CASE STUDY | NOVEMBER 2020

Bottlenecks and opportunities around the use of maternity waiting homes in Malawi

Maternity waiting homes (MWHs) are lodgings or accommodation close to a health facility where expectant women can wait until they go into labor, and have been in existence in Malawi for around two decades.[1–3] While MWHs have great potential to improve maternal newborn health (MNH) outcomes, additional evidence regarding their use is needed.[4] Not much is known about the number, characteristics, and experiences of women who use them.[5] A study in Malawi in 2018 showed that women who were giving birth for the first time, lived far from a hospital, or were of low socioeconomic status were more likely to utilize MWHs, yet this study only examined two model facilities.[6]

KEY POINTS

One fifth of clients who delivered at a facility stayed at a maternity waiting home (MWH).

Most stayed at formal MWHs at district hospitals.

Three-quarters were seen by a midwife every day.

RECOMMENDATIONS

Continue building the capacity of MWHs as part of the health system in Malawi, ensuring they have the space, inventory, and staff to meet the needs of women.

Continue to build linkages between chiefs of communities and facilities to ensure programs are in place to enable women to reach MWHs through affordable transport services and can pay for ancillary services upon arrival at the MWH.

Increase linkages between MWHs and labor wards to promote provider-client engagement and build trust in labor wards among clients.

Support providers to identify opportunities for improving client awareness on danger signs of PPH after birth as well as providing other health education to clients.

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This brief describes activities that are part of a larger portfolio of research led by the APPHC Partnership[a] on prevention, detection, and management of postpartum hemorrhage (PPH) which continues to be the biggest threat to childbearing women in Malawi.[7] Scoping activities, stakeholder consultations, and a formative assessment were conducted between April 2019 and March 2020 to understand key implementation barriers, bottlenecks and opportunities for improved prevention, early detection, and treatment of PPH in Malawi. Despite 91 percent of deliveries in Malawi taking place at a facility with a skilled provider,[8] only 42 percent of women receive a check-up within 48 hours of childbirth.[9] MWHs could potentially be used by postnatal women to improve PPH outcomes by providing women and their guardians or family members information on warning signs for PPH and other MNH issues before birth, as recommended by the Ministry of Health and Population (MoH),[3,10] and providing a place for high-risk women to stay after delivery before traveling home. This case study aims to: 1) describe and contextualize structural or procedural factors that influence provider and client behaviors in relation to use of MWHs; and 2) identify opportunities to enhance MWH use and improve MNH outcomes, including PPH.

The MoH is working with various international and national donors to construct MWHs in 16 districts, many of which have already been completed.[11] Scoping activities conducted by the APPHC Partnership in 2019 included visits to different levels of health facilities and highlighted a wide range of type and quality of MWHs. Some hospitals have formal, designated structures within the larger hospital compounds to use as MWHs, while other facilities have informal, improvised MWHs where women can "come and wait" before labor. These MWHs may be improvised antenatal or postnatal wards, or other unused structures or lodgings, where guardians of women might also stay. Additionally, there is a wide range of characteristics of MWHs, including number of beds, existence of accommodations for guardians, staffing (though all women staying in shelters are expected to be seen by a midwife), and amenities.[6,12] In part, this depends on management and donors of MWHs, where some are government run with national and international funders, and others are private and faith-based, for example.[11] This wide variation of MWHs highlighted the need to understand client experiences and provider perceptions and to generate evidence on ways to enhance the role of MWHs in Malawi. While MWHs have increasingly been adopted in Malawi, more evidence is needed on the extent to which MWHs are used and by whom, and identify opportunities to optimize their use in early identification and management of obstetric complications, such as PPH, including after delivery. This brief describes formative results on MWHs in four districts in Malawi.

Methods

A mixed method study was conducted in 25 faciliities in the Lilongwe, Balaka, Zomba, and Dowa districts of Malawi. Exit interviews with postnatal women aged 15 years and older (n=660) assessed their experiences with MWHs prior to giving birth at a study facility. Indepth interviews (IDIs) were conducted with postnatal women and maternal health providers to examine their perceptions on MWHs, barriers and facilitators for use, and opportunities to improve uptake. Bivariate analyses using quantitative data explored women's experiences with MWHs. Qualitative data were analyzed thematically.

