Antenatal Mothers’ Experience of Staying in a Maternity Waiting Home at Malamulo Mission Hospital in Thyolo District Malawi: A Qualitative, Exploratory Study

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Introduction

The concept of maternity waiting homes (MWHs) has a long history spanning over 100 years [1]. However, in many areas of the world, and especially in sub-Saharan Africa, utilization of maternal health services is low. Low utilization of maternal health services is mainly a result of barriers to access, and lead to high maternal and perinatal mortality and morbidity [2]. In low-resource settings, cost, distance, and the time needed to access care are major barriers for effective uptake of antenatal and particularly intrapartum services. The aim of this study was to explore antenatal mothers’ experiences of staying in the maternity waiting homes in Thyolo District.

In less developed countries, more than half a million mothers die each year from causes related to this life-giving event. These deaths are only part of this tragic picture: For every woman who dies, about thirty suffer from devastating health problems such as infertility and damage to their reproductive organs. Ninety-nine percent of these deaths occur in less developed regions, and most are due to inadequate medical care at the
time of childbirth. Evidence shows that motherhood can be safer for all women. Over the past decade, experts have largely come to agree on a set of lifesaving strategies that can work even in low-resource settings such as MWHs. What remains is for governments to commit to making safe motherhood a priority. Research shows that women’s lives can be saved and their suffering reduced if health systems could address serious and life-threatening complications of pregnancy and childbirth when they occur [4].

One of the best ways to reduce complications is to make sure that women receive skilled care at delivery. Only about half of deliveries in less developed countries take place with the assistance of skilled health personnel. Providing skilled care means ensuring that health professionals such as doctors, nurses, or midwives can manage normal deliveries and treat the life-threatening complications of pregnancy and childbirth. With support from functioning health and transportation systems, these professionals can treat or stabilize women and refer them for appropriate care. Ensuring that women receive skilled care at delivery is an essential part of safe motherhood programs. Skilled care, however, can only be effective in the context of health systems that address women’s health needs and the obstacles women face en route to emergency care. Effective health systems make obstetric care available to all women, including surgical and technical interventions required to treat life-threatening conditions during pregnancy, delivery, and after childbirth [5].

Maternity waiting homes are residential facilities located near health facilities where women can await their delivery. These facilities which are called MWHs by the World Health Organization (WHO) are also described as maternity villages, maternity waiting shelters, or maternity dormitories [6]. The crucial element of an effective MWH is its access to qualified obstetric services. That is why it is located near a hospital with operative facilities. Therefore the essence of a MWH is that, at the time of labour, the delivery could take place with skilled attendance. Furthermore, many consider MWHs to be key element of the strategy to “bridge the geographical gap” in obstetric care between rural areas, with poor access to equipped facilities, and the urban areas [7].

On the other hand, in Malawi, just like anywhere around the world, people celebrate the birth of a new baby. Pregnancy brings joy to the couple as well as to the immediate family in the village. However, apart from being the period of anticipation, the elders in the village are also anxious about the outcome of the pregnancy, because a maternal death in the family is devastating to the family as well as to the whole community. The anxiety comes about because geographical barriers or distance in some areas make it difficult to reach the nearest health facility. As a result, this becomes a challenge when the woman goes into labour and especially if it happens at night.

Consequently, antenatal mothers come to the MWH to await labour. In actual fact, the women are accommodated in the MWH to await labour in order to avoid delays which can result in neonatal or even maternal deaths. According to Multiple Indicator Cluster Survey (MICS) of 2006 [8] the maternal mortality for Malawi is now at 807 per 100,000 live births. However, the Thyolo district health officer, Dr. Beatrice Mwagomba said an estimated 654 maternal related deaths were reported in Thyolo between 2008 and 2009, as compared to 500 reported between 2007 and 2008. The neonatal mortality rate is at 26 per 1000 live births.

