Maternity Waiting Home – A light of hope for pregnant women in tribal areas?
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Complications in pregnancy can be addressed through three possible ways - through flying medical teams, by provision of emergency referral transport system or through a de-centrally available skilled obstetric care(1). Maternity Waiting Home (MWH)(2), also known as ‘Maa Gruha’ in Odiya, is a means to address the last mentioned approach. It is a residential facility located near the delivery point where ‘high risk’ pregnant women can await their delivery and can be transferred in time to the medical facility, or in case any complication arises(1). The concept becomes very important for hard to reach areas with difficult geographic access and poor communication though it may not be applicable for well communicated urban areas.

Even well anticipated cases of delivery may not be able to reach the delivery point in time. Hence the concept can be life-saving in case of complicated pregnancies. If at all the expecting mother and their family reach well before time, the hospitals may not be able to accommodate them pre and post-delivery, thus leading to out of pocket spending (OOPS). MWH is an effective means to ‘bridge the geographical gap’ (1) and caters the need of hard to reach tribal pockets of the community(3)(4).

The waiting homes are supposed to be located near the delivering hospitals. They provide temporary accommodation for the expecting mothers along with her attendants (maximum two persons including ASHA). Free food is also provided under the scheme. A health worker female (HWF) cum coordinator is appointed in the centre who provides medical treatment under supervision of a visiting doctor and even provides counselling services. She is the person to coordinate with hospital and other agencies for providing essential care. Medical health care facility is provided on rotation basis by lady health care assistants.

Though a total of six pregnant women can be admitted in the MWH at any point of time, yet no case can be rejected under any circumstances. Additional expenditure incurred by the MWH in such situations has to be reimbursed from the Zilla Swasthya Samiti (ZSS). Admission of these cases is to be done at least 7-10 days prior to the expected date of delivery (EDD). Re-admission during same pregnancy is allowed in 10% of cases (admission for the first time with false labour pain or with a miscalculated EDD). A maximum stay of seven days stay has been recommended to ensure optimum bed turnover ratio.

Maternity Waiting Houses are usually set up in a Public Private Partnership (PPP) mode. Selection criteria for location of the maternity waiting home are areas having inaccessible population such as vulnerability level 4 (V4) areas, less than 10% institutional deliveries, and covering a maximum of six gram panchayats. Community based NGO is the first choice for implementing such waiting homes and in case one is not available, Rogi Kalyan Samiti (RKS) of the referral institution has to take up the activity. Detailed micro-planning has been recommended to be ensured by the NGO partner in consultation with the district officials. Regular reporting and review has to be ensured, and renewal of the implementing agency is to be done based on the annual evaluation by an independent agency.

There are eight districts in the state of Odisha where a total of 24 MWHs have been implemented(5) with the support of NGO partners (range of 1-4 MWH per district). A total of 11 NGO partners are supporting the initiative. Around 86% of the admitted pregnant women in MHWs have undergone institutional delivery(5).

SWOT analysis was done by the authors with regards to guideline, achievement, secondary data and other available information related to MWH. Core strengths of MWH observed include provision of a visiting doctor, a health assistant round the clock, provision of stay and food for attendants also to reduce OOPS, availability of transfer facility to the delivery point, etc. MWH is a good temporary alternative to delivery points where there is high bed occupancy rate or where sufficient beds are not available. Effective counselling services can be provided which can increase knowledge, attitude and practice of beneficiaries with respect to early initiation and exclusive breast feeding, essential

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new born care practices, family planning measures, danger signs of mother and new born in post natal period, etc.

Few weaknesses were found such as low salary leading to a possibility of attrition of deployed human resource and no mention of the skills needed for the staff of MWH in the program guideline. Similarly there is no mention of the need of triage during admission and treatment, and of the rationale of fixing bed strength in the MWH. No method has been worked out for providing compensation for loss of wages of attendants which is a concern in poor tribal families. It was found that the decrease in maternal mortality rate is lowest in the southern division where most of the MWHs are located, while highest decrease is in central division of Odisha(6).

There are some opportunities available for the improvement in functioning of MWH. Most of the MWHs are implemented in the high priority districts (HPDs) and currently the major focus in the Reproductive Maternal Neonatal Child and Adolescent Health (RMNC+A) Call to Action (CTA) is on the HPDs. MNREGA scheme can be utilised for compensating loss of pay of the attendants (especially husband). Self Help Groups (SHGs) can also provide alternative source of earning for these attendants. Development partners supporting the HPDs can also provide techno-managerial and funding support for improving the quality of services.

Few threats need to be pointed out that exist in the system. The existing PPP plan in Odisha does not incorporate any service that can be provided at the MWH under PPP initiative(7). Effectiveness of utilization of these waiting homes depend on identification of complicated cases of pregnancy, without which the total purpose may be lost(8). Most of the V4 areas in the state have extremist activity (in the form of Maoists or Naxals), which is a hurdle for NGOs taking up these projects. Irregular review of the PPP mode run MWH by the district authorities can become a hurdle for providing quality services. Capacity building of the NGO partners for MWH management was not approved in NHM PIP in the last year(9). Last but not the least, there is insufficient evidence to determine the effectiveness of maternity waiting facilities on improving perinatal and maternal outcomes since there are no trials(10), which again raises the question – “Are we on the right track”?

The authors at the end remain clueless as to whether it the MWHs or something else which can bring about a significant drop in the MMR? Cost effective analysis is always needed before putting a lot of tax payers’ money in the game. Evaluation by external agencies and experts in the field can provide evidence for the outputs provided by these MWHs presently. Operational research might provide the required solution for improving the quality of functioning of the MWHs in place.

REFERENCES