THE EXPERIENCES AND PERCEPTIONS OF MALE PARTNERS OF THE UTILIZATION OF MATERNITY WAITING HOME IN OPUWO DISTRICT, NAMIBIA

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Keywords

Accessibility

Experiences

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Morbidity

Mortality

Perceptions

Pregnant women

Health district

Quality of service

Roles.

Glossary of Acronyms and Abbreviations:

MOHSS	Ministry of Health and Social Service
ANC	Ante Natal Care
PNC	Post Natal Care
NDHS	Namibia Demographic and Health Survey
MWHs	Maternity Waiting Homes
WHO	World Health Organisation

SDGs	Sustainable Developmental Goals
EU	European Union
UN	United Nations
PHARMaCM	Programme for Accelerating the Reduction of Maternal and Child Mortality
PMTCT	Prevention of Mother to Child Transmission
EmONC	Emergency Obstetric and Neonatal Care
MDG	Millennium Development Goals

Abstract

In 2018 Opuwo Maternity Waiting Home (MWH) was inaugurated after its completion with the assistance from WHO and the European Union. This initiative by the Ministry of Health and Social Service and its partners was aimed to ensure safe deliveries as well as to overcome physical and socio-economic barriers such as long distances, communication and high transport costs to access health care facilities for safe deliveries in Opuwo District. However, since its inception the facility has been under-utilized. The aim of the study was to explore male partners' experiences, perceptions and roles regarding the use of the MWH in Opuwo District, Namibia.

A descriptive and qualitative, exploratory design was used to answer the research question as the design wanted to explore the experience and perception of male partners towards utilisation of MWH. The study population consisted of all men in Opuwo district whose partners or wives have made use of Opuwo Maternity Waiting Home from June 2020 to June 2021. A non-probability, purposive sampling technique was used to select 12 participants (men) whose partners had utilized Opuwo Maternity Waiting Home. Data was collected using semi-structured face-to-face interviews, which allow in-depth responses through probing.

Most men perceived potential benefits from using MWHs, including improved access to facility-based, skilled delivery services and treatment in case of labour complications. Their many roles included decision-making, finding money for transport and buying food and clothes for the mother and the baby to use during and after labour. However, financial incapacitation made it difficult for other men to allow their partners to utilise MWH as they could not afford transport cost and also the accessibility of transport in remote areas act as a hindrance in utilizing the health facility.

The finding suggest the provision of transport to collect women from their respective areas especially in remote places to the MWH could improve the utilization of the facilities.

Declaration

I declare that the experiences and perceptions of male partners of the utilization of maternity waiting home in Opuwo is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Tomas Shapumba September 2021

Signed: ……..

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Chapter One: Introduction

1.1 Background of the study

Maternity and perinatal mortality remain a great concern in many African countries, particularly in rural areas. The World Health Organisation estimates that a total of 180-200 million women become pregnant and of these, an estimated 287 000 pregnancies ended up in maternal death (WHO, 2014). Namibia Demographic Health Survey (2013) reports that more than 99% of maternal death occur in developing countries, including Namibia. In 2013, Namibia recorded a perinatal mortality rate of 24 deaths per 1000 pregnancies of seven or more months. Perinatal mortality is particularly high in Zambezi and Kunene regions, with 34 deaths and 32 deaths per 1000 pregnancies respectively. Haemorrhage, eclampsia, unsafe abortions, sepsis and obstructed labour contribute to more than 70% of all maternal deaths (MoHSS, 2014).

Maternity Waiting Homes have been identified as an important intervention to ensure safe deliveries as well as to overcome physical and socio-economic barriers such as long distances, communication and high transport costs to access health care facilities for safe deliveries (World Health Organization (WHO), 2015). Since the beginning of the 20th century, these homes have existed in Northern Europe, Canada and the USA. In Africa one of the early experiments with Maternity Waiting Homes was in Eastern Nigeria in the 1950s, known as 'Maternity villages' followed by Uganda in 1960s. Research suggests that maternal deaths in one remote area fell by half (Minkler, 1972). These maternity waiting areas developed into small buildings adjacent to the district hospital, where women were housed for at least two weeks before expected delivery 1996). In Namibia, as of 2013, Maternity Waiting Homes have been considered a key intervention in bridging the geographical gap of access to obstetric and new-born care between rural areas with poor access to health facilities, and urban areas where

the services are available. Prior to the construction of Maternity Waiting Homes, pregnant women suffered as they were often living in their own make-shift tents situated in front of the hospital before giving birth (MoHSS, 2014).

The former First lady of the Republic of Namibia, Madam Penehupifo Pohamba is a patron of the national maternal and child health agenda. She played a key role in the construction of maternity waiting homes in the country as part of her role in improving access to health information and services for pregnant women and new-borns, who come from remote areas to be closer to health facilities (MoHSS, 2014). In 2011, an assessment of already existing waiting shelters, which were never standardized, was conducted by MOHSS in collaboration with WHO in Ohangwena, Omusati, Oshana and Oshikoto regions of Namibia to assess how they were being utilized and to formulate policy on future use. One of recommendations from this assessment was the construction of more standardized Maternity Waiting Homes in other regions in the country. As a result, the Opuwo Maternity Waiting Home was constructed with financial assistance from European Union, World Health Organization and the Ministry of Health and Social Services, and officially opened in Opuwo health district in February 2018.

However, although many studies show the willingness of pregnant women to stay in MWH, MWHs utilization remains low. This is due to various reasons such as financial incapacitation while staying in the MWHs. The most frequently mentioned reasons for their non-using of MWH were lack of family support and high dependency on family or husband for decision and lack of decision-making autonomy among other reason (Sialubanje C, et al, 2015; Nesane, Maputle and Shilubane, 2016; Wilson J, et al, 1997). One key actor group not well understood is husbands. It is therefore imperative to quest how are men or husbands' experience and perceptions towards the usage of MWHs by their partners in the Namibian context.

1.2 Study setting

This study was conducted in the remote district of Opuwo in the Northern part of Namibia in Kunene region. Opuwo district accommodates 31 percent of the regional total population, which according to the Namibia Housing and Population Census (2011), is estimated at 65,909 people, dispersed over a vast area. The district has 1 hospital, 17 clinics and 2 health centres with approximately 1700 births per year. (HIS, 2019).

The landscape of Opuwo district is "stony and mountainous, with seasonal flooding rivers" (MoHSS, 2014) . The district is one of the geographic areas where culture, traditions and customs are deeply rooted and poverty is rampant. It is a district dominated by the nomadic Ovahimba people. Road networks are poor because of region's mountainous terrain, resulting in some communities experiencing challenges in accessing transport to health facilities.

1.3 Problem Statement

MWHs are crucial in ensuring that women receive the needed antenatal care, information and awareness, skilled attendances and proper monitoring to counter any problems associated delivery. The male partners' major roles and responsibilities include making the final decision on the use of MWHs, finding money for the things that are needed during and after labour including cleaning materials and clothes for the mother and baby, and to ensure availability of enough food for the wife (Ongolly, 2019). Based on the importance of male partners in their spouses' maternal health, it is imperative to find out their experience and perceptions towards the utilisation of MHW.

The Opuwo Maternity Waiting Home, which is the only maternity waiting home in the entire Kunene (Northern Namibia) region. has been underutilised since its inception in 2018. Based on the maternity waiting home admission records, the facility has 35 beds, with an annual

carrying capacity of 420 pregnant women. However in 2018, the occupancy rate was only 104 (24.7%), and 153 (36.4%) in 2019 (HIS, 2019).

