Addressing Delay 2: Maternity Waiting Shelters to Improve Access to Services in Zambia

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May 5, 2014

What Did we Learn, How to Improve
MSD for Mothers: A Brief Overview
**Product Innovation**
Identify and develop new and/or improved life-saving technologies for resource-poor settings

**Access to Affordable, Quality Care**
Increase coverage of sustainable maternal health and family planning solutions

**Global Awareness and Advocacy**
Advocate for increased investment and supportive policies to expand sustainable maternal health solutions
<table>
<thead>
<tr>
<th>Country</th>
<th>Programs</th>
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<tr>
<td>Zambia</td>
<td>Development of entrepreneurial models for maternity homes</td>
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<tr>
<td>Uganda</td>
<td>Social Franchising, Transportation</td>
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<td>US</td>
<td>State-based maternal mortality reviews, Standardized protocols for emergency obstetric care, Community insurance and savings, Community efforts to address preexisting conditions</td>
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<tr>
<td>India</td>
<td>Accreditation, Social franchising - urban &amp; rural, Telemedicine for access to remote care, Consumer Rating Tool</td>
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<td>Senegal</td>
<td>Innovative financing, Informed Push Model to decrease stock-outs of family planning products</td>
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<td>Brazil</td>
<td>Health provider survey to inform program development, In situ obstetric drills (TBD)</td>
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Why Maternity Homes?

- Potential to address geographic barriers to facility delivery (delay 2)
- Globally, questions about their value and impact
- A culture of using maternity homes in Zambia, but they are often in poor condition, lack programming and have insufficient linkages to care
- Quality and sustainability are major issues
To develop and test entrepreneurial models for maternity homes that are responsive to community needs, operationally and financially sustainable and effective in increasing access to quality facility delivery among the most vulnerable women.
**Phase 1**: Community research to inform design and feasibility of entrepreneurial maternity home models

**Phase 2**: MSD for Mothers will select at least one model to implement and test to determine effectiveness in increasing access to quality facility delivery for vulnerable women and potential for long-term sustainability
Phase 1 Partners

* indicates SMGL district
**MSD for Mothers** hosted a “challenge” event in Zambia on April 10 to hear about our partners’ findings and learn about their new models.

- Partners presented formative research findings and pitched preliminary concepts for new maternity home models to a multidisciplinary expert panel.
- Audience included government stakeholders and maternal health donors.
- Panelists provided feedback and coaching to partners to assist them in refining models for phase 2 proposals.
Dr. Stephen Munjanja  
Professor, Department of Obstetrics and Gynecology  
*University of Zimbabwe*

Emily Sikazwe  
Executive Director  
*Women for Change*

Andrew Simpson  
Managing Director  
*Imani Development/Director, Social Enterprise Academy Africa*

Dr. Priya Agrawal  
Executive Director  
*MSD for Mothers*
Dr. Munjanja presented findings from a forthcoming WHO systematic review* and a context and conditions analysis** of maternity home implementation

- Systematic review (31 papers) examined eligibility to stay, costs, intermediate outcomes, maternal and newborn outcomes and women’s views
- Drawing conclusions about the efficacy was challenging due to weak study design (none were RCTs with intervention and control areas, pre- and post-assessment); common findings include:
  - Reductions in obstructed labour, ruptured uterus, and fistulas; reduction in stillbirth and perinatal mortality; reductions in maternal mortality
  - Increase in ANC, facility births, postnatal care; care earlier in labour than non-MWH women; EmOC, C/sections more frequent, earlier in labour
- Context and conditions analysis (22 papers) examined general context, administrative set-up and maintenance, physical infrastructure, health related facilities at maternity homes, barriers and enabling factors
- Conclusions (example):
  - Building maternity homes alone is unlikely to drive facility use, rather they must incorporate individual, cultural, socio-economic, geographical, political and health-system factors to improve utilization

*Systematic review conducted by Matthew Chersich (University of Witwatersrand) Annie Portela (WHO/MCA)
**Context and conditions analysis by Julia Hussein (University of Aberdeen) and Stephen Munjanja (University of Zimbabwe)
Partner Findings and Models
MfM partners used **mixed methods** in their formative research which informed their model designs

- **Qualitative Analysis** | Conducted free listening sessions, interviews and focus group discussions with over **1,170 participants**

- **Quantitative Analysis** | Conducted facility and maternity home assessments at over **80 sites**; willingness to contribute
Key Findings

- Value of facility delivery and maternity homes
- Current conditions widely varied (infrastructure, functioning, management, accountability and utilization), but largely poor
- Weak linkages to facilities and variable distance
- Barriers to utilization
  - Lack of food, security, privacy
  - Disrespectful care at the facilities
  - Lack of activities – boredom
  - Cultural beliefs that shelters are cursed to delay delivery
  - Cultural practices not permitted (e.g. “traditional oxytocin”)
  - Indirect costs associated with stay
- Importance of engaging traditional leaders for community buy-in
- Local commitment to making significant contributions
- Individual willingness to contribute varied geographically (K0-50)
- Strong interest in income generating activities
Boredom was cited as a common barrier to maternity home utilization
Willingness to contribute increased significantly when respondents were introduced to proposed improvements in maternity home attributes and services.
Maternity homes must be linked to facilities that have the capacity to handle patient loads.
Key Features of Proposed Models

• Improved infrastructure (cooking, lighting, amenities, security)
• Improved services (linkage with facility providers; antenatal and postnatal care; bolstering capacity of facility; improving respectful care; engagement of companions/TBAs)
• Improved management and governance
  – Community governance with accountability frameworks
  – Results-based financing
• Sustainability/Revenue
  – Shelter-based IGAs (e.g. tuck shop, sale of CDKs and other mother/baby products, skills training for women to make and sell products to market, gardening, bakeries, chickens, bee keeping, hammer mill, etc)
  – Community-based IGAs (e.g. agricultural scheme to improve yields for larger community in exchange for a portion of profits going to shelter; IGAs for SMAGs; food processing, fish farming)
  – Individual and community contributions (money, construction, maintenance)
• Demand generation
  – Enhanced birth planning including RBF for savings and planning milestones
• Collaboration with government to establish national standards
• Government role and responsibility, regardless of IGAs
• Linkage with high quality facilities with capacity to meet increased demand
  – CEmOC or high-functioning BEmOC with max 2 hour transfer
• Benefits to rooting IGAs in community
  – scale and potential long-term sustainability
  – addressing disconnect between where MH is located and where women come from
• Need to explore “out of the box” IGAs (e.g. solar electricity, entertainment, rocket stoves, microlending) and context specific IGAs (e.g. palm oil processing in Luapula Province, cottage industries in Southern Province)
• Gender Perspective – caution on ensuring adequate representation of women on community committees
• Need to construct economic argument for maternity homes
Thank You