Therefore, the MWHs are there to provide a solution to the issue of distance. Unfortunately, based on the researcher’s observation, most antenatal mothers do not take advantage of the service. However this reluctance to stay in a MWH may be an important factor to consider, in that, when women leave the MWH as users or clients, they should be viewed as potential “ambassadors” of the MWH. Word of mouth, in much of the world, is still one of the most effective and compelling means of communication. Women who are satisfied with the care and services they received at the MWH will encourage their family, friends, and neighbours to use the service [9]. It is therefore essential to establish the experiences of antenatal mothers during their utilization of the MWH.

In rural areas, where women live far from a health facility, MWHs play an important role in reducing maternal and perinatal mortality. However, it has been observed that some antenatal mothers are reluctant to stay in the MWH. There has been insufficient study to identify factors that cause antenatal mothers to be reluctant. How can antenatal mothers be motivated to utilize MWHs? It is important to explore the experiences of antenatal mothers who have stayed in the MWH and utilize the result to improve utilization. This study is therefore important because it will help to establish what antenatal mothers experience in the course of their stay in the MWH in an attempt to make the place more user-friendly. On the other hand, when the experiences are known, they could influence the hospital management to formulate policies that can make the environment more conducive and user friendly. Consequently, the stay in the MWH would be made comfortable and thereby promoting utilization. As more antenatal mothers utilize the MWH to await labour, pregnancy outcome will be improved. It was against this background that this study was conducted to explore the mothers’ experiences in the maternity waiting homes. Specifically this study aimed at; (1) describing the benefits of staying in a maternity waiting home for antenatal mothers. (2) Describing challenges antenatal mothers experience while staying in a MWH.

This study was guided by the following research question. What are the experiences of women in the maternity waiting homes?

Definitions of Terms Central to this Research

In order to have the same understanding between the researchers and the reader the following terms have been defined.

Maternity waiting home: Are shelters where pregnant women await for the delivery of their babies.

Antenatal mothers: Are women in the reproductive age group who are pregnant.

Nurse/midwife: Is qualified person registered by the nurses and midwives council of Malawi.

Hospital: Is the health facility that provides maternity services to the pregnant women.

Methods

Study design and context

An exploratory descriptive research design was used to explore the experiences of antenatal mothers staying in
a maternity waiting home. This design was ideal because qualitative methods are primarily concerned with in-depth study of human phenomena in order to gain insight and understanding of the phenomena [10].

The study was conducted at Malamulo Mission hospital in Thyolo district. Malamulo mission hospital serves about 34,121 people. It offers outpatient services, inpatient services and maternity services to the people around this area who are mainly under privileged.

Participants

In this study the participants was all antenatal mothers staying in MWH. The researcher recruited a sample of ten antenatal mothers residing in the MWH.

Sampling

Generally, a purposive sample is comprised of respondents who are likely to be able to provide information and the phenomenon under study [11]. The identified participants were then approached by the researcher and requested to participate in the study.

Written consent was mandatory for enrollment for the study. The sample size for qualitative research was not predetermined and therefore sampling was done until saturation, when no new data emerged, but previously collected data were repeatedly reintroduced [12], states that data saturation has “become the gold standard by which purposive sample sizes are determined in health science research” and they suggest that data saturation can occur after 12 interviews. According to these authors, smaller sample sizes can be sufficient in providing complete and accurate information within a particular cultural context, as long as participants possess a certain degree of expertise about the domain of inquiry. It is argued that these experiences contribute to the participants’ sense of reality and “truth” [13]. Therefore, the researcher recruited 15 participants in this study.

Data Collection

Data collection was conducted between February and March 2010. An interview guide was utilized for data collection (See Additional file 1).