Furthermore, it is worth noting that there is no research study conducted in Namibia that has investigated the views of male partners towards the usage of MWH. Therefore, this study seeks to explore the experiences and perceptions of men on the use of MWH, and suggestions for changes that could be done for them to actively support and improve their partners utilising the MWH in Opuwo District, Namibia.

1.4 Purpose

While the international literature provides a fair amount of information on reasons for low Maternity Waiting Home utilization, very little is known about the role male partners play in encouraging or hindering attendance of Maternity Waiting Home by pregnant women, either internationally or in Namibia. For this reasons and for reasons of access, which will be discussed in the methods chapter below, this study sought to explore the experiences and perceptions of male partners of the use of Maternity Waiting Home, and suggestions for changes that could be implemented for them to actively support their women utilising the Maternity Waiting Home in Opuwo District, Namibia.

The understanding of male partners' views is important as it will provide crucial insights that might assist interventions to improve acceptability, access and ultimately utilization of maternity waiting homes by pregnant women.

1.5 Aims and Objectives

The study aimed to explore male partners' experiences, perceptions and roles regarding the use of the maternity waiting home in Opuwo District, Namibia.

Objectives

The objectives of the study were as follows:

- To explore partners' knowledge of the importance of skilled birth attendance.
- To explore partners' roles in deciding on utilisation of the Maternity Waiting Home in Opuwo District.
- To better understand partners' attitudes, experiences and perceptions regarding the Opuwo Maternity Waiting Home.
- To explore measures that could improve partners' support for utilization of Maternity Waiting Home in Opuwo.

Chapter Two: Literature Review

2.1 Introduction

There is a substantial body of literature on the use of and barriers to utilization of maternity waiting homes and a fair amount of literature that looks at the role of men in pregnancy and child birth. On the other hand there is very little literature that actually focuses on male partners role in the utilisation of MWHs, although they play a key role in determining women's ability and permission to access ante natal care and maternity waiting homes (Yargawa and Leonardi-Bee, 2015). This chapter therefore, covers the literature review of the study which entails a discussion of the global, regional and national and local literature on the utilization of maternity waiting home.

2.2 Maternal and perinatal mortality trends

There have been substantial improvements in maternal and perinatal mortality in the past three decades. According to a World Health Organisation Report (2015), the global maternal death ratio fell by 44 % between 1990 and 2015. The total number of maternal deaths globally dropped from an estimated 532 000 in 1990 to 303 000 in 2015. This equates to an estimated 216 maternal deaths per 100 000 live births in 2015, down from 385 in 1990. However, this number is still much too high, as most of these deaths could be prevented with appropriate care before, during and after delivery.

The Millennium Development Goals (MDGs) in 2015 in Geneva set a target aimed at reducing the global maternal mortality ratio further, to 70 deaths per 100 000 live births by 2030.In Namibia, maternal mortality stood at 195 per 100,000 live births in 2017, down from 348 in 2000 (WHO, 2017). In line with enhancing maternal health, Namibia, through The Namibian

Vision 2030, established strategies to reduce the maternal mortality rate one of which is the establishment of maternal waiting homes (Government of Republic of Namibia, 2016).

2.3 Maternal and New-born Health Initiatives in Namibia.

In addition to the international and regional initiatives that Namibia was part of, it also implemented its additional programmes that were developed to improve the maternal health outcomes. One such programme is the Safe Motherhood Initiative signed in 1991 because of being a member state of the World Health Organization. Then, in 2000, Namibia adopted the Millennium Development Goals (MDGs), with Goal 4 focusing on reducing the child mortality rate by 2/3 and Goal 5 focusing on reducing maternal mortality by 3/4 by the year 2015 (NPC, 2011). Further, Namibia conducted the Emergency Obstetric and Neonatal Care (EmONC) assessment countrywide, to assess the country's outcomes of maternal, neonatal and child health care (MNCH), which revealed that there were some gaps in the quality of care given to obstetric women and new-borns (MoHSS, 2006).

After that, the Roadmap for Accelerating the Reduction of Maternal and New-born Morbidity and Mortality was developed in 2007. This was done with the aim of guiding the process of delivering the MDGs and to address the gaps identified by the EmONC assessment (MoHSS, 2006). This Roadmap facilitated the deployment of skilled health care providers for EmONC services, expansion of Prevention of Mother to Child Transmission of HIV (PMTCT) services, training of Skilled Birth Attendants (SBAs), initiation of maternal, perinatal and neonatal death reviews, enhancement of referral services and the availing of essential medical equipment by the year 2015 (MoHSS, 2006/7).

Furthermore, the Namibia Maternal Health Initiative Project was piloted and implemented in Windhoek, with some local and international organisations, to help address maternal mortality in (McKenzy Quarterly, 2010). And in 2013, the European Union (EU) funded Programme for

Accelerating the Reduction of Maternal and Child Mortality (PARMaCM) under the leadership of the then First Lady of Namibia Madam Penehupifo Pohamba (MoHSS, 2017; EU, 2016). The PARMaCM then secured funding for the second national EmONC assessment, which was done in 2016 which eventually led to the establishment of MWHs in Namibia generally and Opuwo in particular.

2.4 The History of maternal waiting homes in response to maternal mortality, experiences, benefits and challenges.

The Maternity Waiting Homes represent one widely recommended solution to strengthen the health system and respond to maternal and child health needs in the country, according to the World Health Organization (WHO, 2015). The homes allow pregnant women living in remote areas to access quality maternal and new-born care by bringing them closer to health facilities, and in cases of complications that might arise during pregnancy, child birth and post-partum period, skilled health care providers are readily available (WHO, 2015).

Maternity Waiting Homes have been advocated for several decades to overcome barriers to obstetric care and reduce maternal and perinatal mortality (van Lonkhuijzen *et al.*, 2003; World Health Organization (WHO), 1996).

Over the past few years, several studies investigating the effectiveness of Maternity Waiting Homes were conducted and have reported positive outcomes. Studies conducted in several countries in Eritrea, Liberia, Ethiopia and Zimbabwe showed that Maternity Waiting Homes improve pregnant women's accessibility to health care facilities, which is key element for women to receive skilled birth attendance (Penn-Kekana *et al.*, 2017). As a result, maternal mortality was reduced and maternal new born health outcomes improved among women who made use of Maternity Waiting Homes during the last trimester of their pregnancy (Sialubanje *et al*., 2016).

However, delays in decision-making to seek care due to lack of understanding of complications, lack of trust in the health care delivery system, acceptance of maternal death as norm, low status of women, social-cultural barriers to seek care contribute to continued preventable maternal mortalities, especially in developing countries. (WHO, 1996; Lee et al., 2009; van Lonkhuijzen et al., 2012).

According to a literature review conducted by Penn-Kekana et al. (2017), challenges of establishment and implementation of MWH, which led to poor utilization, were lack of knowledge and acceptance of the MWH among women and communities, long distances to reach the MWH, and deemed culturally inappropriate care. The review reiterates that poor utilization is often due to lack of knowledge and acceptance of the MWH among women and communities. Other barriers include location and distance as well as cultural inappropriateness of care provided. Poor MWH structures were identified by almost all studies as a major barrier, and included poor toilets and kitchens, and a lack of space for family and companions. In South American, evidence from Cuba and Peru, shows that careful tailoring of the MWH to women's accommodation, social and dietary needs, low direct and indirect costs, and a functioning health system are key considerations when implementing MWH (Penn-Kekana *et al.*, 2017b).

