Ensuring Rights and Choices for all

UNFPA Supported Maternity Waiting Homes in Ethiopia

Good Practices and Lessons Learned

November 2018

EXECUTIVE SUMMARY

Introduction:

Ethiopia has close to four decades of experience in maternity waiting homes; however, it is only recently that it took major steps in expanding them. Between 2014 and 2016, the proportion of health centers with either a standalone maternity waiting home or a dedicated room for mothers to wait until labour starts increased from zero to 56%. Recent studies indicate that the design, function, and utilization of existing maternity waiting homes/rooms vary substantially across different parts of the country. Documenting and sharing lessons from relatively better performing maternity waiting homes will therefore have a vital role in shaping the future of maternity waiting homes in the country. This good practice documentation is intended to systematically describe important features, key success factors, and lessons from four better performing UNFPA-supported maternity waiting homes and their respective supervisor health institutions.

Methods:

UNFPA in consultation with the Federal Ministry of Health and Regional Health Bureaus identified four relatively better performing maternity waiting homes from Amhara and Southern Nations Nationalities and Peoples regions. Good practices and lessons were identified through a mix of data collection techniques including review of relevant documents/registers, key informant interviews, focus group discussions with maternity waiting home committees, observation of maternity waiting homes, and in-depth interviews with users of maternity waiting homes. Information from all sources was synthesized to describe the features of maternity waiting homes in general and the visited maternity waiting homes in particular. The focus of the documentation was on identifying and sharing potentially replicable experiences in establishing and running maternity waiting homes.

Results:

The findings suggest that maternity waiting homes are effective interventions in increasing utilization of maternal health services and narrowing the urban-rural gap in levels of utilization. A number of good practices were identified in the areas of establishing and managing maternity waiting homes, financing maternity waiting homes, demand creation, improving quality, and collaboration in supporting maternity waiting homes. (Table 1)

Area	Good practices identifed
General	✓ Establishing and managing maternity waiting homes to increase utilization of institutional delivery services
Financing MWHs	✓ Financing maternity waiting homes through community contributions ✓ Innovative approaches to fill budget gaps in sustaining maternity waiting homes ✓ Integrating collection of community contributions with existing systems
Demand creation	✓ Creating demand for maternity waiting homes and institutional delivery through women development army leaders ✓ Pregnant women's conferences to promote utilization of maternity waiting homes and institutional delivery
Quality/ Satisfaction	✓ Quality improvement processes to increase utilization of maternity waiting homes ✓ Alphabet lessons for mothers staying at maternity waiting homes in Yejube Health Center
Collaboration	✓ Supporting maternity waiting homes through government implementing partners

Table 1: List of good practices identifed from UNFPA-supported maternity waiting homes

Challenges:

- Lack of recognition and approval of the human resource needs of maternity waiting homes by the Public Service and Human Resource Development sector at woreda, region and federal levels
- Lack of regulatory mechanisms to enforce minimum standards of maternity waiting home facilities and services
- Inappropriate targeting of women for stay at maternity waiting homes leading to potential overcrowding and shortage of resources to provide services
- The current health management information system doesn't collect data on availability and utilization of maternity waiting homes leading to data gap for performance monitoring
- Inadequacy and sub-optimal quality of food provided by maternity waiting homes compared to recommendations for pregnant women
- No one to take care of household chores during women's stay in a maternity waiting home
- Lack of transportation service to take mothers back home after delivery

Lessons Learned

Maternity waiting homes contribute in increasing utilization of maternal health services particularly among women living in rural areas where distance, topography, and road access are barriers to timely access health centers. The current healthcare system of Ethiopia supports rapid expansion of maternity waiting homes and sustainable provision of services provided that mechanisms are in place for targeted advocacy and extensive community involvement. Lessons related to specific practices are identified and described.

Recommendations

- Formalize the establishment of maternity waiting homes at health center level by incorporating the needs of MWHs in health center standards, human resource plans, and budgeting to ensure quality and sustainability of services.
- Develop short term mechanisms to enforce minimum standards of services provided in MWHs. Ensuring provision of balanced diet and prevention of overcrowding and communicable diseases have to be adequately emphasized.
- Encourage promotion of MWHs as part of personalized birth preparedness plan instead of universal promotion. This requires appropriate guidance and training to health workers responsible for the management and promotion of MWHs.
- Ensure adequate recording and reporting of data about MWHs by integrating MWH indicators into the national HMIS.
- Conduct a larger scale rigorous study to investigate, document, and share the effect of maternity waiting homes on utilization of maternal health services and maternal and newborn health outcomes at the community level. Most designs for such a study would be feasible only before all health centers establish MWHs.
- Adopt innovative mechanisms to address the concerns of pregnant women in using MWHs including lack of transportation after delivery and challenges related to absence of mothers from home during their stay at MWHs.
- Disseminate good practices and lessons learned from visited sites for possible adoption and adaptation in other MWHs.

ACRONYMS AND ABBREVIATIONS

Acronym	Description
ANC	Antenatal Care
EDHS	Ethiopian Demographic and Health Survey
EFY	Ethiopian Fiscal Year (July 1 to June 30 in Ethiopian Calendar)
EmONC	Emergency Obstetric and Newborn Care
ETB	Ethiopian Birr (Currency of Ethiopia)
FMoH	Federal Ministry of Health
HC	Health Center
HEW	Health Extension Worker
HMIS	Health Management Information System
HSDP	Health Sector Development Program
HSTP	Health Sector Transformation Plan
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MWH	Maternity Waiting Home
PNC	Postnatal Care
SBA	Skilled Birth Attendance
SDG	Sustainable Development Goal
SNNP	Southern Nations Nationalities and Peoples
SSA	Sub-Saharan Africa
RH	Reproductive Health
RHB	Regional Health Bureau
UN	United Nations
UNFPA	United Nations Population Fund
WDA	Women Development Army
WHO	World Health Organization
WoHO	Woreda Health Office
ZHO	Zonal Health Office

DEFINITION OF WORDS/PHRASES

Word/Phrase	Description
Kebele	The lowest administrative structure in Ethiopia comprising an average of 5000 population (1000 households).
Woreda	The third level administrative division in constituting the lowest budgetary unit and administered by a Council. The average population of a woreda is 100,000 people.
Health Post	The lowest level health facility in the Ethiopian health sector staffed mostly with two health extension workers responsible for provision of health promotion, disease prevention, and few selected curative services for a catchment population of 1000 households (5,000 people). Five health posts together with a catchment health center and a primary hospital constitute the structure of Primary Health Care Unit.
Health Extension Worker	Government salaried health workers with one year of training on health promotion, disease prevention, and selected curative services after high school graduation. Health extension workers are females except in pastoralist areas.
Dedicated Room (for MWH)	Room/rooms in a health facility initially constructed for other purposes but currently being used to provide maternity waiting home services.
Maternity Waiting Home	A residential facility, located near a qualified medical facility, where women can await their delivery date and be transferred to where essential childbirth care and/or care for obstetric and newborn complications is provided, to increase access to skilled care for populations living in remote areas or with limited access to services.
Standalone Maternity Waiting Home	A maternity waiting home constructed within or close to the compound of a health facility with the purpose of providing maternity waiting home services.

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I. INTRODUCTION

Global and National Situation of Maternal Health

Reducing maternal mortality, *the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes* (1), has been a global priority for decades (2-4). As a result, concerted efforts have been exerted from international, national, sub-national, and local actors which collectively have led to observable declines in maternal mortality ratio (MMR). According to estimates from the 2015 United Nations Maternal Mortality Estimation Inter-Agency Group, maternal mortality has fallen by 43.9% between 1990 and 2015. The overall progress was commendable; however, it was far behind the aspired target of 75% reduction. Moreover, progress has been uneven with most deaths and very slow rates of reduction still concentrating in developing countries including those in Sub-Saharan Africa (SSA). In 2015, MMR in Sub-Saharan Africa was 546 deaths per 100,000 live births compared to 12 deaths per 100,000 live births in high-income countries (5,6). Reducing MMR to less than 70 deaths per 100,000 live births in every country by 2030, a target of Goal 3 of the Sustainable Development Goals, requires accelerating the annual reduction of MMR to an average rate of 7.5% (5).

Ethiopia has made remarkable progress in reducing maternal mortality during the period of the Millennium Development Goals (MDGs). UN estimates indicated that MMR has fallen from 1,250 to 353 deaths per 100,000 live births making an overall decline of 71.8% between 1990 and 2015 (6). Findings from repeated Demographic and Health Surveys (EDHS) also showed that the seven year average pregnancy related maternal mortality ratio has declined from 871 deaths per 100,000 live births in EDHS 2000 to 412 deaths per 100,000 live births in EDHS 2016. Perinatal mortality (number of stillbirths and early neonatal deaths per 1000 pregnancies lasting 7 months or more) has also declined from 52 in EDHS 2000 to 33 in EDHS 2016 (7, 8). Despite improvements, risks of maternal and perinatal mortality are still very high in the country both indicating problems in access to quality healthcare during pregnancy, labour and delivery, and the postpartum period (6).

Maternal Health in Ethiopia

The Ethiopian health sector has been committed to adopting and implementing global efforts to reduce maternal mortality. The alignment of the third and fourth phases of the Health Sector Development Program (HSDP) (9, 10) and the current Health Sector Transformation Plan (HSTP) (11) with global targets on reduction of maternal mortality are among the major indicators of Ethiopia's commitment to global targets on improving the health of mothers. These initiatives have led to the expansion of primary health care services through construction of health centers and health posts and training of large numbers of mid-level and frontline health workers including Health Extension Workers (HEW), midwives, and Health Officers. As a result utilization of maternal health services including antenatal care (ANC), skilled birth attendance (SBA), and postnatal care (PNC) showed increments. However, the increments have been slow particularly for utilization of skilled birth attendants. Moreover, inequalities in utilization of maternal health services have been stark particularly between urban and rural dwellers (12-14). According to EDHS 2016, the proportion of deliveries attended in a health facility was 19.7%

among women from rural areas compared to 79.2% among women from urban areas. In the same survey long distance to health facility was mentioned to be a serious problem in accessing health facilities by 59.8% of women from rural areas compared to 17.0% of women from urban areas (8).

Maternity waiting homes

In the 1990s, the World Health Organization (WHO) defined Maternity Waiting Homes (MWHs) as *"residential facilities, located near a qualified medical facility, where women defined as "high risk" can await their delivery and be transferred to a nearby medical facility shortly before delivery, or earlier should complications arise"*(15). As the concept of risk evolved towards considering every pregnancy as risky, the focus of MWHs also changed from serving "high risk" pregnant women towards addressing geographical barriers to utilization of maternal health services. The 2015 list of WHO's recommendations on health promotion for maternal and newborn health included a conditional recommendation on establishing MWHs close to a health facility, where essential childbirth care and/or care for obstetric and newborn complications is provided, to increase access to skilled care for populations living in remote areas or with limited access to services (16). Promoted and implemented mainly in developing countries where access to birthing centers and emergency transport services is limited, MWHs are considered effective in increasing utilization of maternal and newborn care services and improving birth outcomes particularly among hard to reach rural-dwelling mothers (15-20).

A study from Zambia indicted that availability as well as quality of maternity waiting homes is associated with utilization of health facility delivery services in rural areas. The study found that mothers living in catchment areas of health facilities with a MWH or a place for mothers to wait until onset of labour were more likely to deliver in a health facility. The study also revealed that health facility delivery was 95% higher among women who lived in catchments of health facilities with MWHs providing good or medium quality services compared to those with poor quality MWHs (21).

Ethiopia has close to four decades of experience in maternity waiting homes. Most of the first batches of maternity waiting homes were established in few Ethiopian hospitals during the 1980s (19, 22); however, expansion to wider geographic areas and lower level health facilities is a very recent initiative. Construction of maternity waiting homes has become one of the major investments at health center level during the periods of HSDP IV and HSTP. The first guideline on establishment of standardized maternity waiting homes at health centers/facilities was issued by the Federal Ministry of Health (FMoH) in December 2015. Despite its young age, expansion of MWHs at health center level has been very fast; according to the national Emergency Obstetric and New-born Care (EmONC) assessment conducted in 2016, the proportion of health facilities (health centers and hospitals) with either a standalone maternity waiting home or a dedicated room for expectant mothers to wait until labour starts reached 53% (56% among health centers and 27% among hospitals) (23). (Figure 1).