In-depth interviews (IDIs) were conducted. These tape-recorded IDIs were conducted on one to one basis. As an interviewer, the researcher would tune the ordering and the depth of probing of individual questions in order to further investigate issues raised, but essentially the questions asked of each participant were the same. Participants were engaged in a conversational style of questioning. This style was adopted to encourage the participants to articulate their experiences they were talking about in their own words. The questioning included descriptive, structure, opinion, and probing type questions. Each interview took approximately thirty-five to fifty minutes. The researcher also used a tape recorder to record the structured and unstructured interviews for transcription verbatim later. The transcription added notes on pauses, sighs and even voice tone. Field notes and observations helped the researcher to construct a description of the meaning of the experiences.

Data Analysis

Data analysis was done manually. All interviews were recorded and each interview was transcribed from the tape immediately following the interview. The trained assistant translated the data from Chichewa to English.

Data was organized by converting it into smaller, more manageable units that could be retrieved and reviewed. The units that reflect distinct ideas were put into categories called themes and were coded. The categorization of the themes was orderly and carefully defined to avoid overlap which could cause loss of information. Careful reading, listening to the recorded interviews and documentation was done to ensure accuracy.

The identification of the underlying themes followed two distinct stages. The first, initial coding of interviews utilized a set of coding strategies which terminated in the identification of a set of two major themes with eight sub themes (See Table 1).

The second stage was the in-depth categorization, which took these themes back to the raw transcript data and investigated each one individually. This resulted in a comprehensive coded and structured dataset for each theme. An expert in qualitative research analyzed data and identified identical themes and sub themes. This procedure addressed the trustworthiness of the data.

Results

Demographic Data

The participants’ ages ranged from 16 to 39 years. The majority were aged between 20 and 34 years (60%) followed by adolescents aged between 16 and 19 years (27%). The 35 to 39 year old age group was in minority (13%). The mean age was 24.6 years. Married antenatal mothers constituted the majority of the participants (86%), while one (7%) was divorced and another single (7%). Peasant farming was the occupation for the majority (80%). The remaining were comprised of business ladies (13%) and one resided with her parents (7%).

The participants belonged to different religions. Seventh Day Adventist (SDA) Church members were in majority with 53%, followed by Church of Christ (13%) and African Church (13%), and the other churches combined 21%. The majority of the antenatal mothers (73%) took 3 to 6 hours to reach the hospital and 27% reported it took 1 to 2 hours to reach the hospital. There were three types of transport which were used to travel to the hospital. Many of the antenatal mothers (40%) traveled to the hospital on foot while 33% used pick-up vehicles, and 27% used ambulances (See Table 2).

Benefits of Staying in a maternity waiting home

The study participants identified a number of benefits from staying in the MWH. These benefits were grouped under the sub themes of physical, psychological, and social benefits.

Table 1: Summary of data analysis.

<table>
<thead>
<tr>
<th>Major themes</th>
<th>Sub themes</th>
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<tbody>
<tr>
<td>Benefits of staying in maternity waiting home</td>
<td>Physical benefits</td>
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<td>Psychological benefits</td>
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<td>Social benefits</td>
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<td>Challenges of staying in maternity home</td>
<td>Congestion</td>
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<td></td>
<td>Poor sanitation</td>
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<td>Lack of privacy</td>
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<td>Rude midwives</td>
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<td>Pets</td>
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<td></td>
<td>Cultural factors (witchcraft and myths)</td>
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When you are at home, transport can be a problem. During one of my deliveries I tried to rush to the hospital but I delivered before arrival. At the waiting home, aaah, I stay comfortably. Mmmmm, there is no problem. While at home sometimes you could have worries. You could be thinking that how will I walk to the hospital when I go into labour since it is far. How will I arrive there? My husband is not here. But as of now, while I am staying here let me say the truth, I do not have any worries. I can just walk across into the ward. When I am told to push, I can have the energy to do so.