While it is acknowledged that male partners have a strong influence on pregnant partners' health and their access to care, evidence on their specific role is very limited. (Nesane, Maputle & Shilubane, 2016). Penn Kekana et al (2017) recommend inter alia reduction or removal of costs associated with using a MWH, community involvement in the design and upkeep of the MWHs, activities to raise awareness and acceptance among family and community members, and integrating culturally-appropriate practices into the provision of maternal and new-born care at the MWHs.

2.5 The involvement of men on pregnancy and child birth

Traditionally, maternal health issues have predominantly been seen and treated as a purely feminine matter (Kinanee and Ezekiel-Hart, 2009). The exclusion of men from MCH services reinforced the notion that pregnancy and childbirth was uniquely feminine (Mumtaz and Salway, 2009) and maternity facilities are exclusively meant for women (Iliyasu *et al.*, 2010)..

Male involvement in maternal and child health has been advocated over two decades. However, many cultures in Africa and Asia have continued to consider pregnancy, childbirth and child rearing a woman's responsibility (Nyondo-Mipando, Chimwaza & Muula, 2018).

According to Aborigo *et al.*, (2018) in patriarchal settings, there are strict gender roles which are often adhered to. This has brought stigmatization and barricaded men participations although some men has a desire to rise above role stereotypes to support their partners during pregnancy. The study further revealed that men risk social derision and stigma if seen accompanying their partners to the maternal health care centres.

Studies have reported that participation of male partners in antenatal care (ANC) counselling can considerably increase women's utilization of HIV-related service (Ditekemena, Koole and Colebunders, 2012). Additionally, other studies have indicated that male involvement results in the increased access to postpartum services reduced maternal smoking and depression; and reduced risks of infant mortality (Feldman et al, 2000; Redshaw and Henderson, 2013).

2.6 Male partners' roles in determining Maternity Waiting Home utilization

There is very limited literature available on the role men play in decision-making about the utilisation of MWH. However, a few studies have been found that address this specific issue.

A study conducted in Ethiopia by Tiruneh, *et al*., (2016) highlights that husbands play a pivotal role on the utilisation of maternity waiting homes by pregnant women as they are the ones that accompany women and bring them food. Also, a much older study conducted in Ghana

reported that women could only use facility-based delivery services if they obtained permission from their husbands (Wilson *et al.,* 1997).

The husbands' major roles and responsibilities included making the final decision on the use of Maternity Waiting Homes, finding money for the things that were needed during and after labour, including cleaning materials and clothes for the mother and baby, and to ensure availability of enough food for the wife and accompanying relatives staying at the Maternity Waiting Home.

According to the study done in rural Zambia the decision-making process regarding utilisation of MWHs mainly involved the husband and wife sitting down to discuss preparations for the baby and whether the woman should go to the MWH or not. However, the final decision is made by the husband, after taking into consideration potential risks of labour complications if the woman delivered at home, the benefits of using MWHs and giving birth at the clinic, as well as the factors that would make it difficult for the wife to use the MWH such as lack of funds for food and other requirements to use at the MWH. Husbands who perceived these barriers did not allow their wives to use MWHs (Sialubanje, Massar, Elisa M Kirch, *et al.*, 2016)

Moreover, the husband has to take care of the children together with one of the assigned family members who will be at home and failing to find a family member to remain with the children at home would result the husband not allowing the women to utilize the maternity waiting home. (Ongolly & Bukachi, 2019). Additionally Sialubanje *et al.*, (2016) reiterates that the poor state of the MWHs, including inadequate sleeping spaces and bedding, water and sanitary services, have been cited as factors that deterred women from utilizing MWH and a research from Zambia has illuminated that poor conditions of the MWH led some husbands to forbid their wives from using them.

2.7 Quality services of MWHs as determination of its utilization

Many studies highlight advantages of facility-based births, but also emphasize the importance of quality and appropriateness of health facilities generally and MWHs specifically as a determining factor of acceptance and utilization. Chibuye *et al.*, (2018), report that women and community groups called for better infrastructure, services, food, security and privacy transportation in the MHWs so that the facilities can be fully utilized. Another study in rural Zambia by Henry *et al.*, (2017), discovered that the implementation of MWHs should center on community accepted quality measures. It is proposed that improving both the availability and quality of MWHs will potentially increase facility delivery. Kaiser *et al.*, (2019), advise that sustaining and improving of MWHs needs to be ongoing address saving mothers and giving life in a timely manner.

Studies conducted in Cuba and Peru also showed that carefully modifying MWH to women's accommodation, social and dietary needs, and low direct and indirect costs are key considerations in implementing MWHs (Penn-Kekana et al (2017). A Malawian study showed a variation in MWHs care provided across health facilities. Perceptions of the quality of care were not uniform and poor standards contributed to the differences (Suwedi-Kapesa and Nyondo-Mipando, 2018). Subsequently, Vermeiden *et al.*, (2018) in Southern Ethiopia mention that unless barriers for women to stay at MWHs are overcome, these facilities will continue to be underutilized, especially among marginalized women. Efforts should be made to improve, sustain, and standardize care in the MWHs in order to improve perceptions of quality of care in the MWHs.

Despite efforts by the World Health Organization and the government to educate and implement MWHs across the population, in developing countries, especially remote areas and culturally traditional communities, skilled birth attendant deliveries and the introduction of

foreign practices that might hinder the community to uphold their traditions and cultural practices, are still viewed as a luxury one can survive without.

Chapter Three: Methodology

3.1 Introduction

This chapter covers the details of the methods used in gathering and analysing information related to the experiences and perceptions of male partners of the utilization of maternity waiting home. According to Ojo (2003), a methodology is a system of explicit rules and procedure in which research is based and against which claims of knowledge are evaluated. The research methodology of this study entails; study design, study setting, study population, sampling process and size, data collection, data analysis, rigour, ethical considerations, and limitations

3.2 Study Design

This study adopted a descriptive and exploratory qualitative design. The descriptive design systematically describes a condition, problem, phenomenon, service or program, or defines attitudes in the direction of an issue (Romm & Ngulube, 2015). Using a descriptive design permitted the researcher to explore and describe male partners' views, knowledge and experiences of child birth and skilled deliveries generally and maternal waiting homes specifically. Adopting the qualitative approach yielded deeper insights into the male partners' views in which the researcher used comprehensive descriptions, interpretation, verification and evaluation which was enabled through inductive reasoning.

3.3 Study Population

The study population included all 318 men in Opuwo district whose partners or wives have made use of Opuwo Maternity Waiting Home from June 2020 to June 2021.The study population of the recent years were selected as participants and were deemed to still have fresh memories about the subject and also it was the peak of the Covid 19 pandemic which was

expected to generate more information on emerging events that might contribute to the non-utilization of the maternity waiting home.

3.4 Sample

Brinks, Van Der Walt & Van Rensburg (2006, p.124) defined a sample as a fraction of the whole population which was selected to participate in the study.

Soeters, Shields & Rietjens (2014), suggest that qualitative sample sizes of 12 -15 participants may be a minimum adequate sampling size for small studies. The study sample consisted of 12 participants (men) whose partners had utilized Opuwo Maternity Waiting Home.

