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Promoting access: The use of maternity waiting homes to achieve safe motherhood

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ABSTRACT

Objective: to examine the structural and sociocultural factors influencing maternity waiting home (MWH) use through the lens of women, families, and communities in one rural county in postconflict Liberia.
Design: an exploratory, qualitative descriptive design using focus groups and in-depth, individual interviews was employed. Content analysis of data was performed using Penchansky and Thomas's (1981) five A's of access as a guiding framework.
Setting: rural communities in north-central Liberia.
Participants: a convenience sampling was used to recruit participants. Eight focus groups were held with 75 participants from congruent groups of (1) MWH users, (2) MWH non-users, (3) family members of MWH users, and (4) family members of MWH non-users. Eleven individual interviews were conducted with clinic staff or community leaders.
Findings: the availability of MWHs decreased the barrier of distance for women to access skilled care around the time of childbirth. Food insecurity while staying at a MWH was identified as a potential barrier by participants.
Key conclusions: examining access as a general concept within the specific dimensions of availability, accessibility, accommodation, affordability, and acceptability provides a way to describe the structural and sociocultural factors that influence access to a MWH and skilled attendance for birth.
Implications for practice: MWHs can address the barrier of distance in accessing skilled care for childbirth in a rural setting with long distances to a facility.

Introduction

Women in the world's developing countries are 300 times more likely to die in childbirth or from pregnancy-related complications than women in developed countries (United Nations Children's Fund [UNICEF], 2009). It is estimated that approximately 99% of global deaths arising from pregnancy related complications occur in the developing world where there is a prevalence of high fertility rates, a shortage of skilled birth attendants, and weak health systems (UNICEF, 2009). Ten countries in Africa have the highest lifetime risk of maternal death, including Liberia (UNICEF, 2009).

Interventions for the prevention of maternal mortality, many with little success, are as varied as its causes. For example, approaches such as the training of traditional birth attendants have not accomplished stable decreases in maternal mortality (World Health Organization [WHO], 2006; United Nations Population Fund [UNFPA], 2012). Over the past 20 years, governments and aid institutions have reached a consensus that facility-based births managed by skilled birth attendants are the best means to reduce maternal mortality. Recently, the focus has shifted from single, silo interventions to a multipronged approach to strengthen health systems and improve access to health facilities and skilled care for improved maternal health (Maine and Rosenfield, 1999; Abou-Zahr and Wardlaw, 2003; Campbell

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and Graham, 2006; WHO, 2012). However, access to facilities and skilled birth attendants are often insurmountable barriers to many women.

Maternity waiting homes (MWHs) are temporary shelters for pregnant women located near a hospital or health centre. MWHs have been endorsed by WHO as one component of a comprehensive package to reduce maternal morbidity and mortality (WHO, 1996). These shelters, also known as maternal waiting homes, waiting homes, or maternal waiting areas are available to pregnant women from rural areas or those at high risk for obstetric complications to help surmount the barriers of distance and time to the health centre (Stekelenburg et al., 2006; Bhutta et al., 2009; van Lonkhuijzen, et al., 2012).

MWHs have existed in various forms for over 100 years in Europe and North America (Liebmann, 1995). In the developing world, the use of MWHs was mentioned as early as the 1950s when they were introduced in rural Nigeria (Poovan et al., 1990; Liebmann, 1995; Figà-Talamanca, 1996). Beginning in the 1960s the idea of MWHs was reenergised and promoted as a potential intervention to bridge the physical chasm that prevents rural women from receiving skilled maternal health care (van Lonkhuijzen et al., 2012).

MWHs are currently located in the Caribbean, South America, Central American, Africa, and Southeast Asia (van Lonkhuijzen et al., 2012). The widespread appeal of MWHs lies in the breadth of their applicability and the simplicity of the concept – a place near a clinic or hospital where women can rest and be monitored until giving birth with a skilled attendant. The use of MWHs as a residential facility near a health care facility has the potential to minimise the barrier of distance for pregnant women to access a skilled birth attendant (WHO, 1996).

Background

Liberia, located on the coast of West Africa, has one of the highest maternal mortality rates in the world (WHO, 2012). A Liberian woman faces a 1 in 20 risk of dying from birth-related causes over the course of her reproductive life (UNICEF, 2009). The reproductive portrait of Liberian women is marked by high fertility, early sexual debut and childbirth, and high levels of unmet contraceptive needs (Lori and Boyle, 2011).