Social Benefits

The antenatal mothers also identified social benefits from residing in the MWH. They made new friends and there was companionship between them. This companionship was vital to them because it kept them occupied and they did not have time to think about home. As they are chatting with each other and exercising together; they build a relationship that is ongoing. When they go home they may continue to network with each other. This is evidenced by this narration:

_There are several of us here and we stay without quarrelling. We joke with each other saying; tomorrow I will escort you to the labour ward. I will carry your basin for you.... (Laughs). We chat with each other as if we are at home._

Challenges of Staying in a maternity waiting home

The antenatal mothers reported challenges faced in the course of their stay in the MWH. These challenges have been grouped under the following sub themes: Lack of Privacy, Poor sanitation, Pests, Congestion, Rude Midwives, Cultural Beliefs (witchcraft and Myths).

**Lack of Privacy**

The major challenge that emerged from the study data was a lack of privacy. The majority of antenatal mothers said that they felt very uncomfortable undressing in their rooms in the MWH because there was no privacy. People were always going in and out during the day. In the night they usually had adolescents sleeping in the same room with the antenatal mothers. This was how it was narrated by one of them:

_As for privacy, when you feel hot, you cannot take off your clothes because other women are there. The problem is that some women enter the room while others bring young children with them and sleep in the same room. This makes us uncomfortable. And there are different types of people. Some have given birth only once while others have never given birth before. So you are forced to have your clothes on all the time._

**Poor sanitation**

Poor sanitation was also identified as a challenge. The toilets were said to be very dirty and not cleaned regularly. As a result some of the antenatal mothers were using the male toilets. The antenatal mothers reported that they were not comfortable using the male toilets because they were afraid that men might find them inside. One of the participants commented about the filthiness of the toilets and bathrooms as cited below:

_The bathrooms.....Eeeeh.........mmmmm, if you have no shoes like me then you cannot go in. the floor is slippery and there is moss going there. The place is really bad. If you are eating and then you want to visit the toilet, you have to think twice. Where am I going_
to step? For the past few days the place has not been cleaned as a result people are using the male toilets at the far end. As it is now, when someone wants to visit the toilet, they just peep through the door and turn back.

**Pests**

Another major challenge was the presence of pests. The antenatal mothers cited mosquitoes and ants as pests that disturbed them or gave them sleepless nights. One antenatal mother talked of fleas being among the pests that were found in the MWH. One participant recounted her experience:

> So when we came, I found that the type of care that is there is somehow difficult for us. We are not able to stay there comfortably because there are a lot of ants. There are a lot of pests there as you can see from the look of my arms.... (Extends the hand to show rash). Fleas are also there. When we tell the watchman that it is not only mosquitoes, they do not take action. They just say as long as you have come to the hospital, you will be assisted. You should tell them those things. What about the ants? They are plucking our hair. Should we also go and explain at the hospital?

**Concurrency**

The antenatal mothers expressed concern that the house they were using was always congested because it was the only local building with a lamp. The other houses did not have lamps; as a result, even guardians from the general wards flocked to the antenatal mothers’ house resulting in congestion of people. One participant narrated her experience:

> Last night I observed that there were a lot of people who came to the extent that if I tried to turn like this ... (Pretends to turn round), I could not find turning space. I told them that you are hurting me. They started giving rude remarks such as, are you the first one to be pregnant. Anybody can sleep here. Some people are just taking this as a rest house. They have no patients in the ward. In the morning they go to tea companies to work. Some are busy with piece work (Shelling maize) in the locations.

**Rude Midwives**

The behaviour of the midwives was commented on by a number of participants, in that they were rude and did not visit the MWH. The interpersonal relationship between the antenatal mothers and the midwives was reported as bad. The midwives did not come to the MWH to check on the antenatal mothers or assess them. When the antenatal mothers went to the labour ward, they reported that they were not assisted properly. Often they were just sent back without being assessed. This led to some of the antenatal mothers delivering on their own:

> When you tell them that I am coming from the MWH and I am not feeling well, they just say aahh, you are running away from mosquitoes at the waiting home.......another girl went through the same experience like me. When she went to the labour ward she was sent back on two occasions but instead of going back she put a basin in between her legs. While standing she delivered her baby in the basin without a midwife.