3.5 Sample technique

A non-probability, purposive sampling technique was used to select 12 participants on the basis that they possessed the characteristics of interest to the researcher (De Vos *et al.,* 2011). To have different perspectives on the central phenomenon, the maximal variation approach was used. It is "a purposeful sampling strategy in which the researcher samples cases or individuals that differ on some characteristic or trait" (Ishtiaq, 2019).

The researcher grouped male partners into four categories according to their proximity to Opuwo maternity waiting home; from those who resides less than 40 km radius, 40km to 80km radius, 81km to 120km radius and above 121km radius. The researcher then selected 3 participants per category from the list of names of husbands or partners collected from Opuwo Maternity Waiting Home admission registers, Maternity ward birth/delivery registers, and Ministry of home affairs hospital birth certificate registration books, to make a total of 12 participants.

To avoid any bias, all the names of husbands or partners in the registers per each category were written on a piece of paper and folded and put on the hat, then the researcher blindly pulled out

names from the hat one by one until the third name. The researcher then telephonically sought their availability and arranged an interview. In the event that the participant selected was not reachable telephonically, a message was relayed to the nearest health facility's manager, who sought their availability/or appointment for the research interview. The researcher was fortunately enough that he managed to get hold of the majority of the participants. Only one participant was unreachable and communication was made to the nearest health facility. The message managed to reach to the participant, and the appointment was made.

3.6 Data Collection Process

Data was collected using semi-structured face-to-face interviews, which allow in-depth responses through probing. According to May (2011), interviews shall be a dialogue, which produces valuable information, thereby permitting easy interpretation and comprehension of the respondents' response to specific questions

The interviews took place at the respondents' place of choice, usually their residence. To ensure that participants fully understand the interview questions, an interpreter was used to interpret the interview questions from English to the local language. Following introductions, the study was explained to the interviewee, using an information sheet, and they were asked to participate in the study. The researcher highlighted that participation was voluntary and participants were free to partake or not, and that they were able to withdraw at any stage, and permission for them to be recorded was sought before any recording was done. None of the participants objected to be recorded. Participants were informed that the interview was going to be approximately 40 minutes. Braun & Clarke (2006) underscore the importance of informing the participants of the period it will take for the discussion to be completed. The researcher was using both Otjiherero (vernacular language) and English, depending on the interviewees' language preference. Following that, a written informed consent form was presented to the

participants to sign if they were willing to participate and for those who could not write a finger print stamp was used.

The interview process was guided by an interview guide containing semi-structured questions addressing the research aims and objectives. Probing and follow-up questions were used to elicit participants' knowledge and experience related to the research topic. These follow up questions emerged from the participants' response.

All responses were recorded and, with the help of the researcher's assistant, notes were taken and also non-verbal gestures were noted as they emphasized some areas which the participants sought to explain and that aided understanding to the researcher. According to Hulley, Cummings & Browner (2008) during interviews, the interviewer must take note of non-verbal communication as it elucidates verbal communication.

The description of the data collection process is adequate

3.7 Data Analysis

The researcher manually analysed the data using the thematic analysis technique, which involved data immersion, familiarization, coding, and examining and theme development as are directed by the data content (Guest, 2012). This inductive approach involved data analysis with little or no predetermined theory, structure or framework (other than those set by the study objectives) and uses the actual data itself to derive the themes (Saldana, 2009). Data familiarization was done through carefully listening to the audio content and reading through all the interview transcripts and field notes and making comments in the margins about the key patterns.

Data codes were generated from corresponding ideas and behaviours in the transcripts and other notes. The same colour codes applied on similar or related themes. According to Robson & McCartan (2016), phenomena which are coded could include actions, events, meanings (or perceptions) activities, states, relationships, or consequences. Coding was done manually by

identifying interesting features of data and segments of text that are answering the research questions and objectives. Once coding had been completed, theme identification was done by sorting initial codes into order and groups, then merged them together to form an overarching themes . All topics were listed, and themes and sub-themes were classified and codes allocated to them (Creswell, 2011).

To ensure data validation, the themes were scrutinized and compared against the dataset to ascribe significance. Data and emerging themes were discussed with the research assistant and with the supervisor. That determined whether the themes are sound and also ascertain if they convincingly satisfy the research objectives. Themes were typically refined, which sometimes involved them being split, combined, or discarded (Hulley, Cummings, & Browner, 2008). Theme defining and naming involved developing a detailed analysis of each theme, working out the scope and focus of each theme and deciding on the appropriate name. Finally, the researcher weaved together the analytic narrative and data extracts and contextualizing the analysis concerning existing literature.

3.8 Rigor

In qualitative research, rigor refers to the measures utilized during the research process to enhance trustworthiness and credibility (Ad`er *et al.*, 2008). May (2011) suggests that rigor is entrenched in ensuring valid data interpretation through dependability, credibility, confirmability, reflexivity and transferability.

Credibility is an internal consistency which ensures the research process' accuracy and consistency (Peat *et al.*, 2010). In this study, credibility was ensured through upholding honesty, iterative questioning, and negative case analysis and data triangulation (May, 2016). The researcher made use of different sources of data to triangulate information which

strengthens validity by finding accord between information from various sources (Robson & McCartan, 2016).

Transferability assesses the level to which the study process can be transferred to other individuals' situations in addressing the main issue under study (Ad`er *et al.*, 2008) .Clear and adequate information about the research process was provided thus elucidating on the reader how he transferred the findings.

Confirmability addresses the core issue that "findings should represent, as far as is (humanly) possible, the situation being researched rather than the beliefs, pet theories, or biases of the researcher" (Morrow, 2005). Furthermore (Gasson, 2004) urge the researcher to be reflexive of his own role and approach at all times within the study process, by self-critique, appraising his influence on the process, and by keeping a journal for references. This was of particular importance in the study as the researcher is a senior health official in Kunene Region, and was centrally involved in the setting up of the maternity waiting home in Opuwo.

The researcher's choice of research focusing on men, rather than women, reflects sensitivity to the cultural norms of the region, which might forbid women to openly speak to males about issues of child bearing. The researcher furthermore ensured sensitivity towards political, cultural and social issues amongst the participants and reflexivity regarding his role in the health system by including the local speaking interpreter during the data collection processes and by keeping a reflective journal.

3.9 Limitations

The topic was considered taboo to some men as traditional roles and values prevail in these deep rural areas, as the majority of participants were hesitate at first to partake in the interview as they perceived the topic feminine. However the researcher persuaded the participants on

significant benefits of such engagement on the betterment of maternal health care service delivery.

The study findings are not be generalizable to other areas with different socio-cultural, economic and geographical contexts. Also, the study was confined to one district which might not represent the whole region or country's perception. Additionally for reasons of what is feasible in such a small-scale study, the researcher only included men whose wives had, in fact, used the MWH. This excludes all those who did not and obviously created a selection bias, meaning there is massive crucial information omitted from those men whom their partners are not utilizing the maternity waiting home. Also the study focuses only on men rather that women who likely could have given different experiences and perceptions about utilization of maternity waiting home rather than getting the experience of women from their partners. It would be interesting that future studies should also involve female partners who had made use of the MWHs to share their experiences and perceptions as they have first-hand information. However, the study focused on men as their voice since they are overlooked and under researched globally yet there are important part of the puzzle.