As part of the strategic objective to improve the health infrastructure as per the norms for proper reproductive health service delivery, the current reproductive health strategic plan of the country intends to establish maternity waiting homes in 75% of health centers by 2020 (24).

1970s	1980s	1990s	2000s	2010s
• The first MWH established in Attat Hospital	• MWHs established in few hospitals	• No major events	• No major events	• Some HCs established MWH at the end of HSDP IV • Subsequent rapid expansion • First national guideline issued by FMoH in at the end of 2015 • EmONC assessment revealed 56% coverage among HCs in 2016 • National RH strategy adopted a target of 75% coverage by 2020

Table 2: Historical milestones in MWHs in Ethiopia 1970s to 2010s

Partly because of the young age of MWH scale up, there are very few studies that examined different aspects of MWHs in Ethiopia. Available studies, though limited in number, suggest that MWHs are generally helping in addressing geographic barriers to timely maternity services but their availability, design, function, and utilization vary substantially across different parts of the country (20, 22, 23, 25, 26). Utilization of maternity waiting homes was in general low because of several demand- and supply-side factors. The 2016 EmONC assessment found that average occupancy of MWH spaces/beds was two as compared to an average capacity of seven (23).

UNFPA's Support for Maternity Waiting Homes in Ethiopia

The United Nations Population Fund (UNFPA) in Ethiopia has been one of the key players providing technical and financial support to the government of Ethiopia in strengthening maternal and newborn healthcare services including in the expansion of MWHs. In its 7th Country Programme, UNFPA partnered with six regional health bureaus (RHB) and the Federal Ministry of Health (FMoH) in strengthening maternal health interventions. During its current 8th Country Programme its partnership expanded to two additional regions namely, Gambella and Benishangul Gumuz (27, 28).

UNFPA has been supporting response to modifiable factors contributing to preventable maternal deaths identified through the Maternal Death Surveillance and Response system. As part of this response at national and sub-national levels, UNFPA has been supporting the expansion of maternity waiting homes. During its 7th and 8th Country Programmes, UNFPA

has strengthened MWHs in health centers located in target districts in six regions. The support included procurement and distribution of very basic and essential materials (cooking utensils, water containers, mattresses, beds, bed sheets, television sets, coffee making materials…) that are important for maternity waiting homes to function, as stated in the national guideline for MWHs. In addition, health worker trainings and regular supportive supervisions were provided in order to increase utilization of maternal health services including that of MWHs (27-29).

Figure 1: MWH in Dalocha Health Center, Dalocha Woreda, SNNP Region

UNFPA's support in the expansion of MWHs, similar to other areas of support, has been through a government implementing partner. FMoH and RHBs receive program funds and implement jointly developed and approved annual plans without duplicating efforts and creating any parallel implementation structure (27).

The need for good practice documentation on MWHs in Ethiopia

The variability in speed of expansion, utilization, and possibly effectiveness of maternity waiting homes across regions, woredas, and facilities in Ethiopia creates an opportunity for identifying and sharing good practices. Documenting and sharing lessons from relatively better performing MWHs will have a vital role in shaping the future of MWHs in the country. This good practice documentation systematically identified and described important features, key success factors and lessons from four better performing UNFPA-supported MWHs, their host primary healthcare units, and administrative health institutions.

II. OBJECTIVES

General Objectives

This good practice documentation was conducted with the objective of facilitating learning from the design, implementation, and results of maternity waiting homes supported by UNFPA. It intends to describe MWHs, identify effective and feasible experiences in establishing and running MWHs, and share lessons to the wider group of stakeholders.

Specific Objectives:

1. To identify good practices and lessons learned on maternity waiting homes
2. To document evidence of positive change on the lives of beneficiaries
3. To document outcome/impact of utilizing maternity waiting homes
4. To link MWH utilization with uptake of other maternal health services (ANC,SBA,PNC)
5. To share the experience of good performing maternity waiting homes to other regions
6. To identify gaps and make recommendations for further improvement of maternity waiting homes in Ethiopia

III. METHODS FOR IDENTIFICATION AND DOCUMENTATION OF GOOD PRACTICES

General Approach

The World Health Organization Regional Office for Africa in its guideline for documenting and sharing best practices in health programs adopted a definition for "best practice" as "a technique or methodology that, through experience and research, has proven reliably to lead to a desired result". The guideline has emphasized that the use of the word "best" is not in its superlative form (30). This definition has been consistent with the purpose of the current good practice documentation on maternity waiting homes.

Good Practice: a working definition

Good practices are practices that, through experience and/or research, have proved to reliably lead to a desired positive result.

A combination of methods employing primarily qualitative techniques was employed to comprehensively understand the structure, functions, and results of maternity waiting homes in selected health facilities. In the process, good practices and lessons were identified regarding what worked and what didn't in relation to establishing and maintenance of maternity waiting homes. Identification of good practices was guided by a set of criteria adapted from the World Health Organization's guide on best practice documentation in Health Programs (30). Practices in establishing and running MWHs were appraised against four required criteria and five optional criteria adapted from the guide.

Criteria for identification of good practice

1. Required Criteria

Relevance: *The practice must address challenges related to expansion, functioning, utilization, and effectiveness of maternity waiting homes.*

Effectiveness: *The practice must work and achieve positive results that are measurable.*

Efficiency: *The practice must produce results with a reasonable level of resources and time.*

Ethical soundness: *The practice must respect the current rules of ethics for dealing with human populations.*

2. Optional Criteria

Sustainability: *The practice must be implementable over a long period of time without any massive injection of additional resources.*

Possibility of duplication: *The proposed practice, as carried out, must be replicable by other health facilities, woredas, regions, and countries.*

Involvement of partnerships: *The proposed practice must involve satisfactory collaboration*

Selection of sites

Four relatively better performing maternity waiting homes were identified in consultation with the Federal Ministry of Health, Amhara Regional Health Bureau, SNNP Regional Health Bureau, and UNFPA regional program officers. The selection considered longer experience, better facilities (construction, furniture), and higher rate of utilization of maternity waiting homes as criteria. The selected facilities included two maternity waiting homes from Amhara and two others from SNNP regions. All the four selected MWHs were hosted by health centers. (Table 2)

Region	Woreda	Facility/Maternity Waiting Home
Amhara	Basloliben	Kork Health Center
		Yejube Health Center
SNNP	Dalocha	Dalocha Health Center
	Mareko	Koshe Health Center

Table 3: Maternity waiting homes selected for good practice identification and documentation

Identification of good practices

A two-week field visit was conducted to the selected sites from 21 October to 2 November 2018. During visits to each site, data was collected through key informant interviews (KII), focus group discussions (FGD), in-depth interviews (IDI), observation of maternity waiting homes, and review of health facility records/reports. Table 3 presents a summary of data collection activities conducted at different levels of the health system.

Methods	Levels	# of sessions
Key Informant / Group interviews	FMoH	1
	UNFPA	1
	RHB	3
	WoHO/ZHO	5
	Health Center	4
	Kebele/Health Post	5
Focus Group Discussion	MWH committee	2
Observation	MWHs	4
In-depth interviews	Mothers who gave birth after using MWH	2
	Pregnant women staying at MWH	3
Document Reviews	Guidelines, strategies, plans, published articles, health facility records and reports	

Table 4: Data collection activities by level

Interviews and focus group discussions were conducted in local languages and audio recorded. Qualitative data collected from all sources were translated to the English language and coded and categorized using Open Code 4.03, an open source qualitative data management software (31). Some of the interviews with MWH users were prepared in the form of stories describing experiences of women in learning about and using MWHs. Quantitative data obtained from registers and reports of visited health institutions were summarized in Ms-excel and presented in tables and graphs.

IV. GOOD PRACTICES IN ESTABLISHING AND MANAGING MWHS

Practice I. Establishing and Managing Maternity Waiting Homes

Introduction

Skilled birth attendance is one of the high impact health sector responses to eliminate preventable maternal and perinatal morbidity and mortality (32, 33). Limited access to health facilities where skilled birth attendants are available has been a major bottleneck to ensuring universal access to this important healthcare service in developing countries including Ethiopia (13, 34, 35). Since the beginning of the Health Extension Program, different individual and community level interventions have been introduced to encourage mothers for health facility delivery. The slogan "No mother should die while giving birth" and the recently introduced community level target for "Home Delivery Free Kebeles" were instrumental in mobilizing all levels of actors towards universal access to health facility delivery. As a result, intention to deliver in a health facility has been increasing in the country including in rural areas (8).

Health Centers, staffed with a health center team composed of a mix of professionals including midwives, are the most accessible providers of skilled birth attendance in Ethiopia. Due to efforts to expand the numbers of health centers over the last decade, several woredas are getting closer to meeting the recommended standard of one health center to 25,000 population (11, 36, 37).

Baso Liben, Dalocha, and Mareko Woredas, are among the Woredas with relatively better status in terms of HC to Population ratio (Table 4). Each of these woredas also have two or three ambulances dedicated for providing emergency transport services to health centers or hospitals mainly for mothers during labour and delivery.

	Population Size	Number of HCs	Population Per HC
Dalocha	113,409	4	28,352
Mareko	86,711	3	28,904
Baso Liben	171,902	5	34,380
Total	372,022	12	31,002

Table 5: HC to Population Ratio in UNFPA-supported Woredas, SNNP and Amhara Regions, 2018

Despite expansion of Health Centers and increasing availability of ambulances, access to skilled birth attendants has still been a major problem. Mothers, including those who had access to health facilities for antenatal care, were giving birth at home because of several reasons including fast progress of labour, delayed transportation, and the influence of neighbours and relatives after onset of labour. Before 2015, there was no arrangement to accommodate pregnant women visiting health centers before active first stage labour. As a result, mothers from far places had to stay home until it becomes too late to travel to a health center.

Maternity waiting homes have been expanded with the purpose of creating opportunities for pregnant women from far places to stay close to a health center during their final weeks of pregnancy so that they can easily get to maternity units upon onset of labour.

Implementation

This sub-section describes the process of establishing and managing MWHs including advocacy, construction, furnishing, services provided, staffing, and financial management of MWHs.

A. Advocacy

The very first step that Woreda Health Offices accomplished in the process of expanding maternity waiting homes was advocating to Woreda administrators the need for construction of MWHs. By then, Woreda administrators already had a target of eliminating preventable maternal deaths and making their kebeles home delivery free. As a result, all of the Woredas were effective in obtaining buy-in from Woreda administrators. This has led to actions including direct allocation of woreda budget for construction of MWH, giving directions to kebele administrators so that they would mobilize community contributions, and allowing health centers to use their internal revenue for construction of MWHs. The main sources of resources for construction of MWHs were woreda administration, health center internal revenue, and community contributions in terms of local construction materials and free labour.

B. Construction

Similar to the national trend, construction of MWHs in UNFPA-supported woredas mostly started after 2014. The current standard for construction of health centers doesn't include maternity waiting homes/rooms; all health centers were constructed without a place intended for maternity waiting services. As a result, the woredas followed different approaches to meet the need for maternity waiting services. Maternity waiting homes in the three visited woredas took two forms: 1) a standalone maternity waiting home constructed for the purpose of maternity waiting services; and 2) rooms initially constructed for other purposes but now dedicated for maternity waiting services.

