 0.81], p = 0.009). Additionally, cultural practices that discourage pregnant women from seeking healthcare facilities were 1.69 times unlikely to choose a healthcare facility (OR = 1.69, 95% CI: [1.03, 1.02], p = 0.037). Traditional cultural ceremonies reinforcing home deliveries decreased the likelihood of selecting a healthcare facility (OR = 0.48, 95% CI: [0.21, 0.75], p = 0.009). Religious beliefs encouraging traditional childbirth practices reduced the likelihood of healthcare facility delivery (OR = 0.50, 95% CI: [0.20, 0.80], p = 0.006). Finally, in communities where traditional birth attendants (TBAs) are respected, respondents were less likely to choose a healthcare facility (OR = 0.52, 95% CI: [0.26, 0.87], p = 0.001). These factors highlight the strong cultural, religious, and community-based influences on delivery location decisions.

The qualitative analysis revealed a wide array of themes on the influence of cultural practices and beliefs on the choice of place of delivery. These were grouped into three main themes as cultural norms and beliefs, trust in traditional birth attendants, and cultural practice of privacy. These were discussed in detail both in the interviews as well as focused group discussions as follows (Appendix 6). Cultural norms and beliefs play a pivotal role in shaping the decisions of many women in Marsabit County to opt for home deliveries. The deep-rooted belief that childbirth should occur within the family home, surrounded by familiar people and objects, was frequently mentioned by participants. For instance, one participant noted,

"*… We believe that childbirth should happen at home, where the mother is surrounded by her family and familiar things*" (Participant 1).

This sentiment was echoed by others who emphasized that

"*In our community, delivering at home is considered the right thing to do. It's how our mothers and grandmothers did it…*" (Participant 8).

Additionally, cultural practices dictate that childbirth should be kept private, away from the prying eyes of strangers, to protect the mother and baby from potential harm. A participant explained,

"*…It's believed that if too many people know about it, it could bring bad luck or a bad omen to the mother and baby…*" (Participant #1).

These cultural norms deeply influence the decision-making process, making home deliveries a preferred choice over hospital births, which are perceived as public and impersonal. The trust placed in TBAs is another significant factor contributing to the preference for home deliveries. TBAs are highly respected within the community, not only for their skills and experience but also for their deep understanding of cultural practices surrounding childbirth.

"*… Traditional birth attendants are highly respected in our community. They know how to conduct the birth in a way that aligns with our beliefs…*" (Participant #2).

This trust is rooted in the belief that TBAs can provide culturally appropriate care that respects the traditions and customs of the community, which is often seen as lacking in hospital settings. As one participant stated,

"*…They know our customs and what's important to us which makes us feel more comfortable delivering at home rather than in a hospital where the staff might not understand or respect our traditions…*" (Participant #5).

The preference for TBAs over medical professionals in hospitals reflects the community's desire for culturally congruent care that aligns with their values and practices.

Privacy in childbirth is a deeply held cultural practice that significantly influences the decision to deliver at home. The belief that childbirth should be a private event, shielded from the eyes of outsiders, was a common theme among the participants.

"*…The actual delivery is kept secret, and it's believed that this protects the family from any bad luck or evil spirits…*" (Participant #1).

This need for privacy is not just about physical seclusion but also about maintaining cultural integrity and protecting the spiritual well-being of the mother and child. As one participant explained,

"*…Childbirth is done in secrecy; even the closest neighbors shouldn't know when a woman is in labor…*" (FGD1).

The preference for home deliveries allows for these cultural practices of privacy to be maintained, whereas hospital deliveries are often perceived as intrusive and disrespectful of these important cultural norms. This cultural emphasis on privacy further entrenches the preference for home deliveries in Marsabit County.