The participant further said: “But for the nurse, just to think even once to say ‘there are waiting mothers there, let us go there and just say good morning,’ they do not come.”

**Cultural Factors**

Under this theme, three sub themes emerged and were witchcraft, beliefs and myths. These were shown in the following narrations.

**Witchcraft**

A few participants talked of witchcraft in the MWH. They heard stories of people who were practising witchcraft in the MWH. Antenatal mothers reported that they were afraid to utilize the MWH because of the stories that they had heard. One participant cited in the following example:

> Some people bring witchcraft here. You find that when we are sleeping they will come to palpate us on the abdomen. This witch happened to have palpated someone who had protected herself. Suddenly we heard the witch screaming while looking for the door to go out. She opened the door, went out and continued screaming.

Another reported the use of local herbs:

> Since I have been here I am having a headache, dizziness and sometimes I feel like fainting. The wife of the watchman saw that I have a problem and she gave me herbs for the headache in the form of oral drugs and cut tattoos on my forehead.

**Beliefs**

Some participants reported that they were worried because of what their friends were telling them. These friends said that since their mothers and fathers were engaged in sexual relationships when they visited each other, they were not supposed to cook for the antenatal mothers when they returned to the MWH. They said that antenatal mothers were not going into labour because they ate food prepared by guardians who have had sexual relationships with their spouses. One participant cited as follows:

> My friends here have been telling me that because when mother goes home she sleeps with my father that is the reason why I am not going into labour. A guardian should not cook for an antenatal mother if she is having sexual intercourse with her husband because she is hot. I do not care, if she wants me to die let me die.

**Myths**

Prolonged use of family planning methods was identified as a belief that was related to difficult labour. A participant who had used Depoprovera was very worried that she was not going into labour because of prolonged use of the method. Friends in the MWH told her that she had used the Depoprovera for too long that was why labour pains were sporadic. They told her that she could even die. This frightened the participant as she narrated:

> Some people are telling me that this is happening because of the family planning method that I was taking. They usually ask me how many times I have had the injections. When I tell them that I had 17 injections they say, “It will kill you, Eeeeh, Eeeeh, Eeeeh, how can you take all those 17 injections. That is why you are having labour pains on and off.

**Discussion**

The findings of the current study identified two major themes common to the lived experience of antenatal mothers living in a MWH which have been discussed below.
The majority of the antenatal mothers said that they benefited from staying in the MWH. They had adequate time to do exercise and to rest. They did not have to do strenuous work like they did at home because they had a guardian who addressed their needs. This finding adds weight to a study conducted by SMP in Malawi, which was revealed that the proximity of the Antenatal Clinic (ANC) and the maternity ward meant the antenatal mothers could go there any time if they needed to consult [14]. Moreover, being near the hospital they were assured of attendance by a skilled person, for a safe delivery.

Psychologically the antenatal mothers reported feeling good and relieved while staying in the MWH. They said that they had peace of mind because they did not have to worry about how they would travel to the hospital when they were in labour. Staying at the MWH assured them of quick access to specialised care. These findings were supported by a study done in Malawi which revealed that antenatal mothers found it beneficial to stay in a MWH because of the easy access to antenatal care and skilled birth attendants [15]. This was contrary to the study findings conducted in Ghana which revealed that the cost of living was higher in a MWH. Women could not take care of their families and farms as they were residing at the MWH [16]. While [17] confirms that being away from the family was considered the main drawback of staying in a MWH by the antenatal mothers.

Even though there were some drawbacks like being separated from their families, the antenatal mothers also benefited socially while staying in the MWH. They made new friends and there was companionship. They encouraged new antenatal mothers who while staying in the MWH. They made new friends and there was presence. The majority of the antenatal mothers in the study were not happy with the living conditions in the MWH. They said the place was congested as such, they were not sleeping comfortably. The house was being used by others in addition to antenatal mothers. Other people, who were not antenatal clients, used the MWH as a base while they were working in the nearby gardens. They sought free accommodation at the expense of the antenatal mothers. This finding of this study add weight to the results in a study by [18] which revealed similar complaints that MWH were too small and crowded. As such, the antenatal mothers were not comfortable during their stay in the MWH.