3.10 Ethics

Ethics are standards or codes of behaviour that differentiate between correct and wrong. They assist to assess the disparity between correct and incorrect behaviour and attitude (Ad`er *et al.*, 2008). Ethical standards in the first instance protect the study participants, and discourage the manufacture or falsification of data and hence encourage the integrity of the study. The researcher ensured by in-depth deliberation and consultation with participants that they were well prepared, understood the risks and benefits that mighty accrued to them as participants, and further ensured that they feel free to make an independent decisions without fear of negative consequences (Fritz, 2008).

Permission to conduct research was obtained from the University of the Western Cape's Biomedical Research Ethics Committee and Senate Higher Degrees Committee. Once the study proposal was cleared, it was then forwarded to the Ethical Bodies in Namibia's Ministry of Health and Social Services Biomedical Research Committee, and Research Management Committee for both ethics clearance and permission, to allow the proposed research study to be conducted in Opuwo district.

As suggested by Soeters, Shield & Rietjeins (2014), 12 participants were deemed adequate for a qualitative design studies and a non-probability purposive sampling technique was used. A signed written consent form was obtained from the participants after detailing the purpose of the study with provisions given to withdraw from the study at any time. Usually the choice of venue for in depth interview was left to the participants and often it's their homes (Legard *et al.*, 2003).

A private and conducive environment was sought preferable outdoors where there adequate cross ventilation taking into consideration that we are still in the middle of the pandemic. All the necessary COVID 19 precautionary measures was adhered to, wearing of masks, social distancing and continue of hand hygiene throughout the interview. Privacy and anonymity was ensured by omitting any identifying information such as names on the research instruments, instead of numerical and alphabetical coding was used. All data was held with strict confidentiality, as the researcher was the only one knowing the source origin of the data. Subsequently, the data was kept in the password-secured computer only accessible by the researcher. Audio recording was used to collect data and that enabled the researcher to capture the language, hesitation and the tone used by the participants which gave an in-depth meaning of the concept. Data collected was used to create codes or triangulation which indicated a

broader or complex understanding of a concept and to deduce the findings of the topic under study.

Themes were derived and identified from the collected data. (Fossey *et al.*, 2002). Furthermore, the participants were clearly informed that they can withdraw from the study at any stage. The findings of the research were disseminated to the Executive Director of the Ministry of Health and Social Services in the form of hard and soft copies and they can be used to formulate policies that might improve the utilization of MWHs.

The methodology section is well documented and the candidate has demonstrated good understanding of the research concepts and processes

Chapter Four: Research Findings

4. 1 Introduction

Twelve (12) male partners were interviewed from all the distance radius from Opuwo Maternity Waiting Home. They perceived many benefits from using MWHs including improved access skilled delivery services and treatment in case of labour complications. Their many roles included decision-making, finding money for transport, food and buying clothes for the mother and the baby to use during and after labour. However, limited financial resources and lack of critical information on the benefits of maternity waiting home was perceived as a hindrance on the utilization of maternity waiting home.

The researcher used the thematic analysis method to analyse the data summarised in the key findings. A total of four main themes were identified relating to answering the research questions and aim of the study. The identified themes were: male partners' roles during pregnancies, factors influencing decisions to utilize the maternity waiting home, experiences and perceptions with the utilization of maternity waiting home and proposal for measures to improve utilization of the maternity waiting home. The main themes and sub themes derived from several code are described in the table below:

Table 1 Themes and Sub themes.

Themes	Sub themes
4.3.1 Male partners roles during pregnancies	4.3.1.1 Financial and moral support role 4.3.1.2 Decision making process 4.3.1.3Demonstrating care love and affection during pregnancy

4.3.2 Factors influencing decisions to utilize the maternity waiting home	4.3.2.1 Cultural practices and traditional beliefs 4.3.2.2 Knowledge and information pertaining MWH 4.3.2.3 Distance and financial implications for transport 4.3.2.4 Covid 19 pandemic 4.3.2.5 Perception of other men towards utilization of MWH
4.3.3 Men Experiences and perceptions on the utilization of maternity waiting home	4.3.3.1 Men and their partner encounter on the utilization of MWH
4.3.4 Proposal for measures to improve utilization of the maternity waiting home.	4.3.4.1 Information dissemination to both women and men on maternity waiting home. 4.3.4.2 Provision of transport to maternity waiting home

4.2 Description of the study participants

A total of twelve (12) research participants of child bearing age whose partners had utilised the maternity waiting home were interviewed during the study period from the 6th -28th July 2021. All the participants were males whose partners or wives have been admitted through the Opuwo

maternity waiting home before delivery. The participants speak Otjiherero as their mother tongues although they also understand other languages such as Oshiwambo and Otjizemba. Except for three, all could understand read and write English. Their ages ranges from 26-52 years old. Of these, seven were in the age range of 26-30 years; four in the 31 -37 years range, and another one was between 38-52 years of age. All the participants have attended the formal primary to secondary schools from grade 1-12 in the following order: One participant has ended up in grade 1-2; one went up to standard 7 (grade 9); two failed grade 10; four failed grade 12 and four completed grade 12. Out of twelve participants three are formally employed, five unemployed and four are informally employed with casual works related to taxi driving, mechanic repairs and security services.

The majority of the participants interviewed were staying with their partners and 6 participants solely supported their pregnant partners while the other 6 participants had the support from their families' members to meet the needs. The participants came from all the distance proximity to the maternity waiting home ranging from 0 kilometres to above 120 kilometres as follows three from each of the radius of 0-40km, 40-80km, 81-120km and 121 and above kilometres respectively. Out of 28 children of the male partners, 17 were born through the maternity waiting home as the other 11 were either born before the official opening of maternity waiting home in February 2018 or outside the study sample time frame which only covered the period from 1st June 2020 to 31st June 2021. Table 2 below, presents an outline of the sociodemographic characteristics of the participants.

Table 2: Socio-demographic characteristics of participants of the study

Male partner	Age In years	Education Level	Employment status	Number of children (born in	Distance to MWH (km)

				MWH in brackets)	
1	26	Failed Grade 12	Unemployed	3 (1)	0-40 km
2	**26**	Grade 2	Informal employed	2 (2)	0-40 km
3	**35**	Failed Grade 10	Informal employed	3 (2)	0-40 km
4	**29**	Completed Grade 12	Unemployed	1 (1)	81-120 km
5	**28**	Completed Grade 12	Unemployed	2 (1)	40-80 km
6	**26**	Completed Grade 12	Unemployed	1 (1)	40-80 km
7	**32**	Completed Grade 12	Informal employed	2 (1)	40-80 km
8	**30**	Completed Grade 12	Formal employed	1 (1)	81-120 km
9	**27**	Failed Grade 12	Unemployed	3 (3)	121 km and above
10	**52**	Grade 9	Formal employed	4 (1)	121 km and above
11	**32**	Grade 10	Informal employed	2 (2)	121 km and above
12	**37**	Completed Grade 12	Formal employed	4 (1)	81-120 km

4.3 Study Themes

These themes and sub-themes are further described as follows.

4.3.1. Male partners roles during pregnancy

Participants interviewed in this study had similar views about support they provide to their partners during pregnancy, labour and delivery. The male partner's major roles and responsibilities included financial and moral support, as well as making final decision on the use of MWHs. The majority of the participants echoed that the decision making process was done by sitting down with partners, weighing their option on the use of MWH and their accessibility of transport to the hospital in time of delivery.