Findings

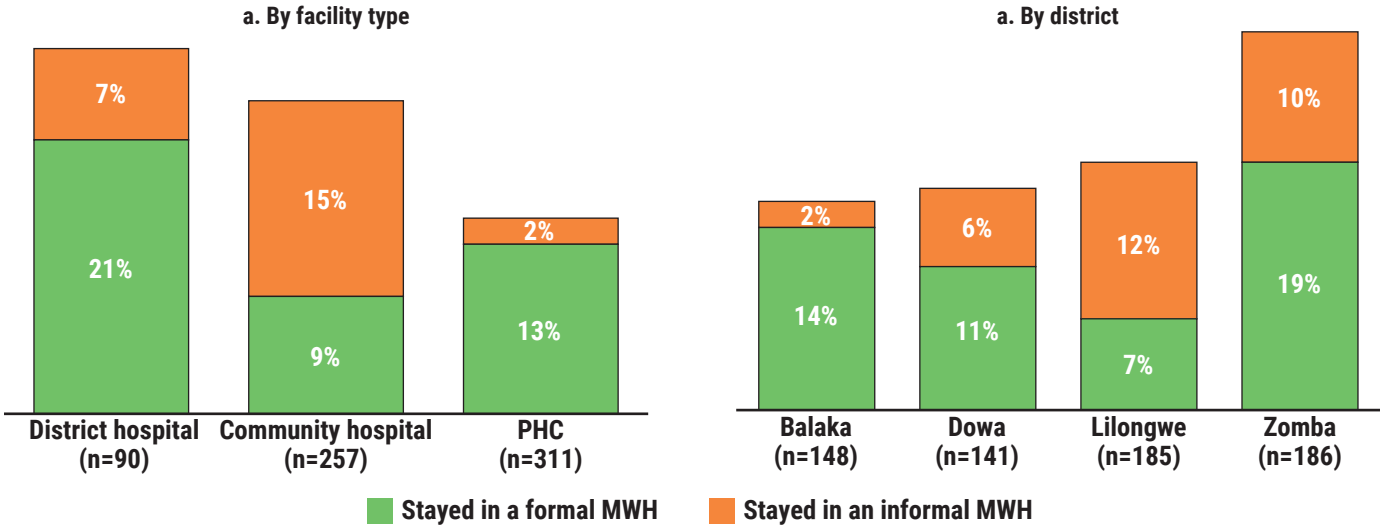
Use of formal and informal MWHs among pregnant women in Malawi

Twenty-one percent of postnatal women interviewed reported staying in or around the hospital before giving birth, 13 percent at a formal MWH and 8 percent at an informal structure, e.g., another hospital unit or a structure also used for guardians or birth companions (see Figure 1). Women who delivered at district hospitals were more likely to stay at a MWH (28%, p=0.004) and in particular at a formal MWH (21%). By district, significantly more women stayed at a MWH in Zomba (29%, p= 0.006).

In examining the use of MWHs by women's characteristics, there were no significant differences in use of MWHs by number of previous births (parity), age, marital status, education, or ANC visits. However, those who lived within 30 minutes of a facility were less likely to stay at a MWH (4%) than those who travelled between 30 and 55 minutes (21%) or an hour or more to the facility (23%), and this difference was significant (p=0.002, data not shown).

[a]The Advancing Postpartum Hemorrhage Care (APPHC) Partnership between Breakthrough RESEARCH and USAID's Health Evaluation and Applied Research Development (HEARD) Project, and the implementing partner Kamuzu College of Nursing under the University of Malawi, conducted formative research to understand key implementation barriers bottlenecks and opportunities for improved postnatal surveillance, prevention, and treatment of PPH in Malawi.