Discussion

The study revealed a high prevalence of home deliveries among women of reproductive age in rural Marsabit County. This prevalence is consistent with findings from similar local and regional studies in pastoralist and remote communities, where home deliveries are often preferred due to cultural practices, distance to health facilities, and limited healthcare access. For instance, a study conducted in rural Turkana County reported a comparable prevalence, attributing it to cultural norms and the significant role of TBAs in childbirth (Okoth et al., 2018). Similarly, a regional study in Ethiopia found that more than half the women population in rural areas delivered at home, emphasizing shared challenges like inadequate infrastructure and socio-economic barriers (Teressa et al., 2024). Despite the community's awareness of the benefits of facility-based deliveries, including reduced complications, the reliance on TBAs indicates a gap between knowledge and practice that requires strategic interventions.

The study highlighted several socio-economic factors that significantly influence the decision to choose home deliveries in Marsabit County. Education level emerged as a critical determinant, with women who have lower levels of education more likely to opt for home births. Employment status and financial constraints also play a crucial role, as women from households with unstable income or unemployment are less able to afford the costs associated with hospital deliveries, even when services are subsidized (Kenya National Bureau of Statistics et al., 2015; Ministry of Health, 2018). The lack of health insurance coverage further exacerbates this situation, making it difficult for economically disadvantaged women to access skilled care during childbirth (Jalango et al., 2017; Nduba et al., 2018; Ministry of Health, 2018).

These findings are consistent with existing literature on the socio-economic determinants of healthcare choices, which consistently shows that lower education levels and financial constraints are significant barriers to accessing institutional delivery services (Gabrysch & Campbell, 2009; Mrisho et al., 2009; Say & Raine, 2007). For instance, studies by Gabrysch and Campbell (2009) have found that women with lower education levels are more likely to give birth at home due to a lack of awareness about the risks of home deliveries and the benefits of skilled care. Similarly, financial barriers, including the costs of transportation and healthcare, have been well-documented as major determinants of home delivery in rural settings (Mrisho et al., 2009; Say & Raine, 2007; Nduba et al., 2018). This study adds to the existing knowledge by illustrating how these factors intersect in the specific socio-economic context of Marsabit County, where poverty and lack of education are prevalent and have a profound impact on maternal health decisions (Kenya National Bureau of Statistics et al., 2015; Nduba et al., 2018; Ministry of Health, 2018).

The broader socio-economic context in Marsabit County significantly influences women's delivery choices, as financial instability and low educational attainment limit their access to healthcare services (Kenya National Bureau of Statistics et al., 2015; Jalango et al., 2017; Nduba et al., 2018). The high levels of poverty in the region mean that many women cannot afford the indirect costs of hospital deliveries, such as transportation, which often leads to a preference for home births (Mrisho et al., 2009; Say & Raine, 2007; Nduba et al., 2018). Additionally, the low levels of education contribute to a lack of awareness about the dangers of home deliveries and the importance of skilled birth attendance, further entrenching the reliance on traditional practices (Gabrysch & Campbell, 2009; Mrisho et al., 2009; Nduba et al., 2018). These socio-economic barriers create a cycle of poor maternal health outcomes that are difficult to break without targeted interventions.

To alleviate these financial barriers and improve access to healthcare services for economically disadvantaged populations in Marsabit County, several strategies could be implemented (Gabrysch & Campbell, 2009; Mrisho et al., 2009; Nduba et al., 2018). First, expanding health insurance coverage to include more women from low-income households could significantly reduce the financial burden associated with hospital deliveries (Jalango et al., 2017; Nduba et al., 2018; Ministry of Health, 2018). Additionally, implementing community-based financial support programs, such as transport vouchers

or conditional cash transfers, could help address the indirect costs that prevent women from accessing skilled care (Gabrysch & Campbell, 2009; Mrisho et al., 2009; Nduba et al., 2018). Education campaigns that target women and their families, focusing on the benefits of hospital deliveries and the risks associated with home births, could also help shift perceptions and encourage greater utilization of healthcare services (Jalango et al., 2017; Nduba et al., 2018; Ministry of Health, 2018).