In the aftermath of the devastating 14-year civil and rebel wars, Liberia has been left with a shattered infrastructure and some of the poorest health statistics on the continent. At the cessation of the war in 2003, the percentage of health workers was reduced by 60%, leaving only 30 doctors to serve a population of three million (WHO, 2003; United Nations Development Program [UNDP], 2006). Additionally, 95% of the country's health facilities had been destroyed (WHO, 2003; UNDP, 2006). Basic public health services including hospitals, clinics, electricity, and potable water were ravaged by rebel forces. Many women in Liberia were exposed to gender-based violence and war crimes including sexual assault, rape, and murder (WHO, 2004). WHO estimates that since 2000 the maternal mortality rate in Liberia has almost doubled to 994/100,000 live births in 2007 (Liberia Institute of Statistics and Geo-Information Services [LISGIS], 2008; WHO, 2011). This increase in poor health outcomes is attributed to poor access to health services including such barriers as distance to health facilities, cultural preferences, and a shortage of skilled birth attendants (Lori and Starke, 2012).

In 2010, a four-year study to evaluate the effectiveness of MWHs in Liberia was funded by the United States Agency for International Development as one of six Child Survival Grants. Five clinics were chosen to receive the intervention; a MWH built next to a rural health care clinic. Five clinics, matched by size, location, and population demographics were chosen for the comparison group.

The purpose of this study was to examine the impact of MWHs to improve access to facility-based childbirth and skilled care in rural areas of a post-conflict country. Focus groups and individual interviews with community members including users of the MWHs, non-users of MWHs, family members, clinic staff, and community leaders were utilised to provide an understanding of the structural and sociocultural factors influencing MWH use through the lens of women, families, and communities. Specifically, this study addressed two research questions:

(1) How do women, family members, and communities understand and describe access to facility care and MWHs?
(2) What are the structural and sociocultural factors that influence access to a MWH?

Literature review

Maternity waiting homes have demonstrated such benefits as an increased proportion of facility-based childbirths (Cardoso, 1986), improved maternal health (Cardoso, 1986; Knowles, 1988), a lower risk of perinatal death (Chandramohan et al., 1995), decreased incidence of obstructed labour (Chandramohan et al., 1994), improved access to essential and emergency obstetric care (Eckermann, 2006), good access to health care (Spaans et al., 1998), and the potential to decrease rates of stillbirths (Chandramohan et al., 1995; Bhutta et al., 2009; Lee et al., 2009). Systematic reviews have concluded that MWHs have proven to be effective, but the evidence is limited because of a lack of properly designed intervention studies (Stekelenburg et al., 2006; van Lonkhuijzen et al., 2012).

There are also recognised barriers to accessing health care within developing countries that apply to MWHs. These include such variables as cost, location, lack of knowledge about the MWH, and cultural barriers. The cost associated with staying in a home can be prohibitive, and for all the risk, home births remain the least expensive birthing option (van Lonkhuijzen et al., 2012). Indirect and direct costs pose significant and often insurmountable challenges to many would-be service users.

In Ghana, a MWH built in an abandoned hospital suffered from very low use (Wilson et al., 1997). The low use of the MWH facility was mainly attributed to its deserted surroundings and distance from the hospital (Wilson et al., 1997). Meanwhile, a MWH in Timor-Leste failed to improve access to facility-based childbirths for women who lived farther from the facility in more remote locations (Wild et al., 2012). In rural or isolated areas, women and communities may be unaware of a home's existence or its uses. In these contexts, the most expedient manner in which to instill knowledge of the home and its services can be through social networks.

A study of a failed intervention in Kenya revealed the majority of women surveyed stated they would need their husband's approval to use the MWH (Mramba et al., 2010), indicating the importance of family and community support, regardless of whether the intervention was initiated by the community or an external organisation. Homes act as a proxy for facility-based births, yet traditional birthing practices may mean that facility-based births are unacceptable due to separation from family and lack of privacy.

The largest study to date, conducted in Ethiopia, cited that acceptance and support by the local community is vital and attributed the success of their MWH to community links (Kelly et al., 2010). Incorporating women's needs for comfort by integrating cultural practices helps to negotiate the space between these systems while maintaining positive outcomes. Traditional