4.3.1.1 Financial and moral support role

Participants interviewed in this study had different views about support they provide to their partners during pregnancies, labours and deliveries. The male partner's major roles and responsibilities included finding money for the things that were needed during and after labour including clothes for the mother and baby, and to ensure availability of enough food for the wife. Moreover, the male partners had to continue motivating their partners during difficult periods in the pregnancy.

> "Because I am not working I was looking for small casual job even if there is someone who wanted help his cattle to take care of them to get money to help my pregnant wife. I also play a role to support her with money, food and cosmetics - only those ones" *(*35 year old, father of 3).

"I have to make sure that resources that are needed by the pregnant woman are present especially food, cosmetics. May be she mighty hate some smell of some types of things, so I have to make sure that I have to take her for a shopping, and say no check for this one may be it is better? So, and I have to take her also to the hospital, stay there for all the times that she attend for her medications or may be her follow ups. Aahm also encourages her so that she can have that positive attitudes within herself about the pregnancy. And also, as a person who has good background also on HIV and AIDS I used to encourage her for to go for HIV test and counselling and so forth. Financially, the brothers they do support, may be some times if you have financial crises, and she need certain types of things, they can send us money and we buy things that we need and also her sisters and my family they also supported her psychologically like " no you do not have to worry about that, may be you are fine you are ok you must go to the hospital and so forth. So we got a lot support from them psychologically, financially even when she has to go home in my absence to my parents' home, she feel welcomed because they really love her." (37 year old, father of 4).

4.3.1.2 Decision making process

The decision-making process regarding utilisation of MWHs mainly involved the male, their partners, and also parents of the female partners are consulted on discussion towards preparations for delivery and whether the woman should utilise the maternity waiting home or not. The majority of the participants were involved in the final decisions on their partners utilizing the maternity waiting home.

"It was my decision. The reason why I took her to the maternity waiting home, as a person I heard from people that maternity waiting home is a good home for pregnant

women. And according to my experience, like a person who is educated I can say there is a reason why I took her there is for her to give birth in the hands of nurses. And again by that time I was thinking that through this process of pregnancy sometimes this person mighty get, might need much help of the nurses rather than giving birth at home whereby she will not get anyone who will help her." (26 year old, father of 3).

"It was me myself. Because here is no enough electricity, it is far from doctors and nurses. And there, there is enough water and electricity. And also the pregnant women used to be checked up even to be massaged /palpated. If she happened to get sick to go to the hospital I do not have a car. So, I decided that she need to go to the maternity waiting home to be near the doctors." (28 year old, father of 2).

"The decision actually came from me but we have to discuss because we are not married, so she stays with her parents, I have to talk to her, so that we can convince the parents, and actually we agreed. Lucky enough the parents also agreed. The problem could be that if the parents couldn't agree, she might give birth at home where there is no health workers, where it is far from the clinic and cars are also scarce to take her to the clinic or take her to the hospital, so for me I think it was not that good for the lady to give birth around those areas where there are no clinics or hospitals." (29 years old, father of 1).

4.3.1.3 Demonstrating care, love and affection during pregnancy

Participants interviewed in this study had different views about support they provided to their partners during pregnancy, labour and delivery. They reported that support they was geared at ensuring the physical wellbeing of both mother and the coming baby. These sentiments were supported by the following quotes:

"Ya, no, during her pregnancy I have been very close to her during her time of pregnancies. So far we have 2 kids together. Aahm but she used to, for the first kid I think she was ok but she used to be very tired, and need a lot of support that may be you need to go and fetch water, wash clothes , you do not need to do a little bit of work that required energy. So, and the second one she was a bit also not feeling ok because she had I think pain in the abdomen, may be the kid was too heavy. So, those are the little things I heard. Otherwise just you know symptoms of a pregnant woman you know sometimes is lazy and you know they need attention for you as a father to be around. Ya, so I used to expect that may be this time she might hate me, she does not want my presence but I have been very well with her and she was very good with me." (37 year old, father of 4).

"Ja, sometimes I was buying for her like some soft drinks and sometimes communicating and telling her stories just to comfort her in case she is not with me. Eehm, then we even did it together we went there and buying some clothes before for our kid. Here and there we were going together to the hospital for check-up which I think was supporting part from myself." (30 year old, father of 1).

4.3.2. Factors influencing decisions to utilize the maternity waiting home.

4.3.2.1 Culture practices and tradition beliefs

Culture and traditional practices are perceived as a factors affecting the utilization of the maternity waiting homes, but other factors, such as paternal age, ethnicity and education also contributes. The interview revealed that ethnic groups of Otjihimba and Ovahero, who were the majority participants, perceived the use of the maternity waiting home as something that came recently and was not practised before. The following quotes supports these sentiments:

"Tradition, seriously we have a lot of hypotheses within our tradition ja.. that may be when a woman is going to give birth she must give birth at home so that they can see who is what, it is a girl or a boy , because they have certain ceremonies that they need to do after a woman gave birth. And also in some other traditions they do not appreciate kids who are living with disability, so during birth they have to observe well whether that kid is healthy especially if he /she is disabled, they have to kill, and it happens. And if a kid an albino, they will say "naave" (you too), so they have to kill him. Because they don't want to appreciate these albinos I think, at home, so they have to kill him. So tradition also play a role of not letting people to not go and attend to those other services that need to be provided by the ministry of health and social services." (37 year old, father of 4).

"It is obvious since these men of Opuwo....Culture can prevent some to send their wives to maternity waiting home because this culture of ours like we Himbas and Hereros we are thinking that no since those years like they think of their forefathers that they never went there, and it like a new thing to them that can start nowadays." (26 year old, father of 3).

"Yes, culture play a role among men not to sending their wives to the maternity waiting home. As I said earlier that in our culture you see, like for example let me say this, they afraid that their children, their wives they are not going to follow the tradition way that they are not allowed to sit on higher things like chairs and while they are there they will use it, which means they are going to be cursed. They are afraid that if the wife is going

to do wrong there, you will receive a blind children or disabled children." (27 year old, father of 3).

4.3.2.2 Knowledge and information pertaining maternity waiting homes

Other participants disputed culture playing an influencing role and instead cited lack of knowledge among male partners about the benefits of maternity waiting home as a factor influencing decision to utilise maternity waiting home. Male partners are the final decision makers in the families, and if they are not invested with adequate proper information on maternal health services they turn to revert to the culture and traditional practices that are normally done. Most of the participants agreed that:

"Tradition in Otjihimba does not play a role amongst men not to sending their wives to the maternity waiting home, not really. It is only that they do not know that there is something like that/maternity waiting home." (26 year old, father of 1).

"Mostly I think, most of them do not any experience, and they do not know a lot about this maternity waiting home. So, that lack of skills and that lack of knowledge that also show experience explain a lot to them.- how does this work, how does this assist , how does this. I mean there, there is scarcity in knowledge. They do not know about it." (29 year old, father of 1).

"Probably some men are poor, some may be they do not have money, but mostly they don't know about the maternity waiting home. They don't hear about it, and they have not even been told about it. May be that's why they are not sending their wives or young pregnant women to the maternity waiting home." (28 year old, father of 2).