The data also showed that most respondents had experienced 1-3 home deliveries, with TBAs attending almost all of these cases. The continued reliance on TBAs aligns with findings from other studies in Kenya's northern counties, where TBAs remain a trusted and accessible option for childbirth despite national efforts to promote skilled care. However, the disconnect between knowledge and behavior is noteworthy, as a majority of respondents recognized that healthcare facilities reduce delivery risks (Teressa et al., 2024). This discrepancy suggests that barriers such as transportation challenges, cost, and cultural perceptions outweigh the perceived safety of institutional deliveries. Comparing these results with regional trends highlights the urgent need for targeted community education, improved healthcare infrastructure, and policies addressing systemic barriers to maternal health services in rural and underserved areas.

The study revealed that cultural practices significantly influence the preference for home deliveries in rural Marsabit County. The findings indicated that women often choose to give birth at home due to the strong cultural attachment to TBAs, who are perceived as more aligned with the community's cultural and spiritual beliefs. The privacy associated with home deliveries, where women can adhere to cultural rituals and customs, further strengthens this preference. The role of family members, particularly elder women, is also crucial, as they often encourage adherence to traditional practices, viewing home births as safer and more appropriate according to cultural norms. This cultural inclination towards home deliveries remains prevalent despite the availability of modern healthcare facilities.

These findings align with existing literature, which emphasizes the role of cultural practices in childbirth decisions in rural and marginalized communities. For instance, studies by Bohren et al. (2014) and Sialubanje et al. (2017) highlight the influence of TBAs and the deep-rooted cultural norms that drive women to opt for home deliveries in similar contexts. However, the study also contrasts with findings by Gabrysch and Campbell (2009), who argue that increased awareness and education can lead to a shift towards hospital deliveries. The persistence of these cultural practices in Marsabit County suggests that cultural beliefs often outweigh the perceived benefits of institutional care, highlighting the need for culturally sensitive approaches in maternal health interventions.

The implications of these findings are significant, as they suggest that cultural norms and the role of TBAs are deeply embedded in the community's approach to childbirth. The preference for home deliveries is not merely a matter of access or convenience but is strongly tied to the community's identity and traditions. This cultural context must be considered when designing interventions aimed at promoting safer childbirth practices. Integrating TBAs into the formal healthcare system, as proposed by Byrne and Morgan (2011), could provide a bridge between traditional practices and modern medical care, ensuring that cultural beliefs are respected while improving maternal and neonatal outcomes. Public health campaigns should also be tailored to address cultural concerns, using messaging that resonates with the community's values and promotes the benefits of skilled birth attendance without alienating traditional practices.

Understanding the cultural influences on childbirth practices is crucial for developing effective interventions in Marsabit County. By acknowledging and integrating cultural practices into maternal health strategies, it is possible to create a more acceptable and effective approach to reducing the risks associated with home deliveries. For example, training TBAs to work alongside healthcare professionals could help maintain cultural practices while ensuring that women receive the necessary medical care during childbirth. Additionally, community engagement initiatives that involve elders and other key cultural figures can help shift perceptions towards the benefits of facility-based deliveries, gradually reducing the reliance on home births without undermining the community's cultural identity (Bohren et al., 2014; Byrne & Morgan, 2011; Sialubanje et al., 2017).

Conclusions

The study's findings revealed that the prevalence of home deliveries is still high in Marsabit County with the preference for home deliveries in Marsabit County influenced by a complex interplay of factors, including deeply embedded cultural practices that favored traditional birth attendants and valued family influence and privacy during childbirth. Socio-economic challenges, including low education levels, unstable employment, and financial constraints, limited access to skilled care, especially in the absence of health insurance coverage.

Recommendations

The Marsabit county health office should implement culturally sensitive community education programs that involve influential local leaders and traditional birth attendants to promote the benefits of institutional deliveries and shift harmful cultural norms around home childbirth.

The Marsabit county health office should expand access to affordable maternal healthcare services by strengthening initiatives like Linda Mama and providing financial support to low-income households, while also promoting maternal education through targeted adult learning programs.

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