The time gap between decision to provide maternity waiting services and construction of standalone maternity waiting homes was mostly bridged by dedicating some rooms of the health center to serve as waiting rooms. In the meantime, health facilities collaborated with their respective WoHOs and catchment communities to raise resources and construct a standalone maternity waiting home. Two of the four Health Centers visited in this study started providing MWH services by dedicating some rooms from maternity units for pregnant women to stay during their last weeks of pregnancy. Later on, one of them constructed a standalone MWH based on guidance provided in the national guideline for establishment of standardized maternity waiting homes. (Table 5)

Health Center	Type of MWH	Year MWH service started		Budget and source of budget for construction of standalone MWH
		Dedicated Room	Standalone Home	
Yejube	Standalone	2015	2017	HC internal revenue ETB 200,000
Kork	Dedicated room	2007		
Dalocha	Standalone		2015	Woreda Health Office: ETB 38,000 covering factory products required for construction (eg., cement, nails) Community: All local construction materials (eg. wood, grass) and free labour
Koshe HC	Standalone		2016	Only with community contribution

Table 6: MWH characteristics in four selected Health Centers

All MWHs in the selected Woredas were constructed within the compounds of respective health centers. Observed MWHs were located at the back of clinical service provision blocks and relatively closer to maternity units. In addition to main rooms serving as sleeping areas for MWH users, each home has toilet, and kitchen dedicated for MWH users. Standalone MWHs varied in their design, capacity, and construction materials. This was primarily because of the intention to make MWHs similar to local residential structures of intended users. Availability of resources and size of catchment populations were the other factors.

Figure 2: Maternity Waiting Home, Dalocha Health Center, Dalocha Woreda, Siltie Zone, SNNP Region

C. Furnishing

Each MWH observed during field visit was furnished with a complete set - according to the guideline for MWHs in Ethiopia (29)- of kitchen utensils, beds and/or mattresses, bed sheets, blankets, television set, and carpets (Figure 3, Figure 4). Furnishing already constructed MWHs was considered to be an area of effective collaboration between WoHOs and non-governmental partners. Constructing a new home or dedicating a room/rooms for maternity waiting services was considered as a sign of commitment from health centers and WoHOs. This has created trust about the potential sustainability of support from partners' perspective. In the observed health centers, WoHOs furnished the MWHs using UNFPA's financial support.

Figure 3: MWH in Kork Health Center, Baso Liben Woreda, Amhara Region

Figure 4: MWH in Dalocha Health Center, Dalocha Woreda, SNNP Region

D. Provided Services

The MWHs provide a range of services including shared accommodation, food, medical, and recreational services during prenatal and postnatal stays.

Category of services	List of services
Medical services	– frequent antenatal check-ups – daily vital sign monitoring – health education sessions on family health related topics – 24 hour ready delivery and referral services
Shared accommodation and food	– Bed/mattress for each mother – Sanitary facilities – toilet, pipe water, shower facility, soap – Three meals per day
Recreational services	– Televisions with satellite dishes
Traditional Practices	– Daily traditional coffee ceremony – Postnatal porridge (Genfo) also called "Yemariam Meshegna"
Other services (practiced by some facilities)	– Teaching Amharic alphabets – Demonstration of how to cook vegetables – Telephone services to connect mothers with their families – Separate accommodation for men (caregivers/visitors)

Table 7: Services provided in MWHs

E. Staffing

The human resource needs of MWHs include the time of both medical and non-medical personnel. In all of the four visited sites, MWHs were considered as one part of maternity unit. As a result, midwives rotated one at a time to provide medical services to women staying at MWHs. In addition to rotating midwives, the MWHs also have at least one full time non-technical staff, commonly referred as kitchen attendant, responsible for cooking, cleaning, and other household chores. Except in Koshe Health Center, where kitchen attendants were government salaried health center staffs, all kitchen attendants were hired on a contract basis with community contribution resources with monthly salaries ranging from ETB 600 to 800.

F. Financing and financial management

Community contribution has been the major source of finance for running maternity waiting homes. Contributions are channelled to the MWHs through HEWs. Each MWH has a bank account with three signatories, the head of the health center, the coordinator of maternal and child health team, and a health extension worker working close to the health center. This team of staff is responsible for making deposits and withdrawals from community contributions. In some of the health centers, there is also an additional committee named "MWH feeding committee" responsible for assessing the resource needs of the MWHs and providing advice on purchase of food and non-food items.

Results

A. Availability and Utilization of MWHs

Since 2014, there has been a rapid expansion of maternity waiting homes/rooms. The proportion of health centers with either a standalone MWH or a dedicated room/rooms for maternity waiting increased from zero in 2014 to 78.2% in SNNP and 91.8% in Amhara in 2018, both exceeding the 2020 national target of 75% stated in the National Reproductive Health Strategy 2016-2020 (24).

	Number of HCs	Number of HCs with MWH/Room	% of HCs with MWH/Room
SNNP Region	720	563	78.2
Amhara Region	840	771	91.8
Siltie Zone	33	32	97.0
Dalocha Woreda	4	4	100.0
Mareko Woreda	3	3	100.0
Baso Liben Woreda	5	5	100.0

Table 8: Coverage of MWH/Rooms in Health Centers

Data on utilization of MWHs was not routinely compiled and reported to administrative health institutions. A summary of registers obtained during a visit to the four MWHs in Yejube, Kork, Dalocha, and Koshe Health Centers showed that the monthly average number of admissions to MWHs ranged from 5 to 10. On average, mothers staying at MWH constitute 9.0% of deliveries attended in the health centers. Average occupancy at the time of field visit was 65.8% while the average occupancy rate for the lifetime of the MWHs was 43.2% (Figure 5).

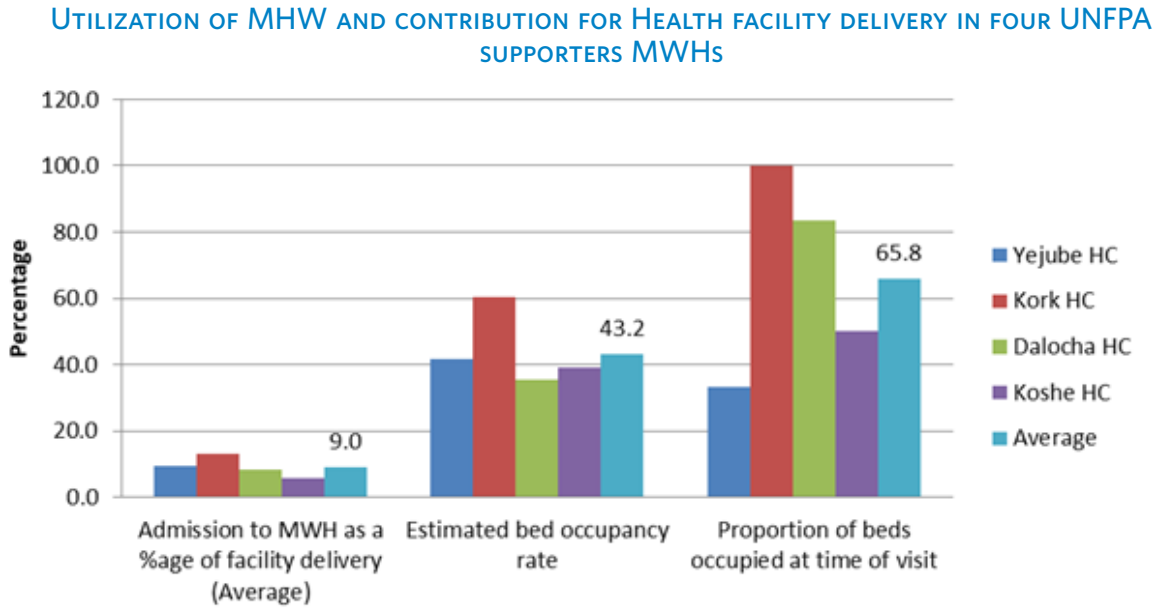

Figure 5: Utilization[1] of MWH and contribution for health facility delivery in four UNFPA-supported MWHs

1 Estimated occupancy rate is based on assumed average length of stay of 2 weeks

In addition to contributing for increasing utilization of institutional delivery in general, MWHs were also important in addressing the urban-rural disparity in utilization of institutional delivery services by favouring mothers from hard-to-reach areas. According to key informants and users of MWHs, most users were mothers from very far and inaccessible places. A key informant from one of the health centers in Baso Liben Woreda explained this as:

> *Some of the catchment communities of our health center are very far from here. They live in hilly geographic locations close to the Abay Gorge. Pregnant women from these communities cannot travel from home to health center after the onset of labour. The maternity waiting home takes the major share in creating access to institutional delivery particularly to those living in hard to reach areas.*
>
> Midwife, Kork Health Center

B. Relevance of MWHs: community and health workers' reflections

All health workers and community members involved as key informants in this study agreed that maternity waiting homes are very relevant to the needs of mothers in their respective catchment areas. The primary justifications include distance, topography, inadequate road access, and limited numbers of ambulances.

1. **Distance:** Because of the scattered settlement of the population, several villages are very far from their catchment health centers. Traveling from home to health centers after onset of labour almost always involves unnecessary delay and unacceptable inconvenience in receiving care.
2. **Topography and limited road access:** Several Woredas and kebeles have difficult topography even though they seem to be close to health centers. Hills, gorges and rivers were among the major barriers identified. In addition, road access was reported to be limited. As a result, ambulances called after onset of labour do not arrive on time.

Figure 6: Hilly landscape from Baso Liben Woreda, East Gojam, Amhara Region, Ethiopia

3. **Limited numbers of ambulances:** Currently, most Woredas have one or two ambulances that are shared between three to five health centers. Available ambulances also stop for regular service and they travel long distances to take referred mothers to hospitals. Because of these reasons, not all calls for ambulances would be responded to on time. MWHs relieved part of the burden of existing emergency transportation systems.

Figure 7: Typical traditional stretcher from Baso Liben Woreda, Amhara Region, Ethiopia

4. **Social problems:** Some mothers do not have the necessary social support during their last weeks of pregnancy. They may need help on different things including food. In addition to preventing delay, the maternity waiting homes can also address these types of social problems among pregnant women.
5. **Need for closer follow-up:** Some mothers need closer follow-up because of different medical and obstetric conditions. Frequent check-up at a health center wouldn't be feasible for most rural-dwelling mothers. Maternity waiting homes were reported to allow such mothers to have frequent check-ups without being obliged to frequently travel from their home.

Explaining the relevance of MWHs, a Reproductive Health Officer from Baso Liben Woreda Health Office, who also worked as a midwife in different health centers prior to assuming his current office position said:

> *Before construction of maternity waiting homes, there were problems to access health facility delivery services. Some pass through a challenging journey to reach health facilities; mothers were expected to travel all the way from their home to a health center after onset of labour. Ambulances are not adequate in number and they mostly do not reach all villages. As a result, mothers were expected to be transported long way on a traditional stretcher or they deliver at home … Maternity waiting homes in our woreda have addressed these challenges.*
>
> RH Officer, Baso Liben Woreda Health Office

A woman development army, in a focus group discussion also explained the importance of maternity waiting homes particularly for mothers living in hard to reach villages:

> *The maternity waiting home is important for us. As you have already seen on your way to this place, it is impossible to transport a labouring mother to the health center. If we wait at home until labour starts, the only way to get to the HC or to the place where ambulances can reach is by a traditional stretcher … We have to wait until men gather and that sometimes takes forever as men may not be around for several reasons. Staying in the MWH during the final weeks of pregnancy helps us to easily get to the health center for delivery.*
>
> WDA leader, Dejat Kebele, Baso Liben Woreda

Stories of mothers who used MWHs also confirmed how relevant MWHs are for the visited rural communities. Maternity waiting home users decided to stay in the MWH after previous experiences of adverse consequences of home delivery, a challenging journey from home to health center while in labour, or other challenges faced during attempts to stay close to a health center during final weeks of pregnancy. (Story 1, Story 2, Story 3)

Lessons Learned

- Maternity waiting homes contribute in addressing geographical disparities in access to and utilization of health facility delivery services.
- Engaging woreda administrators early in the process of MWH expansion efforts facilitates resource mobilization for construction.
- Users of maternity waiting homes are happy with their experiences and interested to share their positive experiences with their relatives and neighbors. This in turn will increase demand for maternity waiting services.

Practice II. Financing MWHs through community contributions

Introduction

Health Centers in Ethiopia mostly run with very limited recurrent budget most of which is allocated for purchase of drugs and other medical supplies. There is very little room for most health centers to absorb the cost implications of feeding mothers without receiving additional budgets from their respective woredas. As a result, at the beginning of the period of expansion of maternity waiting homes, mothers were expected to take care of their own food and other expenses while staying in a MWH. This had been a major source of inconvenience for mothers staying in MWHs as they had to bother their families transporting food from home to the health center throughout their stay. Health centers are currently using community contributions to cover the cost of running MWHs including food for mothers.