4.3.2.3 Distance and financial implication for transport.

Participants cited perceived long distances from their place of residence to Opuwo maternity waiting home, which required one to get transport money to reach the health facility. For one to make a decision to utilise the maternity waiting home, transport expenses are taken into consideration as some participants reside in remote areas where even transport accessibility is limited. These finding were supported by the following quotes:

> "And again the distance where they are living. Many people are living away from town. That's one reason some men they do not take their wives even if they know that there is a maternity waiting home in Opuwo. But the distance is very far. And again on top of the distance is the transport. From their houses to the maternity waiting home, to take their women, as I said previously, we footed from my home going to the maternity waiting home. And then for them to foot from their villages to come to the maternity waiting home, it is really hard because they cannot afford transport. Then they can just decide short way of giving birth at home or their women to give birth at home." (26 year old, father of 3).

> "I do not know exactly but one would think it depends from different men. Some of the men for example stay far at Oroutumba village, but when you are asking him that what is the good thing or challenges of the maternity waiting home at Opuwo, then some of them just campaign among themselves and say there people are paying high price about 80 Namibian dollars for transport, which is not like that/true." (26 year old, father of 2).

4.3.2.4 Covid 19 pandemic.

One of the emerging stumbling block on the utilization of maternity waiting home is the Covid 19 pandemic that had interrupted the whole universe. The majority of the participants highlighted that the pandemic make men hesitant to send their partners to the maternity waiting home as they feel their partners will contract the virus in the facility. This sentiments were supported by the following quotes:

> "And again let me say for now, the way we are talking about Corona, people they might think that no my wife cannot go to maternity waiting home because it might be full of people and when my wife go there she can give birth there, she can get nice service but she can get Corona. That's something under their mind set." (26 year old, father of 3).

> "In this time of Corona, it is difficult to take our wives there to the maternity waiting home because of Corona. Now, each and every person want to live the way he live he is afraid to get corona there. Like there a lot of people are coming different places. Some places are having Corona. Now it would be difficult to take their wives to the maternity waiting home. This time they are not taking. But some of them are taking their wife there." (28 year old, father of 2).

> "Corona, ya, some men they won't send their wives to the maternity waiting home because they can say when they are there they won't take care themselves when they are there. Because If I am following the rules of this disease like there must be a meter and other things - when they are there they used to put up just story and sometimes they eating together, sometimes she is not washing herself , ja a lot of things . You can think when we are together at home she is just home, there is no way to go she is pregnant.

Like now some of them they used to drink, bars used to close - they are just home. I think that one is also a problem." (32 years old, father of 2).

4.3.3. Experiences of maternity waiting home

Participants perceived many benefits from using MWHs. They believed that MWHs increased access to facility-based skilled birth assistance and mitigated long distances. Staying in the MWHs made it easy for pregnant women to walk to the clinic to see the nurse or midwife as soon as they knew they were in labour. However participated also cited their experiences they encountered during their partner stay in MWH.

4.3.3.1 Men perceptions on maternity waiting home

The majority of the participants cited that MWHs were important for the pregnant women who lived far from the health care facility, as it was extremely difficult for them to find transport during the night. They explained that while staying at the MWH, women had immediate access to health care and felt protected against labour complications, and this influenced their decision making. The following quotes from the participants supports these finding:

*"*As I have experienced, the good thing is that the person would be closer to the hospital, and the time for her to go meet the doctor or nurse is also short, and stay closer to hospital. And also she would be around the same shelter that she also discuss around how and she would also be with those you now people those ladies that's born first those that have been there . So, the person that has got a child experience on that. So, she will also get some experience, some opinions from the colleagues that staying inside there." (29 year old, father of 1).

"Honestly the good thing about that maternity waiting home is that it keeps our children (pregnant women) in a good way. It also can help mostly like our young

pregnant women just to be helped by doctors and nurses because they are now coming from nearby place (the maternity waiting home)." (28 year old, father of 2).

"I benefited a lot to take my wife there because we stayed far from the hospital, then you leave her here a far place, when she want to deliver you are far, I think that it is very very important and benefiting to take her at maternity waiting home because it is near the hospital. I appreciate a lot because she is a person who usually be tired when she is pregnant. Here at home she used to go look for woods and fetch water, but at maternity waiting home she was very resting." (26 year old, father of 2).

But study participants also reported a number of challenges.

The majority of the participants rarely visited the MWH and those who visited reported that while making efforts to see their partners they were confronted by some challenges which made them failing even to deliver their parcels and they were met with non-conducive environment to sit with their partners during visitation . These sentiments were seconded by the following quote:

"Oo, the thing is sometimes when I sometimes I used to transport from Oshakati because if I came late, there is a security guy there at the gate. Normally when you come there, you come up with something I want to give to my wife then when I talked to the security guy so that I can give something to her then they used to do like they do not want to give, or may they do not want to, they are not permitting them to come out at the gate or to come out at the gate talk to the wife. They security guards say that it is Kama dark just bring them tomorrow or something and they not allowed to come out or to move around. May they need to put something there , they need to put something like a program like may to make some changes like to permit if somebody is asking for somebody may they can allow them to come in or to allow them to come out so that

they can get their things. The moment I arrived in Opuwo then it is after may be work, or arrive may be seven or eight in the evening. When you come there at the gate, you are talking to the security guard, then you tell them no I need I need to give something to her then security just say no it is too dark , no just bring them tomorrow or something ." (32 year old, father of 2).

In addition since the majority of participants rarely visited their partners in MWH, they could only hear from partners what is really happening inside the MWH. The following sentiment enlightened men:

"Ya personally as a man I was not physically there most of the time. But hearing information from her, it is just that they got a lot of support from the colleagues, from the ministry since their people who are employed who are taking care of them - they are giving them a lot of information and also something good about the place is that it is next to the hospital" (37 year old, father of 4).

"And the bad part that we hear as men about the girls only the loosing of the girls' cosmetics when they are in the maternity waiting home. That's the only bad part." (26 year old, father of 3).

"So, in a bad side, so there are no cupboards, where she where most cases those ladies store their things like where to put food where to put their clothes you know, sometimes you would hear something have missing, and no one to kit . You would have no opinion who to ask, and who to blame. So, the only thing I think should be provided there I think we need cupboards and padlocks. So, ladies would put in the cupboards and lock, and when she is leaving she just take her things and leave everything there." (29 year old, father of 1).

Moreover men were left alone and those that stayed only with their partners had no one to do house chores for them, they missed companionship of their partners and they had to spend more money to take care of their partners in the MWH. The above notions was supported by the following quotes:

> "Aa, I have two options or feelings; first of all I love her and I am used to stay with her, it made me to feel bad for her to stay far from me because we used to stay together. Secondly, is what I used to loss because I was spending much when she was there at the maternity waiting home" (32 year old, father of 2).

> "When she is at the maternity waiting home, Now I am alone, then because we have to communicate either via the phone, texting and calling, then sometimes because she was the one cooking for me, now I have to do it myself., I have to sometimes doing the laundry alone and those are the only challenges /changes that came up that I came across and I experienced so far. That's was the only ones." (30 year old, father of 1).

> "The greatest challenges that I faced, I saw that, I used to spend more. Let me say this, I used to spend more. That was a challenge. Because you stay with someone who is pregnant. As I said first that with the first born she used to like sometimes I want meat I want what but by the time you sent her to the maternity waiting home, you can't spend more like the way you used to spend." (27 year old, father of 3).