FIGURE 1 FORMAL AND INFORMAL MWH USE AT LAST BIRTH AMONG CLIENTS IN MALAWI



Attendance by health care providers during MWH stay

While staying at a MWH, approximately three-quarters of women said they were visited by a midwife every day (see Figure 2), where the expectation is that women who are stable are seen at least two or three times a week, and women with a risk factor are seen at least once every day for monitoring. There were no significant differences by facility type (p=0.064), though attendance did differ by district (p=0.044), with those in Lilongwe most likely to be visited by a midwife every day (83%).

Length of stay at a MWH

Two-thirds of respondents stayed at a MWH between one and four weeks (68%), see Figure 3 for further detail. There were no significant differences by facility type (p=0.319) or district (p=0.651) in length of stay.

Provider and postnatal womens' perceptions of MWHs

Findings from the qualitative interviews provide more information on the facilitating and constraining factors for utilization of MWHs by women.

FIGURE 2 ATTENDANCE BY PROVIDERS AT MWHS (N=135)

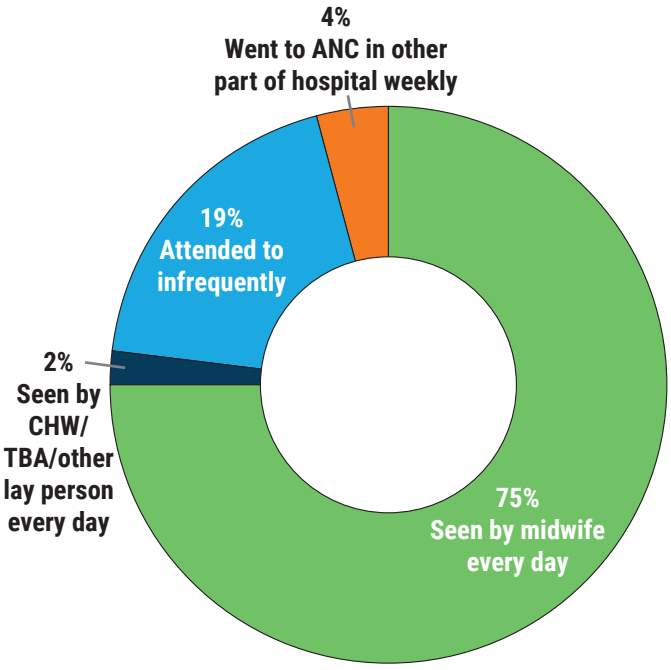
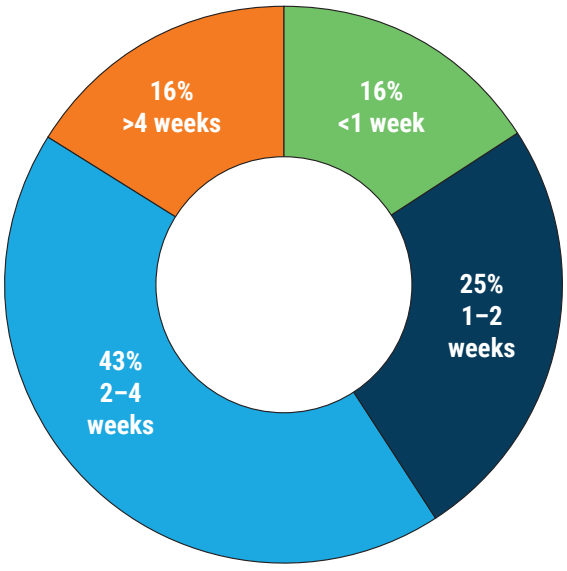


FIGURE 3 DURATION OF STAY AT MWHS (N=135)



Costs of staying in a MWH

Clients reported that while they did not have to pay service fees to stay at the MWHs, they did have to cover the costs of both transport to the MWH and food while staying there.

> **"[The cost] depends on the village of your origin. Some pay, but for us the government takes care of that…. The food was scarce due to the lack of money.**
>
> **—IDI, Postnatal woman**

Providers confirmed that cost was a prohibiting factor for women staying in MWHs.