Expectations of health services are often affected by former interactions with health care providers. In the current study participants expressed negative sentiments about the behaviour of the midwives. It was said that the midwives never went to the MWH to see how the mothers were doing. Additionally, participants reported that when the antenatal mothers came to the labour ward, they were told to go back to the MWH. Studies that were done noted that too often health care service providers were rude, unsympathetic, and uncaring. They often did not respect women’s cultural preferences for privacy, and birth position [15]. This lack of sensitivity by providers may account for underutilization of the MWH.

Furthermore, in a study conducted in Malawi [19], documented the concerns raised by the antenatal mothers about lack of supervision by midwives and poor staff attitudes as factors which hindered the antenatal mothers from using the MWH. If the midwives supervised the antenatal mothers in the MWH it could be an opportunity for them to get acquainted with the antenatal mothers before they went into labour. The midwives could also take this opportunity to conduct health education to the mothers and their guardians. Some of the negative cultural beliefs about midwives could be reduced through a change in their care. Moreover, the MWH is an ideal location for family planning counselling, including counselling for sterilization.

Culturally antenatal mothers were also practicing other traditional rituals while in the maternity waiting home. This has adverse effects as such action may worsen or confuse the health workers as they would not know what caused it because they were not aware of the herbal treatment. To support these findings [20], in his study in the northern part of Malawi found that when antenatal mothers stayed too long in the MWH, they used local herbs to induce labour. Labour was induced to reduce days spent in the MWH. This was unsafe because some of the antenatal mothers developed ruptured uterus. Additionally, a study conducted by [20] revealed that culture was an important aspect of the community. It played a role in the social interaction, values and tradition of that particular community. Consequently, it may contribute positively or negatively to the antenatal mothers’ health. If these stories continued, they could have a negative impact on the future utilization of the MWH.

**Limitations and Strengths of the Study**

Since this study was conducted at one health facility therefore transferability could be limited. On the other hand, this is an under researched area that is of vital importance to the health and care of antenatal mothers and this is a ground breaker study. The researcher was of similar sex to the participants therefore the participant expressed themselves freely. This contributed to collection of rich data. Furthermore, there was no refusal to participate. All the antenatal mothers who were asked to participate in the study responded favourably.

**Recommendations**

**Nursing and midwifery research**

Since this study was conducted at one hospital. Therefore, further studies should be conducted in other hospitals.

**Nursing and midwifery practice**

It is recommended that nurse midwives should manage antenatal mothers when they report to the labour ward instead of sending them back to the maternity waiting homes. This could assist to reduce maternal and neonatal morbidity and mortality as complication could be identified early.
Nursing and midwifery education

Health workers need education and training on interpersonal skills, ethics, and attitudes to address the issue of rudeness by midwives this could portray a better midwifery image to the community.

Conclusion

The maternity waiting home has potential as a tool to increase the number of deliveries by skilled birth attendants. The use of MWHs will also increase in the context of the current health care environment where the traditional birth attendants (TBAs) have been given new roles. The maternity waiting home is vital for keeping antenatal mothers close to the hospital. Additionally, health care professionals providing care to antenatal mothers living in MWHs and their families will benefit from this study.

Ethics and consent to participate

Ethical permission was given by COMREC ref P11/09/847 to allow the researcher to conduct the study. Permission was also sought from the District Health Officer: Written informed consent was obtained from all participants. Participants were briefed about the objective and procedures of the study.

They were also informed about their right to agree or refuse to participate and their right to withdraw from the study at any time even after they had signed the consent form. Further, participants were made clear that they were not to receive any remuneration for participating in the study. Special permission was obtained from participants on the use of audio recorder during interviews. All participants who agreed to take part in this study signed an informed consent. Participants were also informed that information they provided would be treated with strict confidentiality and would only be used for the research purposes.