Implementation

Woreda Health Offices worked with Woreda administrators to pass a directive on the need for and amount of community contributions for maternity waiting homes. This has been accompanied by a close follow-up from health centers and HEWs in their respective catchment areas. Kebele administration team members supported HEWs and WDA leaders in the collection of community contributions. A typical flow of activities in the process of introducing community contributions for MWHs is presented in Figure 8. Figure 9 shows how community contributions are channelled to maternity waiting homes.

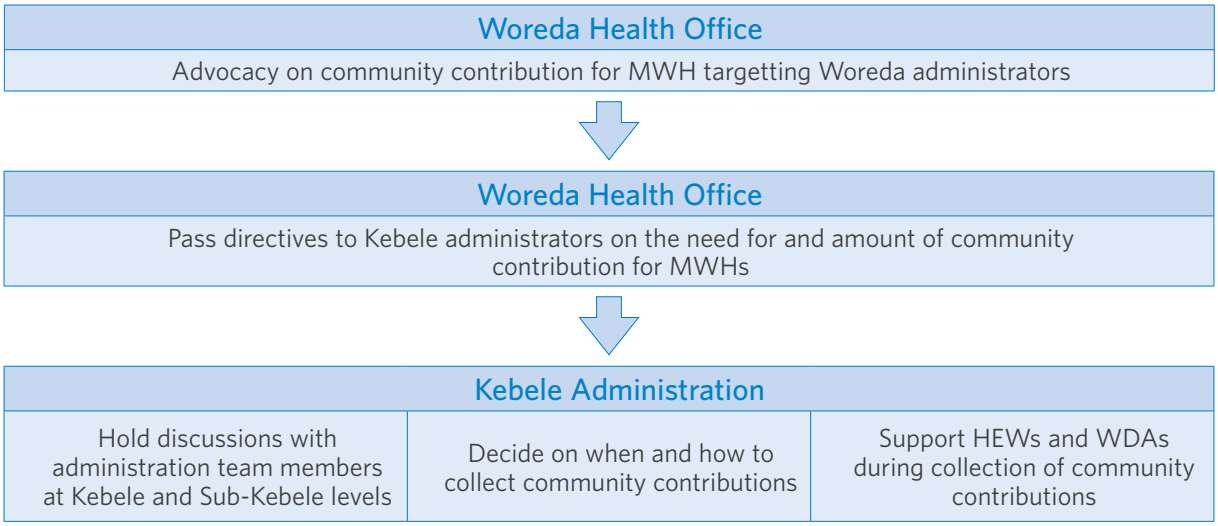

Figure 8: Flow of activities in introducing community contributions for MWHs

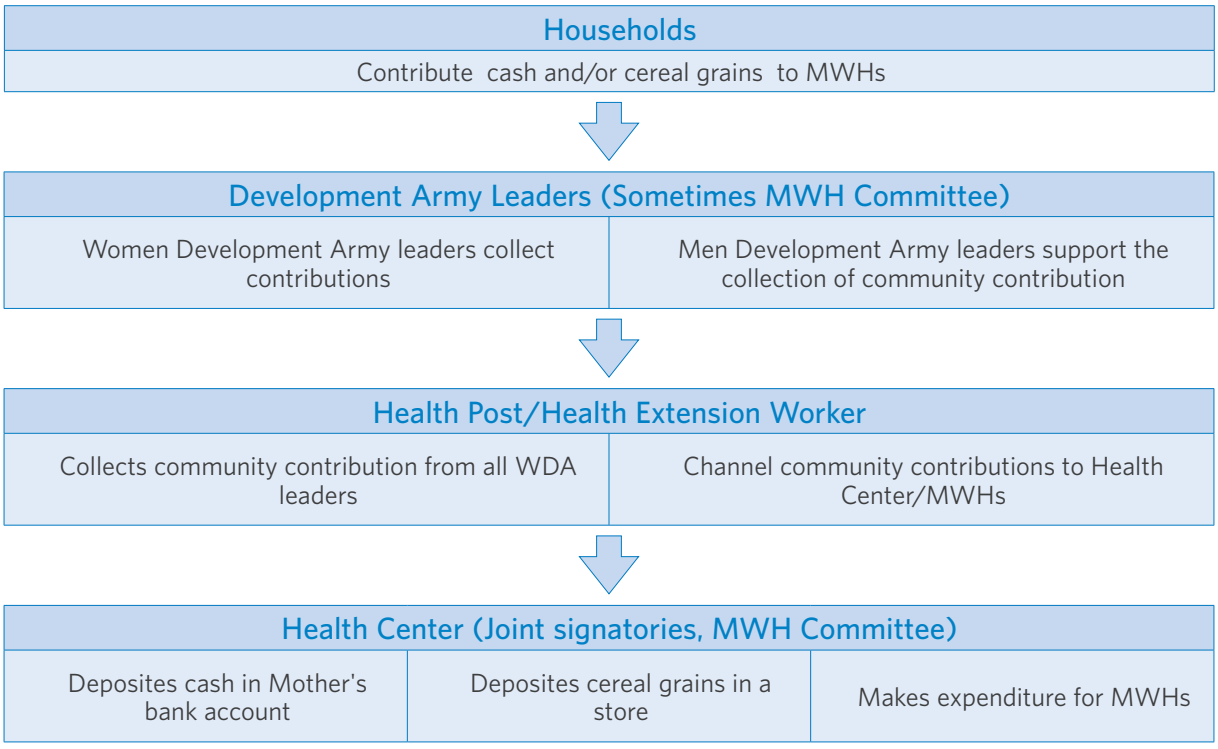

Figure 9: Flow chart of channelling community contributions for MWHs

Community contribution for MWHs has been expanding from time to time. At the beginning, contributions were only in kind (cereal grains produced locally). Health Centers were expected to sell some of the collected cereal grains and buy other necessary items. Later on, additional cash contribution was introduced. Currently, there is a move towards changing all contributions into cash in order to minimize the burden of collecting, transporting, storing, and exchanging cereal grains.

Contributions in visited areas ranged from 10 to 30 birr per household and 0.33 to 1kg of cereal grains per household. Collection of community contributions in cash has been coordinated with tax collection and that of cereal grains has been coordinated with previously introduced systems like community support for HIV affected families.

Results

Community contributions cover either the full or major share of running cost of MWHs in the visited Woredas. In EFY 2010, each of the three visited woredas collected community contributions ranging from ETB 183,000 to ETB 196,583 making an average of ETB 46,904 per maternity waiting home. (Table 8)

Woredas	Community contribution for MWHs in 2010 EFY			Number of MWHs in Woreda	Community contribution per MWH
	Cereal grains (in Quintal)	Cash	Total		
Dalocha	10	ETB 184,583	ETB 196,583	4	ETB 49,146
Mareko	66	ETB 104,070	ETB 183,270	3	ETB 61,090
Baso Liben	0	ETB 183,000	ETB 183,000	5	ETB 36,600
Total			ETB 562,853	12	ETB 46,904 (Average)

Table 9: Community Contributions for MWH in 2010EFY in three UNFPA-supported Woredas in Ethiopia

Contributions have been made voluntarily and are becoming universal in each of the Woredas as the number of men and women who used the services themselves or heard about it from close relatives and neighbours increases. Feedback from mothers who already used MWHs has been an important driver of willingness to contribute for MWHs. An administrator of one of the visited Kebeles described his observations as:

> *In the past there were some people who complained about the increase in the amount of community contribution from one glass to three glasses of cereal grains. There were also concerns about what happens to cereal grains collected; some were asking for receipts for cereal grains they contributed ... there was no trust... This challenge was solved as awareness increased and more mothers who used the MWH tell their experiences to the community. Now each mother, her neighbours, or her relatives have already used the MWH. They contribute for the MWH happily.*
>
> Kebele administrator, Koro Chimo Kebele, Dalocha Woreda, SNNP Region

In addition to financing MWHs, community contributions have also created a sense of ownership of the services. Users of maternity waiting homes interviewed during fieldwork had a feeling that they were using their own resources. A comment on the meal service from a mother who delivered after staying in a MWH reflected this sense of ownership

> *We contributed 'teff' for the maternity waiting home; however, they served me 'injera' made from a mix of other cereal grains ... The good thing was that they corrected it during subsequent meal times.*
>
> MWH user, Dejat Kebele, Yejube Woreda, Amhara Region

A HEW from Dida Midore kebele in the catchment of Koshe Health Center from Mareko Woreda described this sense of ownership as a result of the contribution that communities make to the MWHs. For her, the community contribution has been more important in creating ownership among mothers and the community than in financing the MWHs.

> *In 2010 EFY, we collected four quintal of maize and 14,000 birr for the MWH. This contribution has helped in financing the maternity waiting home. However, the most important benefit of collecting community contributions has been creation of community ownership. If they wanted, it wouldn't have been difficult for Koshe Health Center to cover the cost of running the MWH. It is good that they allowed communities to contribute. Mothers consider the MWH as their own home served by their own resources. They don't feel dependent on the health center for their stay at the MWH.*
>
> HEW, Dida Midore Health Post, Koshe HC catchment, Mareko Woreda

Lessons Learned

- Community contribution is a viable and major financing mechanism to sustain maternity waiting homes;
- Community contribution for maternity waiting homes creates a sense of ownership of services supported by their contributions; and
- Communities are willing to meaningfully contribute for health facility based interventions if mobilized for a convincing cause.

Practice III. Creating Demand for MWH and Institutional Delivery through WDAs

Introduction

Low utilization has been reported as a major limitation of maternity waiting homes in different parts of Ethiopia. The existence of functional networks of women including one-to-five networks and women development armies has been one of the opportunities for promoting utilization of MWHs. Visited health centers used WDAs as important players in creating demand for MWHs.

Implementation

A. Organization of Women Development Army

The Women Development Army, also referred to as Health Development Army at the kebele level, is a community structure intended to connect every household in a kebele to the HEW in-charge through a hierarchy of networks of women. (Figure 10).

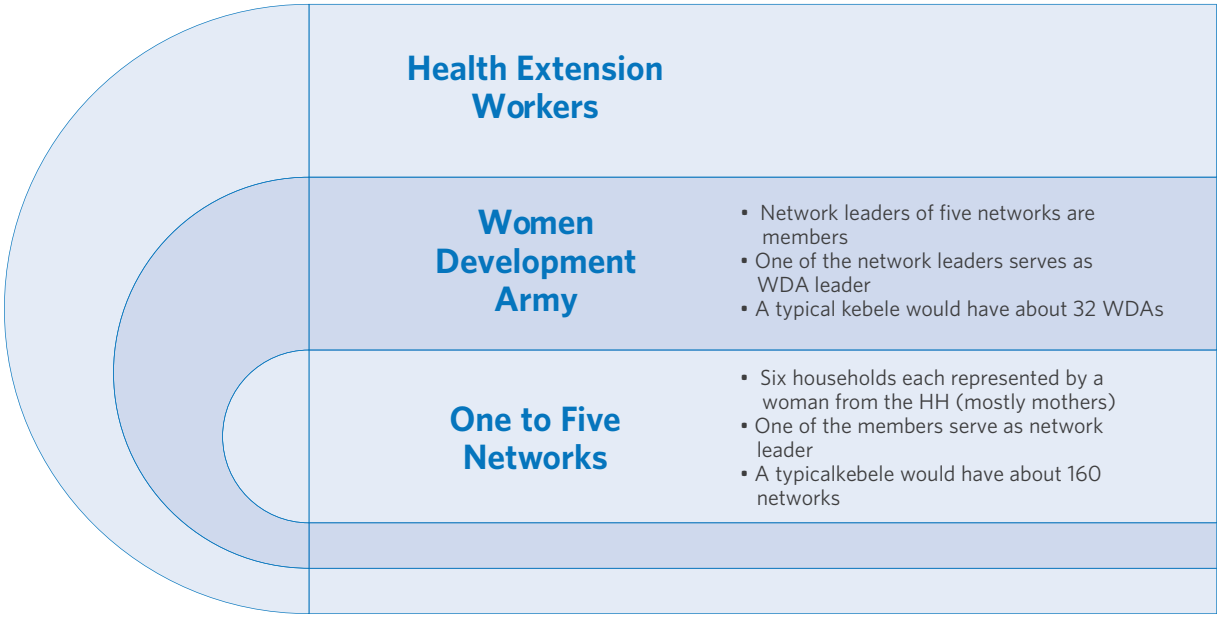

Figure 10: Structure of women development army in rural Ethiopia

B. The role of the Women Development Army in promoting MWHs

One-to-five networks of women are expected to meet every week. Women development army leaders are expected to meet with the Health Extension Workers (HEWs) every month. HEWs used these opportunities to orient WDAs about the availability of MWHs and roles they are expected to play in the promotion of MWH utilization. Figure 11 shows the role of WDAs in maternal health care in general and the promotion of MWHs in particular.