> **"They pay nothing. They don't pay anything but they would. But that is a challenge and as I said they stay with a guardian in the same place, they eat hospital's food but the guardian needs food so can't stay here with no money.**
>
> **—IDI, Provider**

Availablity of space in MWH

Providers also reported limited space in MWHs and the maternity unit, especially those that are informal:

> **"It would be better if it was a special place…. It's the same room with few beds for postnatal mothers and a few beds for antenatal mothers waiting...sometimes some women may come for waiting but when the room is full they are told to go back.**
>
> **—IDI, Provider**

Similarly, women's experiences at MWHs echoed the physical constraints. Some reported inadequate conditions as well as being asked to do chores by hospital workers:

> **"I found myself at the maternity waiting home because I had malaria in pregnancy…. The space for sleeping was not adequate. We were woken up early in the morning because they wanted to mop the room. They will wake us up to do chores in the morning…like hospital workers. Hygienically it was not good especially in the bathrooms.**
>
> **—IDI, Postnatal woman**

Community by-laws

Providers reflected on the effect of community by-laws which established penalities for babies born before arrival (BBA) for women who delivered at home or on the way to a facility. While this created a demand for MWHs, it also led to crowding. Some communities have since revoked these by-laws.

> **"When the BBA penalties were happening, people would come, and it was challenging because we had no place to put them and we couldn't ensure their safety…. We would put bed nets on couches used for antenatal…. As a result, we had to wake them in the morning to say they have to give way for the clinics, and they had to move their belongings…. The women would end up walking around all day with no place to rest…. After the penalties were abolished, the people come out of their own free will.**
>
> **—IDI, Provider**

Though BBA penalties are not in place everywhere, it appears that some continue to receive information that they do still exist:

> **"[Health surveillance assistants] said that if I start draining liquor that is a sign that I am in labor and I should start off to the hospital. I should not have a home delivery; it will attract a penalty.**
>
> **—IDI, Postnatal woman**

Provider attitudes

Providers mentioned client perceptions of provider attitudes as a barrier to optimal use of MWHs, especially their tone of voice and provision of mixed advice that may be confusing to clients. One provider mentioned that women preferred to stay in the MWHs longer than they should, due to providers' attitudes in the labor and delivery ward.

> **"Attitudes for some of the providers: this is also another factor because**

some providers have got their voices which is very loud…. [The providers] may say 'hey I told you to go and ambulate' and [the clients] may feel like maybe I should come when the labor is well established. As a result, they come in second stage of labor or some may just opt to say 'oh I just go there with a baby'.

—IDI, Provider

Discussion

Little is known about behavioral and structural factors that affect PPH prevention and treatment. Results of this case study on MWHs showed that around a fifth of postnatal women had stayed at some form of waiting home before delivery at a facility. Qualitative findings suggest that financial and space constraints, community by-laws, and client perceptions of provider attitudes are barriers to MWH use. These findings build on recent research on satisfaction, perceptions, and use of MWHs in Malawi which demonstrated that toilets/showers, guardian spaces, safety, building maintenance, sleep area, and private storage were important factors in client satisfaction with MWH experiences.[13] Previous research[6] showed that women giving birth for the first time were more likely to use an MWH, as were those who lived farther away from a facility. While the present case study found no difference by parity, it did find that those who lived farther away from a facility were more likely to stay at an MWH.

This case study suggests that MWHs could be used to strengthen prevention and early detection of PPH. MWHs allow providers to communicate messages about PPH danger signs, among other MNH concerns and health education messages, to women and their companions or family members,[10] and provide opportunities for midwives to build relationships with women to improve their trust in providers by the time they go in for labor.

Recommendations

- Continue building the capacity of MWHs as part of the health system in Malawi, ensuring they have the space, inventory, and staff to meet the needs of women.
- Continue to build linkages between chiefs of communities and facilities to ensure programs are in place to enable women to reach MWHs through affordable transport services and can pay for ancillary services upon arrival at the MWH.
- Increase linkages between MWHs and labor wards to promote provider-client engagement and build trust in labor wards among clients.
- Support providers to identify opportunities for improving client awareness on danger signs of PPH after birth as well as providing other health education to clients.

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