Consent to Publish

Not applicable.

Availability of Data and Supporting Materials

Data supporting the findings is contained within the manuscript.

Additional file

Interview guide

Abbreviations

COMREC: College of medicine research and ethical committee.
EDD: Expected Date of Delivery.
IDIs: In-Depth Interviews.
MWH: Maternity Waiting Home.
WCBA: Women of Child Bearing Age.
WHO: World Health Organization.

Competing Interests

The author(s) declare that they have no competing interests.

Authors’ contributions

SS designed the study, developed the protocol organised and collected data, analysed and interpreted the results and edited the manuscript.

MOG, drafted the manuscript, reviewed and edited the study protocol and critically revised the manuscript. Both authors read and approved the final manuscript.

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References

APPENDIX H

Interview Guide.

Code Number-----------------------------
Date of Interview----------------------
Name of Interviewer---------------------

SECTION A: Demographic Data.

I am going to ask some information about yourself.

1. Age: [ ]

2. What is your marital status?
   a) Married [ ]
   b) Single [ ]
   c) Divorced [ ]
   d) Separated [ ]
   e) Widow [ ]
   f) Living together [ ]

3. Educational level
   a) None [ ]
   b) Primary [ ]
   c) Secondary [ ]
   e) Tertiary [ ]

4. How many children do you have? [ ]

5. Which denomination do you belong to? -----------------------------

6. What type of work do you do? ---------------------------------

7. How long does it take you to walk to your nearest health facility?
   a) 6 hours [ ]
   b) 12 hours [ ]
   c) 2 days [ ]
   d) Other Specify [ ]

8. What mode of transport is readily available in your village to take you to the hospital?
   a) Pick-up vehicle [ ]
   b) Bicycle ambulance [ ]
   c) Ox cart [ ]
   d) Other Specify [ ]

9. How long have you stayed in the MWH?
   a) one week [ ]
b). two weeks  [  ]
c). other Specify  [  ]

SECTION B

Women’s knowledge about MWH.

Now I am going to ask you the following questions in relation to MWH.

1. How did you know about the MWH at Malamulo?

Probes:
  o Who informed you?
  o How were you informed?
  o Why do you think they informed you?
  o What did they say about the MWH?
  o What perception did you have about the MWH after the information?
  o How did you react to the information?

2. Now, I would like to know what motivated you to come and await labour in the MWH.

Probes:
  o Who motivated you?
  o How were you motivated?
  o How long did it take you to decide to come to the MWH?
  o Whom did you involve in making the decision?
  o Whom did you inform about your decision?
  o How did the other people react when you informed them of your decision?
  o Have you ever stayed in a MWH before?

3. I would like you to tell me what your attitudes are towards MWHs.

Probes:
  o How do you feel about staying in the MWH?
  o Why is it necessary for an antenatal mother to stay in a MWH?
  o What do you think are the benefits of staying in the MWH?
  o How can you differentiate between staying at home while waiting for labour and staying in the MWH?

4. Now, I would like you to tell me what you liked while in the MWH.

Probe on:
  o How comfortable she was during her stay in the MWH?
  o How she spent her time?
  o How she was welcomed on her arrival?
  o What she liked about:
    • Sleeping arrangements
    • Interaction with peers
    • Interaction with health care personnel
    • Support from family
5. I would like to know the challenges that you have experienced during your stay in the MWH.

Probes on challenges related to:

- Sanitation?
- Maintaining privacy?
- Being supported by family while in MWH?
- Care of children at home?
- Length of stay?
- Financial support?
- Availability of food?
- Receiving visitors from home?
- Food preparation?
- What made it difficult to:
  - Interact with other antenatal mothers?
  - Interact with the health service providers?
  - Have problems attended to?
  - Receive antenatal care?

Lastly:

- What information would she share with peers who found her in the MWH?
- What information would she share with relatives at home about the MWH?

THANK YOU