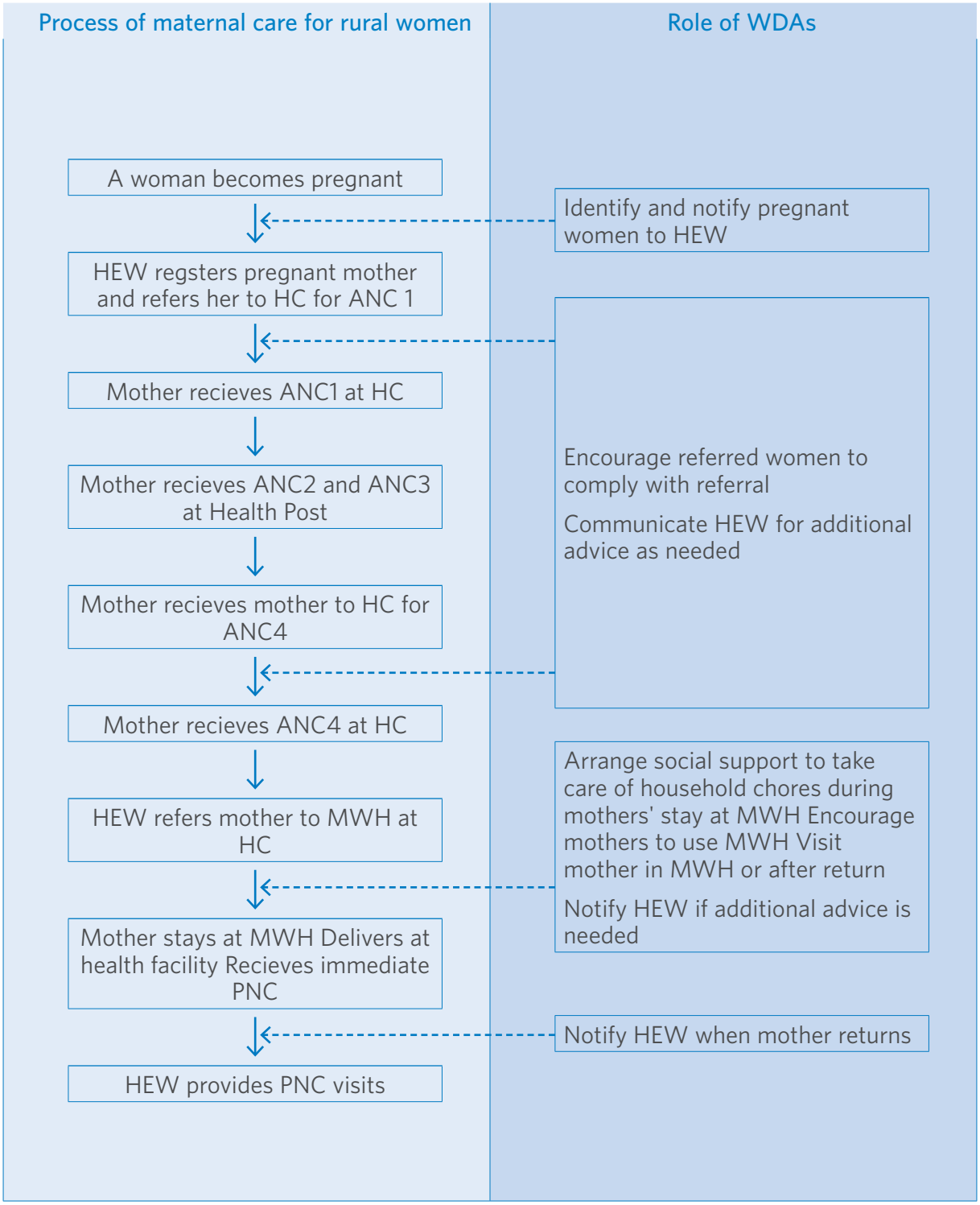

Figure 11: The role of WDAs in maternal care for rural women

Results

Women development armies played important roles in promoting utilization of maternity waiting homes and addressing potential barriers to their utilization. Mothers who used MWHs have mentioned women development army leaders as one source of information about MWH services (Story 1, Story 2, and Story 3). According to key informants at different levels of the health system and focus group discussants at community level, a very important barrier to utilization of maternity waiting homes was fear of mothers to leaving their homes (husband, children, and cattle) unattended during their stay at a MWH. Women development armies played important roles in mobilizing neighbours and extended family members so that they take care of mothers' concerns during their stay at a MWH.

Explaining the role of WDAs in the promotion of MWHs and provision of maternal health services, a HEW from Dejat Health Post said:

> *Women development armies advise and support pregnant women to stay at a MWH during their final weeks of pregnancy ... They mobilize relatives and neighbours of pregnant women so that they will take care of their family and cattle during their stay in a MWH ... They also help us in identifying pregnant women from the beginning. We have monthly meetings with the 42 WDA leaders in the kebele. These leaders help us in reaching the 187 one-to-five networks and 1,130 member women in the kebele. WDA leaders notify to us who in their respective networks is known to be pregnant. Then we provide different maternal health services.*
>
> HEW, Dejat Health Post, Baso Liben Woreda, Amhara Region

Another HEW from SNNP region also mentioned her strong collaboration with WDAs as a primary driver of her success in providing maternal health services including linking mothers with health centers.

> *WDA leaders work with us in the identification of pregnant women. As soon as identified, we can link them to Koshe Health Center and provide them different services ... WDAs are the main reason for our success ... One or two HEWs cannot reach all households in a Kebele. If a HEW tries to do so, she will simply get tired and won't be able to transfer her health messages to communities. Therefore, it is important that HEWs empower WDA and one-to-five network leaders with the right knowledge and skills ... HEWs alone cannot change their communities.*
>
> HEW, Dida Midore Health Post, Mareko Woreda, SNNP Region

Lessons Learned

Appropriate utilization of existing community structures provides additional human resource to the healthcare system at the community level. Performance of HEWs in promoting health service utilization highly relies on their ability to organize these structures and make them fully functional.

Practice IV. Pregnant women's conferences to promote utilization of MWHs and institutional delivery

Introduction

Lack of awareness about risks of pregnancy and childbirth and benefits of skilled care during pregnancy and childbirth are still among the major determinants of low utilization of antenatal care, institutional delivery, and postnatal care services among rural women in Ethiopia. Pregnant women's conferences were introduced in most parts of the country with the purpose of creating awareness and motivating mothers for seeking maternal and newborn health services in a timely manner. The conferences also intend to facilitate peer to peer support among pregnant women in relation to seeking and obtaining skilled care during pregnancy, childbirth, and the postpartum period. Health centers used this forum to promote utilization of maternity waiting homes.

Implementation

A. Organizing pregnant women's conferences

Pregnant women's conferences are meetings among pregnant women from a kebele or sub-kebele convened either in a health post compound or any other convenient location. The conferences are held on a monthly basis and are facilitated by midwives from catchment health centers in the presence of a HEW. Health extension workers and WDAs play a major role in inviting pregnant women to the conferences.

Dates for the conferences are selected with due consideration of routines of local communities. For example, in kebeles where the majority of residents are followers of Orthodox Christian religion, pregnant women's conferences are scheduled on monthly religious holidays because mothers won't be very busy on those days.

In some woredas (eg. Baso Liben), there were reports that religious leaders, other influential community members, and men also attend pregnant women's conferences.

B. Discussion topics

Root causes identified during pregnant women's conferences

- Poor hygiene
- Food quality and quantity
- Manner of kitchen attendant

Discussions in most conference sessions cover a range of topics relevant for maternal and newborn health including 1) danger signs of pregnancy; 2) benefits of ANC, institutional delivery, and PNC services; 3) how to prepare for health facility delivery; and 4) feedback about maternal health services provided at the health center. Midwives and HEWs from the three visited woredas have reported that they have given substantial emphasis to the benefit of staying in maternity waiting homes as part of their discussion on preparing for health facility delivery.

Results

Data on conference attendance was not available. Health extension workers mentioned that most pregnant mothers participate in multiple sessions because the conferences are held on a monthly basis. MWH users also mentioned that they participated in pregnant women's conferences and they have heard about MWHs from the conferences. Explaining the reason behind better utilization of MWHs among mothers in her catchment area, a HEW from Dalocha Woreda said:

> *Pregnant women's conference has been our major strategy to promote the use of MWH among term mothers. One of the priority topics we discuss during the conferences is the use of MWH. That helped us considerably because conference attendance is very high.*
>
> HEW, Koro Chimo Health Post, Dalocha Woreda, SNNP Region

Figure 12: Koro Chimo Kebele officials discussion with HEW about MWH, Dalocha Woreda, SNNP Region

In addition to its informational/educational role, pregnant women's conference was also reported to be an opportunity for learning for the health centers. One health center (Kork Health Center) used feedback obtained during pregnant women's conference as an input in its quality improvement process (described under practice #5). A HEW also identified this role as a very important function of the conferences.

> *Pregnant women's conference facilitated by midwives from the health center has been important in the promotion of MWH use. Technically, we (HEWs) can facilitate the conferences. However, facilitating the conferences by someone from the health center encourages provision of direct feedback from community to the health center. If there are complaints, women raise them during conferences. That facilitates prompt improvement actions by the health center.*
>
> HEW, Lemechem Health Post, Basoliben Woreda, Amhara Region

Lessons Learned

Pregnant women's conferences offer ample opportunities to promote utilization of MWHs, address concerns of mothers, and obtain feedback about services provided by health centers.

Practice V. Quality improvement processes to increase utilization of MWHs

Introduction

Kork Health Center is one of the five health centers in the Baso Liben Woreda of the Amhara Region. The health center serves a total population of 31,521 residing in kebeles most of which border the Abay Gorge. The catchment area of Kork Health Center is characterized by difficult topography and very low road density. As a result, access to different maternal health services has been limited for several kebeles.

With the intention to improve historically low utilization of institutional delivery services, the health center introduced different interventions including the initiation of maternity waiting services in 2015. As a result, there has been a steady increment in the numbers of both deliveries attended in the health facility and mothers staying at the maternity waiting home.

In August 2016, a team of midwives observed that the number of maternity waiting home users and that of women delivering in the health facility has started to decline. The team then applied concepts of quality improvement to get utilization back to its former trend.

Implementation

The team implemented a process that involved problem identification, root cause investigation, and improvement actions (Figure 12).

