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## CLINICAL ARTICLE

## Husbands' experiences and perceptions regarding the use of maternity waiting homes in rural Zambia

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## ABSTRACT

**Objective:** To explore men's experience and beliefs regarding the use of maternity waiting homes (MWHs) in Kalomo District, Zambia. **Methods:** As part of a qualitative study, in-depth interviews with the husbands/partners of women attending the under-five clinic at a health center with a MWH were conducted between April 1 and May 31, 2014. Men aged 18–50 years whose partner/wife was of reproductive age and who had lived in the area for more than 6 months were eligible for inclusion. **Results:** Overall, 24 husbands/partners were interviewed in seven rural health centers. Men perceived many potential benefits of MWHs, including improved access to facility-based skilled delivery services and treatment in case of labor complications. Their many roles included decision making and securing funds for transport, food, cleaning materials, and clothes for the mother and the neonate to use during and after labor. However, limited financial resources made it difficult for them to provide for their wives and newborns, and usually led to delays in their decisions about MWH use. Poor conditions in MWHs and the lack of basic social and healthcare needs meant some men had forbidden their wives/partners from using the facilities. **Conclusion:** Important intervention targets for improving access to MWHs and skilled birth attendance have been identified.

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## 1. Introduction

Many women in rural Zambia do not receive assistance from skilled birth attendants during labor because of limited access to health facilities [1–3] and the long distances to be travelled to reach them [4–11]. To increase access, maternity waiting homes (MWHs) have been established in many low-income countries, including Zambia [12,13]. WHO has defined MWHs as “residential facilities, located near a qualified medical establishment, where women with high-risk pregnancies can wait for their delivery and be transferred to a nearby medical facility shortly before delivery, or earlier, should complications arise” [12].

Currently, evidence to support the effectiveness of MWHs to increase access to skilled birth attendance for women living in remote areas or with limited access to services is scarce [14]. However, studies conducted in low-income countries suggest that MWHs could help to

improve maternal and newborn health outcomes [13,15–17]. In Ethiopia, Kelly et al. [16] reported that women attending MWHs before hospital admission had lower maternal mortality rates and fewer stillbirths than did those who were directly admitted to a hospital.

Moreover, studies show that women have a positive attitude to MWHs [15,18]. Nevertheless, use of MWHs is still low in most low-income countries [13,15–19] because of various reasons, including the lack of financial resources available while staying in the MWHs and women's lack of decision-making autonomy [18,20–23]. For example, a study in Ghana [20] reported that women could only use facility-based delivery services if they obtained permission from their husbands. Moreover, Mpembeni et al. [22] showed that single Tanzanian women with some financial autonomy were more likely to use institutional delivery services than were married women. Nevertheless, there is a lack of evidence on husbands' perspectives and their role in supporting their families to seek healthcare services. One qualitative study conducted in Egypt [23] and involving women of reproductive age, as well as men and elderly women, showed that husbands played an important role in supporting their families and assisting their wives in seeking healthcare services.

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The aim of the present study was to explore men's experience and perceptions regarding their role as decision makers and providers for their partners' healthcare needs during pregnancy and childbirth, as well as the use of MWHs. This understanding is important because it will provide a starting point for interventions focusing on improving use of MWHs and facility-based skilled delivery services in rural Zambia.

## 2. Materials and methods

A qualitative study was undertaken in Kalomo District, Zambia. This district has an estimated population of 275 779, with an annual growth rate of 4.4%. The district has two first-level referral hospitals, 34 health centers, and several health posts. Of the 34 health centers, only 10 have MWHs. Ethical approval was granted by the Zambian Tropical Diseases Research Centre Ethics Review Committee and the Ministry of Health Research and Ethics Committee. All participants provided written consent.

Study participants—husbands/partners of women who had attended a health center with a MWH—were purposefully selected at health centers with MWHs using multistage convenience sampling. First, all 10 health centers with MWHs in the district were identified. Second, senior health officers in charge of these centers were contacted regarding the purpose of the study and were asked to inform mothers attending the under-five clinic about the study. Mothers were then advised to inform their husbands/partners (hereafter, husbands) about the study and ask them for possible participation. If they were willing to participate, they attended the clinic with their wives/partners during their next under-five clinic visit.

