Maternity Waiting Homes (MWHs) were introduced in Loima and Turkana West sub-counties of Turkana county to reduce high maternal mortality rates. International evidence shows that MWHs can be highly effective; this was corroborated by results from three sites in Turkana county where MWHs resulted in increased uptake of skilled birth attendance and no maternal deaths among women who stayed in the MWHs. Women who stayed in the MWHs were extremely satisfied and felt that word of mouth communication between women would reassure those who had doubts or lacked information about MWHs. Important lessons were also learnt in how best to establish MWHs in geographically remote, and culturally sensitive areas.

A strong, and growing, body of evidence indicates that well implemented maternity waiting homes (MWH) are an effective, acceptable, feasible and sustainable way of addressing multiple barriers faced by pregnant women living in remote rural areas. Studies in several countries in Africa including, recently, Malawi, Tanzania and Zambia also show positive maternal and newborn health (MNH) outcomes among women who utilise MWHs and, as a result, access facility-based care for delivery and in the immediate post-natal period.

MWHs are a particularly appropriate solution in places where women face very significant barriers to the safe delivery of their babies. These may be the distance to health facilities, difficult terrain, cultural beliefs and practices that limit timely decision-making to access health care, and lack of easily available transport.

The purpose of the MWHs in Turkana county was to minimize women’s distance from health care, ensure women delivered at a facility, and enable timely and rapid referrals for any maternal complications. The ultimate objective was to reduce the very high maternal and newborn mortality rates.
Approach

The Pambazuka (New Dawn) project drew on lessons learnt from a pilot study in Samburu county, to develop 2 MWHs in Loima sub-county and 1 in Turkana West sub-county. All the MWHs were constructed inside or next to the health facilities’ compounds.

From the outset, local communities, the sub-county and County Health Management Teams (S/CHMT) and other key stakeholders were consulted. Participatory meetings resulted in clear understanding of duty bearers’ and communities’ views, resulted in appropriately designed and equipped MWHs, and led to a sense of ownership among both the communities and the S/CHMTs.

Decisions reached through this participatory process included the MWH design. This was based on a Turkana traditional hut (Manyatta) structure and used local materials. It was also agreed that the homes would be equipped with traditional items such as cooking utensils, local beds and a cooking fire place. A place was also provided to accommodate Turkana traditional rituals and practices, particularly those associated with pregnancy and childbirth.

This meant the MWHs were welcoming in appearance, provided a familiar environment, and were culturally appropriate (failing to achieve this has been a major shortcoming of earlier MWH initiatives in low- and middle-income countries).

Throughout the construction process all stakeholders were kept informed and involved.

Based on lessons from the Samburu pilot, women staying in the MWHs were also provided with food, water, basic hygiene products and security. This meant that there were no direct costs for women and their families. Instead, the range of benefits they received incentivised them to arrive at the MWH in good time.

It has made it convenient for pregnant mothers to reach the facilities in time and be able to stay in the Maternal Waiting Homes until they deliver.”

Focus group discussion with elders, Turkana county

Outcomes

An end of project evaluation identified the following outcomes:

- 98 women delivered in health facilities after using a MWH.
- 90% of these women reached the MWH by foot.
- The main reasons for women using a MWH were the distance from their home to the health facility (48%) and being at potentially high risk of complications (40%).
- There were no maternal or neonatal mortalities among women who stayed in a MWH.
- 62% of community women were positive about MWHs. The remaining women were anxious or lacked information about MWHs. Those who had used MWHs believed that communication between women in the community would, relatively quickly, dispel other women’s reluctance to use the MWHs.

MWHs in Turkana County

- Durum health centre
- Napa health centre
- Turkana West sub-county
- Loima sub-county
- Kakuma sub-county hospital
Community consultation is essential to ensure ‘buy in’ and agreement on appropriate design, materials and furniture. A strong sense of ownership among the community increases acceptance of MWHs by both men and women, and results in higher levels of utilisation of MWHs.