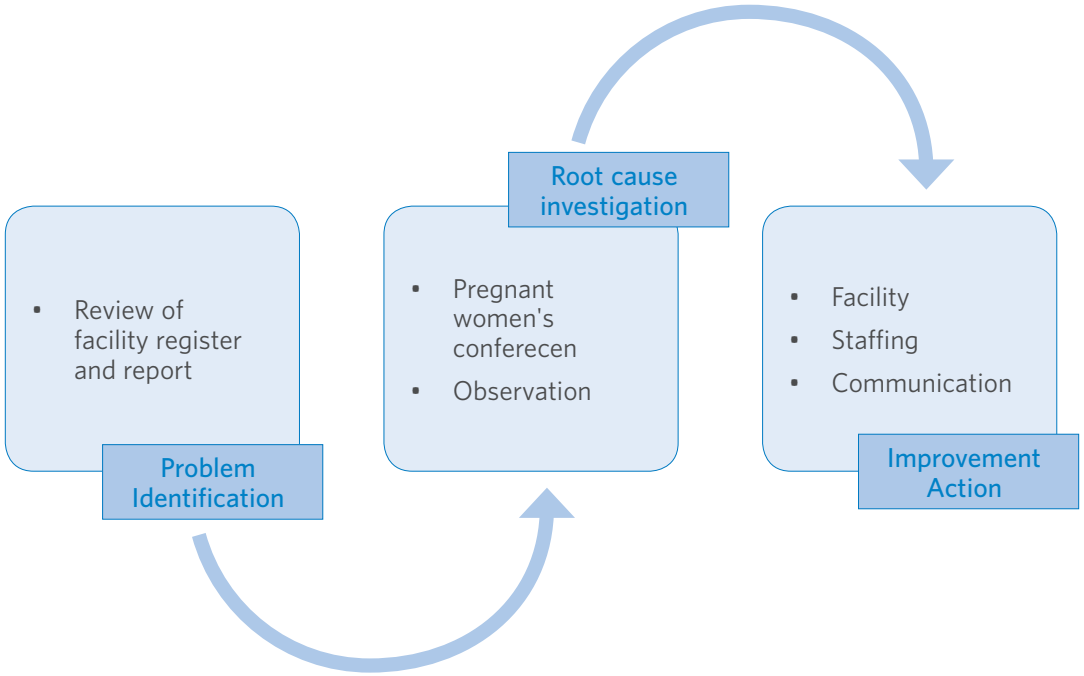

Figure 13: Quality improvement process to improve utilization of MWH, Kork HC

A. Problem identification

A team of midwives from the Maternal and Child Health unit of Kork Health Center wanted to address the root causes of the reduction in utilization of institutional delivery. The team considered the reduction in number of mothers staying at the maternity unit as one of the primary drivers of decreasing performance. As a result, the team focused on investigating why the number of mothers staying at the maternity waiting home decreased.

B. Investigating root causes

The team used pregnant women's conferences as its source of data for investigation of factors responsible for declining utilization of the maternity waiting home. Mothers attending conferences were asked to reflect on what they think about the maternity waiting home in Kork Health Center based on information they got from previous users. The process was also supplemented by observing the maternity waiting home. Findings revealed three major problems:

1. **Hygiene:** The maternity waiting home was reported to be infested with fleas.
2. **Food:** Mothers who used the MWH complained about the quality and quantity of food.
3. **Kitchen attendant:** The attendant use to give food to the mothers and leave without showing any sign of attachment with the mothers. This was perceived disrespectful for mothers.

C. Improvement actions taken

The MCH Unit coordinator liaised with the MCH team and the MWH Committee which was by then responsible for managerial decisions related to the MWH. Based on recommendations from the investigation, the committee took improvement measures including:

1. A new kitchen attendant, who could stay full time in the MWH, was hired.
2. Space was arranged for the new kitchen attendant to live in the MWH with the purpose of allowing more frequent and closer interaction with mothers.
3. The MWH was cleaned thoroughly and treated with insecticide to clear infestation.
4. The improvement actions were communicated with communities in subsequent pregnant women's conferences and other forums
5. Midwives started to communicate more frequently with mothers staying at MWH

Results

Midwives from the health center mentioned that the number of MWH users started to increase immediately after these changes were made. Data on number of MWHs were not available for analysis; however, trends in utilization of institutional delivery service in the health center suggest effectiveness of the actions taken (Figure 13).

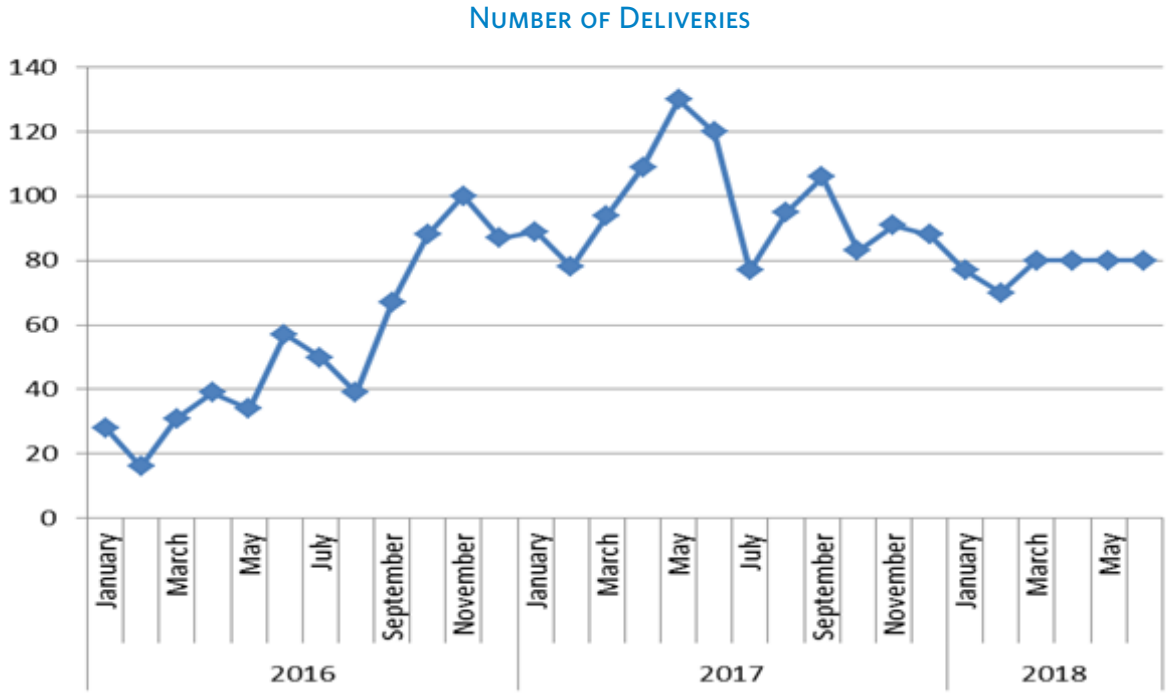

Figure 14: Trends in number of health facility deliveries, Kork HC, 2016-2018

Lessons Learned

Simplified approaches to quality improvement processes, allow identification of major performance gaps, investigation of their root causes, and implementation of solutions with expertise available at the health center level. Institutionalizing such processes would allow continuous improvement in the volume and quality of services including MWH utilization.

Practice VI. Innovative approaches to fill budget gaps in sustaining MWHs

Introduction

Maternity waiting homes are mostly run by using resources contributed by catchment populations of health centers. Even though the commonest challenge of MWHs in Ethiopia is underutilization, some MWHs have very high case load that hosting health centers face financial constraints to sustain MWH services. Few health centers used innovative approaches to address their budget gaps.

Implementation

Three relevant practices were reported by health institutions as measures taken to overcome financial constraints in sustaining MWHs.

1. Nutrition garden
2. Primary Health Care Unit staff contribution
3. Assigning health center cleaning staff to work in MWHs

A. Nutrition Garden – Kork Health Center

The management and staff of Kork Health Center in Baso Liben Woreda of the Amhara Region collaborated with locally available agriculture professionals to set up a nutrition garden where they grow vegetables for the consumption of the MWH. Staff regularly participate in either directly taking care of the garden or mobilizing volunteers from the community to do some work as needed.

B. Primary Healthcare Unit staff contribution - Koshe Health Center

Staff of Koshe Health Center including Health Extension Workers in its catchment kebeles recently decided to make contributions of five birr per staff per month to cover some expenses of the MWH in their health center. The contribution is included as deductible from payroll. The health center has 104 staff (including HEWs). The total contribution of the health center will be ETB 6,240 per year.

C. Assigning health center cleaning staff to MWH – Mareko Woreda Health Office

One of the major costs of running MWHs is paying for kitchen attendants. Mareko WoHO worked with the Woreda administration team and health centers and facilitated the assignment of two cleaning staff from each health center to work for respective MWHs. This was done by hiring additional cleaners in order not to compromise the functions of the health centers. MWHs in these health centers have two full time staff allowing community contributions to MWHs to be allocated for other expenses.

Results

All the innovative financial support mechanisms helped respective maternity waiting homes in narrowing or eliminating budget gaps. The nutrition garden had also additional benefits including diversification of food and demonstration of production and preparation of vegetables for mothers staying at the MWH.

Figure 15: Nutrition garden, Kork Health Center, Baso Liben Woreda, Amhara Region

Lessons Learned

Financing mechanisms for MWHs can be expanded beyond community contributions. Empowering health center staff will bring different innovative approaches to financing MWHs. Sharing these experiences with other health institutions on a regular basis would allow scale-up of effective and locally appropriate alternatives.

Practice VII. Alphabet lessons for MWH users in Yejube Health Center

Introduction

Pregnant women get relaxed time during their stay at MWH. The only responsibility they have at MWHs is taking their own personal care, attending biweekly antenatal visits, and participating in health education sessions. For rural women who use to have very busy routines at home, this type of schedule is very relaxed even for their last weeks of pregnancy. The MWH in Yejube Health Center considered this as an opportunity to introduce alphabet lessons for mothers.

Implementation

The objectives of the alphabet lessons were 1) to motivate mothers on adult literacy and child education; 2) to prevent a feeling of idleness among MWH users; and 3) to increase ability to read among MWH users. The kitchen attendant of the MWH in Yejube Health Center has been providing regular sessions of alphabet lessons for pregnant women. The lessons include both group as well as individual sessions depending on the need of each mother.

Figure 16: Pregnant women attending alphabet lessons by MWH attendant

Results

Women who participated in the alphabet lessons liked the activities. The lessons helped in minimizing a feeling of idleness and allowed mothers to learn reading and writing. Midwives from the health center consider the alphabet lesson as an effective way of using the pregnant women's time during their stay in the MWH. A midwife from Yejube Health Center described the process and results of alphabet lessons as:

> *The kitchen attendant and sometimes midwives are involved in teaching alphabets to mothers. This allows avoiding boredom among mothers. They also develop positive attitude towards education. Mothers staying long enough also learn how to read and write their names.*
>
> Midwife, Yejube Health Center

A pregnant mother staying at the MWH of Yejube Health Center considered the alphabet lessons very important for her and other pregnant women from multiple perspectives.

> *In addition to medical check-ups, food, and accommodation services, it is important to keep mothers engaged in something to make sure they are not bored sitting here.... One of the things I have enjoyed here is the lessons on Amharic alphabet. I left school when I was 4th grader 28 years back. It has been a long time; I had forgotten everything. I never thought that I would be able to read and write again .... I started studying the alphabets with our attendant here in the waiting home. When she helped me a little bit, I started remembering the letters. I can now read; I can also write my name.*
>
> 40 years old, Gravida 9 Para 8 MWH user, Yejube Health Center

Lessons Learned

Engaging pregnant women in non-labour intensive activities during their stay at a MWH helps in keeping mothers active and at the same time achieve desired outcomes. Alphabet lesson is one viable option.

Practice VIII. Integrating collection of community contributions with existing systems

Figure 17: Dejat Kebele community representatives' meeting with WDA and HEW, Baso Liben Woreda, Amhara Region

Introduction

Rural-dwelling Ethiopians mostly rely on subsistence farming for a living. Almost all rural kebeles are characterized by scattered settlement patterns. Collecting community contributions for maternity waiting homes poses enormous logistical burden as it requires making one or more visits to every household in the kebele. Existing systems for collection of cash and cereal grains from households include tax collection system administered by Woreda Finance and Economy Offices and collection of cereal grains for HIV affected families is overseen by Woreda Women and Children Affairs Offices. Kebeles coordinated the collection of community contribution for MWHs with these existing systems to minimize the burden of collection.

Implementation

After reaching at agreements regarding the need for and amount of contributions that have to be made by each household, kebele administrators gave directions for administration team members including men and women development armies on how to coordinate collection of contributions for MWHs with existing systems.

Cash contributions were coordinated with tax collection. Kebele administration team members responsible for collecting tax money were given the responsibility and pads of receipts for collecting contributions for MWHs.

Cereal grain contributions were integrated with collection of contributions for supporting HIV affected families. Women development armies collect the two contributions together and then the collected grains would be divided between the two programs.