Convenience sampling was then used to select men for inclusion. Among the men presenting to the clinics, those aged 18–50 years, whose wife/partner was of reproductive age (i.e. aged 15–45 years) and had given birth within the last year (either at the clinic or at home), and who had resided in the area for more than 6 months were eligible for inclusion. Additionally, men who had lived in the district for less than 6 months were excluded because it was considered that they would not have sufficient local experience of MWHs and facility-based delivery. Respondents were selected from different health centers, villages, and families to allow researchers to elicit and encounter as many different views as possible from the selected respondents. Thus, a holistic investigation of the differences in roles and perceptions on the basis of husbands' experiences with the MWHs was possible, providing in-depth insight into the subject under investigation [24].

Between April 1 and May 31, 2014, interviews were conducted in Tonga by two trained research assistants outside the health center premises, normally under the shade of a tree, while the women were in the under-five clinic. To ensure privacy and confidentiality, each in-depth interview was conducted in a quiet place, and lasted 30–50 minutes. Written consent was obtained from participants before the interviews by requesting them to read and sign the consent form, which had been translated into Tonga. Additionally, respondents were asked to complete a short demographic questionnaire. For those who could not read and write, the consent form and the questionnaire were read to them and completed by a research assistant. The interview was conducted by one research assistant, while the second recorded the session using a digital voice recorder.

A semi-structured interview guide (Supplementary Material S1), translated into Tonga, was developed on the basis of a literature review and researchers' experiences and findings from their previous studies in the area [5,6,18]. Husbands' perceptions about the perceived benefits and barriers, decision-making process, and their roles in their wives' use of MWHs, were explored. Interviews continued until data saturation was achieved.

The research assistants transcribed and translated the voice recordings into English, and 20% of the transcripts were back-translated into Tonga to check the translation accuracy. The Tonga and English versions were compared for differences and similarities by the research

assistants while listening to the original voice recording. Following proof-reading and corrections, transcripts were saved on a password-protected computer, exported into Nvivo10 for Mac (QSR International, Melbourne, VIC, Australia) for processing, and data were coded and categorized. An inductive approach was used to identify the key themes by content-analyzing and grouping of all the similar statements made with respect to particular themes. The demographic information of the respondents was analyzed using descriptive statistics in SPSS version 21 (IBM, Armonk, NY, USA).

## 3. Results

A total of 24 in-depth interviews were conducted with husbands in seven health centers, after which data saturation was achieved. The research team decided to stop the interviews and, thus, leave out the remaining three selected clinics. Table 1 summarizes the demographic characteristics of the respondents.

Most husbands perceived many benefits from their wives' use of MWHs, including the belief that MWHs increased access to facility-based skilled birth assistance and mitigated the long distances and transport costs to health facilities. Staying in the MWHs made it easy for pregnant women to walk to the clinic to see the nurse or midwife as soon as they knew they were in labor. One husband aged 39 years stated "The mothers' shelters provide a lot of benefits for the mother and the child, because it will be easy for them to walk to the clinic and tell the nurses that they need help." Moreover, nurses and midwives could easily identify women with a high risk of labor complications and provide timely treatment. Those with complications could then be referred to the district hospital for further management and care.

Furthermore, husbands indicated that MWHs provided family accommodation facilities, allowing pregnant women to be accompanied

**Table 1**  
Characteristics of the respondents (n = 24).<sup>a</sup>

Variable	Value
Age, y	35.02 ± 8.60
Number of children	3.22 ± 2.21
Marital status	
Unmarried	2 (8)
Married	22 (92)
Widowed	0
Divorced	0
Level of education	
Lower primary (1–4 y)	1 (4)
Upper primary (5–7 y)	7 (29)
Junior secondary (8–9 y)	8 (33)
Senior secondary (10–12 y)	8 (33)
Occupation	
Farmer	15 (62)
Self-employed	5 (21)
Formal employment	4 (17)
Income per month, kwacha	
None	1 (4)
<100	5 (21%)
100–250	10 (42%)
251–500	4 (17%)
501–1000	4 (17%)
Walking time to the clinic, min	160 ± 20
Place of delivery for the youngest child	
Home	12 (50)
Health center	4 (17)
Hospital	8 (33)
Use of maternity waiting homes	
Yes	11 (46)
No	13 (54)
Complications during previous childbirth	
Yes	7 (29)
No	17 (71)

<sup>a</sup> Values are given as mean ± SD or number (percentage).

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