Engagement with S/CHMTs is also essential. They also need to strongly support the initiative, feel involved, and understand MWHs relevance to policy and health outcomes. These are the structures who will need to fund MWHs so as to ensure sustainability S/CHMTs need to be willing to do so.

Traditional building designs, materials and furnishings should be used or adapted. This increases women's confidence and comfort and the familiarity makes MWHs both welcoming and culturally appropriate. This also increases uptake.

Space for traditional rituals associated with pregnancy and childbirth needs to be provided as this encourages both husbands and wives to support the use of MWHs.

Providing food, and basic sanitary and clothing items is good for women’s health, ensures there are no direct financial costs to their family, and create non-monetary incentives to encourage utilisation.

A post-partum package on discharge benefits women and their newborns.

It is very much appreciated and helps to reinforce positive community views of MWHs.

Placing MWHs close to/within facility compounds enables health workers to easily carry out routine checks on women, ensures timely referrals when needed, and enables MWHs to utilise facility security, thus reducing running costs.

The outcomes of the Pambazuka MWH project effectively incorporated lessons from the earlier pilot study in Samburu county. This resulted in high levels of community acceptance; recognition of the benefits of MWHs by men as well as women; and very positive maternal and newborn outcomes in remote areas where cultural beliefs and traditions do not encourage institutional delivery.

MWHs also link well to the Kenya Health Sector Strategic Plan (2014-2018) as they increase equitable access to essential health services while also reducing maternal and newborn mortality in poor and marginalised communities.

The maternal (sic) waiting home also has a great experience because after delivery you are given drugs, a bed and food and you are also being taken care of by the health workers until you are well enough to go back home.”

Focus group discussion with women in Turkana county

“Those who are yet to use these waiting homes are encouraged to use it because of the experience they have heard from the others who have used it.”

Focus group discussion with women in Turkana county

Start up and running costs for MWHs are required from S/CHMTs but levels of uptake and positive maternal and neonatal outcomes strongly suggest that MWHs are both appropriate and cost effective where women would not otherwise be able to reach MNH services.

This means that there needs to be a high level of buy-in, funds available and willingness by the S/CHMT to support MWHs.

Community buy-in is also essential to ensure sufficient levels of up-take. Community consultations and co-design of MWHs to reflect traditional structures and culture, and using traditional materials are important ways of achieving this. This enhances acceptability and utilization by local communities and reduces the cost of maintaining buildings. It is also critical to involve S/CHMTs to ensure MWHs adhere to Ministry of Health standards.

Time is needed for MWHs to become fully accepted by men and women and communities, and an established part of women’s health seeking behaviour in pregnancy.

MWHs closeness to health facilities means that it is easy for...
service providers to synchronise visiting women in the MWH with their duties at the facility.

MWHs are not necessary for all areas. They are most appropriate for remote areas with poor MNH outcomes where women face distance and transport barriers to timely access to quality MNH services. In these settings investing in MWHs is more appropriate than focusing on taking services out to women in the community.

Well designed and managed MWHs appear to be cost effective, but once MWHs have had time to become established, a social return on investment (SROI) study would provide important evidence to inform S/CHMT planning and budgeting.

Any intervention which increases uptake of services needs to be matched by improvements to the supply-side, for example in staffing levels and capacity, and equipment. MWHs should be implemented as part of comprehensive efforts to improve MNH.

"Through the construction of maternal waiting shelters, the design of those waiting shelters were very much relevant and the community gave a positive feedback that whenever (they are) involved in such kind of things they are going to be able to deliver at the facilities."

Key informant interview with S/CHMT member

Footnotes
4. Satti H, McLaughlin MM, Seung KJ. The role of maternity waiting homes as part of a comprehensive maternal mortality reduction strategy in Lesotho. PIH Reports 2013;1(1).
8. The Pambazuka project (December 2015 – August 2017) was implemented by International Rescue Committee (IRC), Kenya with funding from the UK Department for International Development (DFID) through the County Innovation Challenge Fund (CICF) managed by Options Consultancy Services and KPMG.