Results

The integration allowed kebeles to collect community contributions for MWHs from a large proportion of households in a very short period of time. In addition, the burden of collecting contributions has decreased because of the coordination.

One kebele administration team member from Dajat Kebele described the process as

> *The committee (a sub team among kebele administration team members) collects community contributions for MWHs and channels it to Kork HC through the HEW. In the past this contribution was in food items. Now it is changed to 20 birr per HH which is easily collected along with tax.*
>
> Kebele administration team member, Dejat Kebele, Baso Liben Woreda, Amhara Region

> *The kebele administration collects 20 birr per household during tax collection. I receive the collected money and hand it over to our health center. In EFY 2010, we collected and transferred 19,000 Birr.*
>
> HEW, Dejat Health Post, Baso Liben Woreda, Amhara Region

Lessons Learned

Integration with existing platforms is a feasible, effective and efficient strategy to collect community contributions for initiatives accepted by the majority of rural populations. Community contributions for MWHs are better collected through integration with tax collection systems.

Practice IX. Supporting MWHs through Government Implementing Partners - UNFPA

Introduction

Effectiveness of UN assistance to national governments highly relies on identification of appropriate implementing partners. National Execution is the preferred implementation modality for UNFPA. Maternal health related activities under the 7th and 8th Country Programmes of UNFPA have been implemented through the Federal Ministry of Health and Regional Health Bureaus.

Implementation

With the objective of contributing to reduction of MMR in Ethiopia, UNFPA has been providing technical and financial support at national and regional levels. In its 7th Country Programme, UNFPA partnered with six regional health bureaus and the Federal Ministry of Health. In the 8th Country Programme (the current programme), two additional regions (Gambella and Benishangul-Gumuz) have been included.

The partnership includes both technical and financial support for jointly planned maternal health interventions including support to MWHs. The Country Programme of UNFPA is informed by the strategic plan of the health sector. Areas of partnership were thus identified based on UNFPA's mandate and the need of the country as described in the strategic plan of the health sector.

UNFPA and representatives of government implementing partners conduct joint planning exercises on annual basis. These plans serve as the basis for provision of technical and financial support for each planning period. Accordingly, UNFPA channels financial support to FMoH and RHBs through the Ministry of Finance and Bureaus of Finance and Economic Development respectively. Allocated resources are then channelled to UNFPA-supported WoHOs. Program experts at the UNFPA Country Office and regional levels provide technical support to implementing partners through participation in technical working groups, joint supervision, and monitoring and evaluation activities at different levels of the health system.

Results

UNFPA partnered with Regional Health Bureaus and the Federal Ministry of Health in supporting the expansion of maternity waiting homes and other maternal health initiatives. Financial support for procurement of furniture and utensils through government channel has reached MWHs in UNFPA target Woredas.

Lessons Learned

Working with government implementing partners on projects that involve the public health sector avoids creation of a parallel implementation structure and thus facilitates efficient utilization of limited resources. Close follow-up and joint processes for planning, implementation, monitoring and evaluation of program activities with earmarked resources are important in harmonizing efforts and resources for a shared objective.

V. CHALLENGES

Interviews with health workers and community members revealed some challenges in relation to implementation and utilization of maternity waiting homes.

1. **Human Resource:** Despite high level of integration of the functions of MWHs with other maternal health services at health center level, the human resource needs of providing MWH services has not yet been recognized and approved by the Public Service and Human Resource Development (PSHRD) sector at woreda, region and federal levels. As a result, there are no positions to hire personnel for MWHs at health centers.
2. **Lack of a Regulatory Mechanism:** Maternity waiting homes are expanding at a rapid rate. However, there are no formal regulatory mechanisms to enforce minimum standards in relation to MWHs' facilities and services. Existing health center standards also do not address maternity waiting homes.
3. **Inappropriate targeting:** In some health posts, referral of mothers to maternity waiting homes is not selective enough. HEWs refer all pregnant mothers to MWHs during their final weeks of pregnancy irrespective of availability of alternative ways to access health facilities for institutional delivery services. With the increasing acceptability of MWHs, non-selective referral to MWHs will lead to overcrowding at MWHs and shortage of resources to provide services.
4. **Data gap to monitor MWHs:** The current Health Management Information System (HMIS) doesn't collect any information about availability and utilization of MWHs. This has created challenges to monitor the status of MWHs at different levels of the health system.
5. **Inadequacy and sub-optimal quality of food:** Users of MWHs mostly reported that food provided to them (three meals per day, mostly Injera with stew) has been adequate and of good quality. However, compared to the nutritional needs of women during pregnancy and nutritional advice provided during antenatal care visits, both frequency and diversity of meals are sub-optimal.
6. **No one to take care of household chores during women's stay in MWHs:** Many women are not comfortable in leaving their houses "without" an attendant during their stay at a MWH. They are concerned mostly about their children. This challenge has been addressed in some communities by mobilizing neighbours and extended family members through WDAs.
7. **No transport service to take mothers back home after delivery:** Mothers who deliver after staying at a MWH are discharged just after 24 hours postnatal follow-up. Yet, they are not provided transportation service to get back to their home.

VI. SUMMARY OF LESSONS LEARNED

1. Maternity waiting homes contribute in increasing utilization of maternal health services particularly among women living in rural areas where distance, topography, and road access are barriers to timely access to skilled delivery services. Appropriate admission criteria favoring women from hard-to-reach areas will have a notable impact in addressing the current urban-rural disparity in utilization of maternal health services including fourth antenatal care, skilled birth attendance and immediate postnatal care.
2. Appropriate advocacy and promotion can lead to high degree of community acceptance of MWHs among rural communities leading to voluntary contributions for constructing and sustaining MWHs. Diversifying source of finance through contributions by volunteers and government budget can serve as a backup to minimize the probability of financial bankruptcy and provision of sub-standard care.
3. The role of WDAs and HEWs is indispensable throughout the process of establishing and running MWHs. Collection of community contributions to MWHs, referral of pregnant women to MWHs, and feedback on satisfaction of MWH users largely rely on the performance HEWs and the functionality of WDAs. Pregnant women's conferences facilitated by health center staff support the efforts of HEWs and WDAs in creating demand for MWHs among rural-dwelling women.
4. Positive feedback among mothers who ever used MWHs is an important driver of decisions to use MWHs among pregnant women in rural areas. Quality of medical as well as non-medical care provided for mothers staying at MWHs determines the nature of information circulating among mothers. It is important that health centers monitor and continuously improve quality of care in their maternity waiting homes. Simple approaches involving identification of problems based on available data, investigation of root causes, and implementation of improvement actions is feasible at health center level. Institutionalizing such processes would allow continuous improvement in the volume and quality of maternal health services including utilization of MWHs.
5. Non-medical services for mothers staying in MWHs are as important as close medical follow-up. Engaging pregnant women in non-labour intensive value adding activities during their stay at a MWH helps in keeping mothers active and at the same time achieving additional positive outcomes. Alphabet lesson is one viable option.
6. Integration with existing platforms is a feasible, effective and efficient strategy to collect community contributions for initiatives accepted by the majority of rural populations. Community contributions for MWHs are better collected through integration with tax collection systems.

RECOMMENDATIONS

- Formalize the establishment of maternity waiting homes at health center level by incorporating the needs of MWHs in health center standards, human resource plans, and budgeting to ensure quality and sustainability of services.
- Develop short term mechanisms to enforce minimum standards of services provided in MWHs. Ensuring provision of balanced diet and prevention of overcrowding and communicable diseases have to be adequately emphasized.
- Encourage promotion of MWHs as part of personalized birth preparedness plan instead of universal prescription. This requires appropriate guidance and training to health workers responsible for the management and promotion of MWHs.
- Ensure adequate recording and reporting of data about MWHs by integrating MWH indicators into the national HMIS.
- Conduct a large scale rigorous study to investigate, document, and share the effect of MWHs on utilization of maternal health services and maternal and newborn health outcomes at the community level. Most designs for such a study would be feasible only before all health centers establish MWHs.
- Adopt innovative mechanisms to address the concerns of pregnant women in using MWHs including lack of transportation after delivery and challenges related to absence of mothers from home during their stay at MWHs.
- Disseminate good practices and lessons learned from visited sites for possible adoption and adaptation in other MWHs.

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ANNEX 1: STORIES OF MWH USERS

Story 1: Shukuru Juwar, mother who delivered after using MWH at Dalocha HC

Background: Shukuru Juwar was a Para 7 mother from Meisa Got in Koro Chimo Kebele of Dalocha Woreda in SNNP Region. She delivered her youngest child at Dalocha Health Center after three weeks stay in the maternity waiting home. Shukuru delivered her first four children at home. For her fifth delivery, she walked to the nearest road access and took bajaj (three wheel shared taxi) to the health center after onset of labour. For the sixth delivery, she stayed at a relative's house close to Dalocha Health Center during her last week of pregnancy.

Most Recent Pregnancy: Shukuru was repeatedly visited by a HEW during her most recent pregnancy. She also attended pregnant women's conferences facilitated by midwives from Dalocha Health Center. During the conferences she learned about the importance of staying at the maternity waiting home. She also attended ANC at the health center during which she was provided additional advice on staying at the maternity waiting home.

Stay at MWH: During her fourth ANC visit, Shukuru was advised to stay at the Maternity Waiting Home until she gives birth. That was not a surprise for Shukuru and her husband; they were already ready for it following previous advice from the Health Extension Worker and pregnant women's conference. She stayed in the MWH for three weeks. During her stay, Shukuru received repeated medical check-ups, food and accommodation services.

Shukuru's Reflections on her experience at the MWH:

Describing how important the MWH was, Shukuru compared her three most recent births as follows:

"This is my third time to deliver in a health center ... but it is my first time to use the maternity waiting home. The first time I gave birth at the health center, I went there after labour started. I walked all the way from home to the main road where I took bajaj to the health center. My walk was interrupted several times by painful contractions. It took me five hours to get to the health center. Had it not been for my early decision to go to the Health Center, I would have delivered on the way ... I gave birth in two hours after my arrival..."

"The second time I gave birth at the health center, I decided to stay at a relative's house in town during my final week of pregnancy. I stayed with them for five days and returned home after giving birth at the health center ... Staying with relatives during pregnancy was not a good option but there was no other alternative. It makes you uncomfortable ... I contributed for food and other expenses but still I was not feeling at home....

On the third time, I spent the last three weeks of my pregnancy at the maternity waiting home in the health center ... It was an amazing experience. I was provided with good food for breakfast, lunch, and dinner, pipe water and soap for my personal hygiene; I chatted with other pregnant women over coffee ceremony; and we watched different television programs together. I also had frequent medical check-up by health workers. When labour started, I was taken to the delivery room and taken care of ... The postnatal ceremony was also great; they did everything I would have done at home. Now I am back with good health and a healthy baby ... I had good time.

Story 2: Yezina Abateneh, pregnant mother staying at Kork Health Center MWH

Background: Yezina Abateneh is a 23 years old Gravida 2 Para 1 mother staying at a maternity waiting home in Kork Health Center. She is from Yeweynit Got of Dejat Kebele in Baso Liben Woreda of the Amhara Region. Yeweynit is 2 hours walking distance from Kork Health Center and one hour from the nearest Health Post. Yezina and her husband do farming and animal husbandry for their livelihood. Her husband also travels to urban centers and does small businesses to make additional income during non-farming seasons of the year.

Yezina didn't know so much about pregnancy and childbirth by the time she got married 8 years back; she was 15 then. She didn't use any contraceptive that she got pregnant immediately after marriage and delivered her first baby girl after a year. She also didn't attend antenatal care during her first pregnancy. She gave birth to her first daughter seven years ago, a year after she got married. The delivery was attended by her mother at home. Remembering her first pregnancy and delivery, Yezina considers herself as lucky because she and her baby were healthy even though she delivered at home. Yezina was later visited by a Woman Development Army leader who taught her about family planning. As a result, she used injectable contraceptive for two years and implants for three years.

Current Pregnancy: A year ago, Yezina and her husband wanted to have a second child. Yezina got the implant removed at Dejat Health Post. A few months later, Yezina was feeling sick when a HEW visited her house. After listening to her history of illness, the HEW referred Yezina to Kork Health Center where Yezina was confirmed to be pregnant and advised to attend antenatal care. During subsequent months, HEWs visited her repeatedly and advised her about the need for institutional delivery and the availability of a MWH where she can stay during her last weeks of pregnancy. The HEW has also discussed the importance of staying at a MWH with Yezina's mother-in-law, who was an important decision maker particularly because Yezina's husband was not around.

Stay at MWH: Yezina had four antenatal care visits at the Health Center. Her fourth visit was six days ago. By then, she was in her 39th week of gestation. As she was feeling tired and her husband was away from home, her mother and brother accompanied her to the health center. The midwife in-charge of antenatal care suggested Yezina should stay at the MWH until delivery. Yezina discussed with her mother and brother and decided to stay at the MWH. Yezina called her husband and informed him about her situation. All the family agreed that Yezina has to stay in the MWH.

Yezina is currently waiting for the arrival of her new baby. It has been six days since she joined a group of pregnant women staying in the MWH. During her stay, her mother-in-law has been taking care of her daughter and neighbours have been taking care of her cattle. Medical records of Yezina show that she has no complications so far; her vital signs are within normal ranges; and her expected date of delivery is after a day.

Reflections on MWH: Reflecting on services provided at the maternity waiting home, Yezina described her experience as:

> *"There is regular check-up; I had three check-ups since I got here. They also feed us good food with variety of stew three times a day ... prepare coffee ceremony twice a day and provide us tea once a day. The bed is very comfortable and clean; I also take shower daily.... These things don't exist back home. At home, I focus more on my household chores than taking care of myself."*

Responding to a question on what would have happened had she not stayed in the MWH, Yezina said:

> *"Had I not stayed here, my family still will consider bringing me to the Health Center because now they know the danger of giving birth at home. However, ambulances do not access our village and carrying me on a traditional stretcher would be very challenging. Labour may also start at a time when men are not available in the village. That may delay my travel to the Health Center ... endangering the life of myself and my baby.... Staying here is a good option."*

When asked if she will consider staying in the waiting home in the future, Yezina said:

> *"I don't have a plan to have more than two children but I will strongly advise my sisters and pregnant women in my neighbourhood to stay in this waiting home."*

Story 3: Etenesh Abate, pregnant mother staying at Yejube Health Center MWH

Background: Etenesh Abate is a 40 years old Gravida 9 Para 8 mother from Yewujet Got of Yegelew Kebele in Baso Liben Woreda of the Amhara Region. She lives an hour's walk from a nearby Health Post. The nearest access to road, from where she can take public transport to the health center also takes an hour.

Previous pregnancies: Etenesh has five daughters and one son. She had one still birth and one neonatal death. Her youngest child was born in Yejube Health Center two years ago after she attended antenatal care in the same facility. Etenesh didn't get any information about maternity waiting home during her previous pregnancy. When she delivered her youngest child, she started having back pain on a Friday night but it was not that strong. Strong and frequent contractions started Sunday early in the morning. That was when she remembered her experience of still birth and asked her husband to take her to the health center. As it was early morning, men were still in the village; her husband called his neighbours for help and they carried her on a traditional stretcher to Yejube Health Center. The membrane ruptured on the way. After three hours of a tiresome journey, Etenesh arrived at Yejube Health Center. Soon after arrival, she gave birth to her youngest child. Describing her experience on a traditional stretcher, Etenesh said:

> *"Traveling on a traditional stretcher was the worst thing I ever experienced as a pregnant woman. It was tiresome; I couldn't move because I was tied with the stretcher; and there was very painful frequent contraction ... no one listened to me when I complained."*

Current Pregnancy: Etenesh attended three ANC visits at Yejube Health Center during her current pregnancy. Her first visit was at about 16 weeks of gestation. During her second ANC visit, she took an appointment for a third visit and agreed to stay in the maternity waiting home then after. Etenesh deliberately missed that appointment because she felt a prolonged stay at the MWH would affect her children at home. Just three days past her date of appointment, she was feeling sick at home; she decided to visit the health center and started to walk but she was too weak

to do so. Her husband dialled the ambulance number, which was written on the ANC follow-up card, and slowly walked her towards the nearest access to road. After walking for more than an hour, she arrived at a road point from where she was picked up by an ambulance. Etenesh was accompanied by her oldest daughter on her way to the health center as her husband got back to take care of children and their cattle at home.

Stay at MWH: Examination at the maternity unit showed that Etenesh was not yet in labour and she had no complications. She was then let to the maternity waiting home in the health center. The decision was communicated to her husband through phone; he accepted and continued to take care of household chores along with older children at home.

Etenesh, accompanied by her oldest daughter has stayed two weeks in the maternity waiting home. She is now one week past her expected date of delivery. The delivery room, is just next door to the maternity waiting home. An ambulance is also ready to take her to Yejube Hospital, a primary hospital located in the same town, just in case she gets referred. Etenesh considers the support she gets from her family is what allowed her to stay in the MWH.

> *"The support I have from my family is what helped me to stay here. All my husband wants is my safety. We told him about my stay over the phone and he said go ahead. Now he is taking care of everything at home. He visited me four times and he calls me every day. My children also visit me in turns. My son-in-law also allowed his wife to stay with me."*

Experience in MWH: During her two weeks stay in the MWH, Etenesh used different services including daily medical check-up, Injera-based food three times a day, coffee ceremony, television channels, shower, bed service, and Amharic alphabet lessons.

Reflecting on her alphabet lessons, Etenesh said:

> *"In addition to medical check-ups, food, and accommodation services, it is important to keep mothers engaged in something to make sure that they are not bored sitting here....One of the things I have enjoyed here is studying the Amharic alphabet. I left school when I was 4th grader 28 years back. It has been a long time; I had forgotten everything. I never thought that I would be able to read and write again .... I started studying the alphabets with our attendant here in the waiting home ... When she helped me a little bit, I started remembering the letters. I can now read; I can also write my name."*

Asked what she would tell to other mothers about the MWH, Etenesh replied:

> *"I recommend pregnant women to come and stay here when they are term. I will tell them my story. I have suffered giving birth to many children at home; I lost very much blood, it was painful and traumatizing. I have also suffered traveling to the health center on a traditional stretcher while in labour; that was tiresome and painful. Waiting for labour in this house is very good. If they want, they can also get additional food from their home. The only challenge in staying here is leaving the house for a while; let husbands and older children take care of it for few weeks."*

ANNEX 2: COMPENDIUM OF GOOD PRACTICES

Good practices identifed	Targeted Problem/ Opportunity	Implementation	Results	Lessons
1. Establishing and Managing MWHs to increase utilization of maternal healthcare services	Distance, topography, and limited road access continue to be barriers to utilization of maternal health services despite rapid expansion of health centers	MWHs have been constructed in the compounds of health centers by mobilizing local resources through targeted advocacy at Woreda level. MWHs are considered one unit of health centers and provide medical, accommodation, food, recreational, and traditional services to pregnant women during their last weeks of pregnancy.	Between 2014 and 2018, the proportion of health centers with a MWH increased from zero to 78.2% in SNNP and 91.8% in Amhara regions. On average, mothers staying at MWHs constituted 9% of deliveries at health centers. Most users have been from hard-to-reach areas. MWHs have been reported relevant both by pregnant women and healthcare providers	MWHs contribute in increasing utilization and addressing geographical disparities in skilled maternity care services.
2. Financing MWHs through community contributions	MWHs do not have regular budget. Requiring MWH users to take care of their own food and other expenses affects convenience and utilization.	Mobilized through Woreda and kebele administrators, households contribute cash and/ or grains to sustain MWHs. WDA leaders and HEWs collect and channel community contributions to MWHs at health centers.	In Baso Liben, Dalocha, and Mareko Woredas households contributed an average of ETB 46,904 per MWH. Contributions have been voluntary and women developed a sense of ownership in the MWHs because of their contributions.	Community contribution is a viable financing mechanism to sustain maternity waiting homes.
3. Innovative approaches to fill budget gaps in sustaining MWHs	MWHs are mostly run by using resources contributed by catchment populations of health centers. MWHs with high case load face financial constraints.	Health Centers adopted their own mechanisms to fill budget gaps. These include nutrition garden, cash contribution from health center staff, and assigning health center cleaning staff to work in MWHs	All approaches contributed in addressing budget gaps.	Financing mechanisms for MWHs can be expanded beyond community contributions. Empowering health centers will bring different innovative approaches.

Good practices identifed	Targeted Problem/ Opportunity	Implementation	Results	Lessons
4. Integrating collection of community contributions with existing systems	Collecting community contributions for MWHs involves logistical challenge to HEWs and WDA leaders	Cash contributions were coordinated with tax collection system and cereal grain contributions were integrated with collection of contributions for HIV affected families.	The integration allowed kebeles reaching high coverage in a short time The burden of collecting contributions has decreased because of the coordination	Integration with existing systems is a feasible, effective and efficient strategy to collect community contributions for initiatives accepted by the majority of rural populations.
5. Creating Demand for MWH and Institutional Delivery through WDAs	Low utilization of MWHs; Women development armies provide an opportunity to easily reach pregnant women.	WDA leaders were assigned with tasks to support HEWs in the provision of maternal healthcare.	WDA leaders played important roles by – identifying pregnant women, – encouraging pregnant women to comply with referrals to MWHs, and arranging social support to families of MWH users	Appropriate utilization of existing community structures provides additional human resource to the healthcare system at the community level.
6. Pregnant women's conferences to promote utilization of MWHs and institutional delivery	Low utilization of maternity waiting homes Pregnant women's conference has been routinized in most parts of Ethiopia.	Midwives from health centers lead pregnant women's conferences in the presence of HEWs and WDA leaders. Discussions were revised to include information about MWHs, the use of MWH as part of birth preparedness plan, and how mothers can support each other during a pregnant woman's stay in a MWH.	Pregnant women's conference has been an important source of information about MWHs. Conferences facilitated feedback from community members (including previous users of delivery & MWH services) directly to health center staff.	Pregnant women's conferences offer ample opportunities to promote utilization of MWHs, address concerns of mothers, and obtain feedback about services.

Good practices identifed	Targeted Problem/ Opportunity	Implementation	Results	Lessons
7. Quality improvement processes to increase utilization of MWHs	Kork Health Center observed a decline in utilization of MWH and institutional delivery services after an increasing trend for a certain period of time.	A team of midwives from the Health Center implemented a quality improvement process involving identification of problem, investigation of root causes, and improvement actions.	Utilization of MWH and institutional delivery started to increase following implementation of quality improvement actions and communication of the same to communities through pregnant women's conferences.	Simplified approaches to quality improvement allow identification of major gaps, investigation of their root causes, and implementation of solutions with expertise available at health center level.
8. Alphabet lessons for mothers staying at MWH in Yejube Health Center	Pregnant women from rural areas are used to busy daily routines. Staying at a MWH creates a sense of idleness.	Yejube Health Center provided alphabet lessons to MWH users on a regular basis. The kitchen attendant of the MWH holds regular sessions of alphabet lessons for pregnant women staying at the MWH.	Women liked their alphabet lessons. The lessons helped in minimizing a feeling of idleness and also enabled some mothers to learn how to read and write.	Engaging pregnant women in non-labour intensive activities during their stay at a MWH may help in keeping mothers active and at the same time achieve desired outcomes. Alphabet lesson is one viable option.
9. Supporting MWHs through Government Implementing Partners - UNFPA	Effectiveness and efficiency of UN assistance to national governments highly relies on identification of appropriate implementing partners.	Maternal health related activities under the seventh and eighth country programs of UNFPA-Ethiopia have been implemented through FMoH and RHBs as implementing partners. Technical and financial support to the expansion of MWHs was provided through joint processes of planning, budgeting, supervision and performance review.	UNFPA reached MWHs through partnership with RHBs and FMoH. Financial support for procurement of furniture and utensils through government channel has benefited MWHs in UNFPA-target Woredas	RHBs can be effective implementing partners if close follow-up and joint processes are in place for planning, implementation, monitoring and evaluation of program activities with earmarked resources. The arrangement eliminated the need for establishing parallel implementation structure thus increasing efficiency.


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