4.3.4. Proposal for measures to improve utilization of the maternity waiting home

4.3.4.1 Information dissemination to both men and women on maternity waiting homes.

Participants indicated that education, awareness campaigns and radio talk shows are major aspects that can be used to disseminate the information to the communities about the benefits

of utilization of maternity waiting home. This will assist in particular to men who are decision makers at home to send their wives/ partners to maternity waiting home because they will be well equipped with necessary information. Knowledge and information about maternity waiting home in the communities will improve the utilization of the maternity waiting home as currently there are still some communities who are unware about the facility and its rendered services, in Opuwo. The findings were supported by the following quotes:

> **"**As I said I think health workers need to be send out and give this information about the maternity waiting home and explain a lot on the advantages that's there if the lady is there in the maternity waiting home and also sometimes you don't need to send all health workers because outside in some villages there are health assistants workers that assist there here and there. You should also give information on this people to organize a day to explain everything about this maternity waiting home and that will bring knowledge and people everyone at least most people in the region will know about the maternity waiting home." (29 year old, father of 1).

> **"**Let's speak in the radio, some people are staying very far in Otjinungua areas, we can fuel the car and travel there to have a meeting with the people there, it would be a good thing if it was not for this corona. If you are speaking from the radio, a lot of people will hear/listen you, to say please each and every person who got a pregnant women, you supposed to bring here at the maternity waiting home, where it is near the hospital to deliver. To be that far, when you are about to deliver, by the time the ambulance will arrive in Okaoko-Otavi or Otjinungua, it is too late, by then the woman is already dead. But if she was here, it would be easy to transport her to Windhoek or Oshakati." (28 years old father of 2).

“I do not know if we can make awareness where more people may be can be called at soccer field/stadium, so that many people will know about the maternity waiting home. Because I do not think many people know about that maternity waiting home. It is only those ones that had their girlfriends there already or before. So, if you can make awareness may be to call people at the soccer stadium, then you tell them about it or maybe you be you can put papers on the notice boards to notice the people in the community, and a lot of things like that.” (26 year old, father of 1).

4.3.4.2 Provision of transport to maternity waiting home

Due to residing in the remote areas with limited access to transport, the results from the interview revealed that transport provision to collect pregnant women to the maternity home would play a significant role in improving the utilisation of the facility as many have challenges when it comes to transport. The participants were quoted saying the following:

“Ja.., I think the hospital or the maternity waiting home- it must have a transport itself whereby people are going to visit, just my opinion. Let me say for people, those people are just like sick people. It is like an emergency situation. Sometimes a person if it is a maternity waiting home car, it can even access to people who live outside to go and pick them up. People might have the telephone number of that maternity waiting home. Please even there is some money that needs to be paid- people they can pay because they are suffering with that footing from their villages to the maternity waiting home, it is like even an obstacle for them to reach maternity waiting home, it is because of the transport. Then it (maternity waiting home) must have own car or its own transport to pick the people from out of the villages to the maternity waiting home.” (26 year old, father of 3).

"One thing to improve access of the pregnant women is to the maternity waiting home is just tell them that here at home/village is far, there is no transport to go to maternity waiting home. Once you are coming late there you will find the place is closed, but if you only tell them they would be able to say yes, then they be able to go there." (35 year old, father of 3).

4.4 Summary of the findings.

The majority of participants who were interviewed expressed gratitude of the initiation brought by the maternity waiting home as it has assisted to accommodate their partners from far areas to be able to have access to skilled health personnel during deliveries.

However, inadequate knowledge, cultural factors and financial and transport challenges especially from far and remote areas were found to have huge impact on the utilisation of Opuwo maternity waiting home. Despite the facility being officially opened in 2018, there are some community members who are unaware that such services are rendered, and that they have significant benefits to the pregnant women. Although men are not direct beneficiaries of safe motherhood services, their understanding, participation, involvement and support is crucial in order for women to access basic reproductive health services as they are decision makers in the families and households. Furthermore, the majority of participants are residing in the remote areas where there are limited access to transport and low socioeconomic status, which have negative implications on the utilisation of the Opuwo maternity waiting home.

Chapter Five: Discussion, Conclusions and Recommendations

5.1 Introduction

The aim of this study was to explore men's experiences and perception regarding the utilization of Maternity Waiting Home in Opuwo Namibia. The study consisted of men whose partners had utilized the MWH, with the majority of participants fairly educated and most of them being of younger generation, and who responded to the researcher phone call to sought appointment. The respondents were asked about their own perceptions as experiences, and as well as about their views of what other men might think about their role in pregnancy and childbirth and as well as their role towards the use of the MHW.

Overall, the researcher only used male partners whose wives had utilized the MWH and the findings show that these men had a positive attitude towards maternity waiting home, and perceived benefits from using this services included mitigating long distance and improving access to facility-based delivery services. However, several challenges including lack of financial resources and concerns about the accessibility of transport to the MWHs made it difficult to utilize the facility. These findings are discussed in detail below.

5.2 Demographic characteristic of the participants in the study

The study consisted of men whose partners had utilized the MWH, with the majority of participants fairly educated and most of them being of younger generation, and who responded to the researcher phone call to sought appointment. The respondents were asked about their own perceptions as experiences, and as well as about their views of what other men might think about their role in pregnancy and childbirth and as well as their role towards the use of the MWH.

5.3 Men involvement in maternal health care and their role towards the utilization of maternity waiting home

Men involvement during pregnancy and childbirth mainly consists of making the final decision on their partner's use of MWHs, providing money for food, transport and clothes for the mother and the baby. These findings are in line with a study from Zambia which reported that men played an important role in providing for their partners during pregnancy and childbirth, and in encouraging them to use health services. (Sialubanje *et al.*, 2015)

Additionally, the current study findings highlights that, although men often make the final decision whether or not the woman should utilize the MWHs, they do not make decisions unilaterally. Rather, the decision-making process involves the husband and wife sitting down together and even consult external individuals such friends and family members. Discussions for childbirth, taking into consideration several factors including potential risks of labor complications if the woman delivered at home, and benefits of using MWHs and giving birth at the maternity waiting home. This findings concur with a study findings in Zambia which reiterated that decision making is not done by men unilaterally but rather men and women discuss all the prone and cons of making use of MWH before coming with a final decision (Sialubanje, Massar, Elisa M Kirch, *et al.*, 2016).

In addition, the findings of the current study echoed limited involvement of men on maternal health is due to culture and traditional beliefs. The majority of respondent eluded that cultural practices and traditional beliefs might be contributing factors which deter other men not to partake on maternal health as in Ovahimba and Ovaherero culture child birth and rearing are considered feminine responsibilities. The findings are in accord with several studies which perceived culture and traditional beliefs as barriers in male involvement in maternal health and highlights patriarchal settings, that explicit differentiate gender roles which viewed maternal

health care as a female dominated environment and thus deemed inappropriate for men (Adongo *et al.*, 1997).

5.4 The male partner's experience and perceptions towards the utilization of maternity waiting home

The findings in the current study perceived that MWHs are an important means on improving access to skilled and facility-based delivery and to prevent complications during labor and delivery. The sentiments are in agreement with the study done in rural Zambia, where men believed that MWHs plays a significant role to increased access to facility based skilled birth assistance and mitigate long distances and transport costs to health facilities (Sialubanje, Massar, Elisa M. Kirch, *et al.*, 2016) .Staying in the MWHs made it easy for pregnant women to walk to the clinic to see the nurse or midwife as soon as they knew they were in labor. Moreover, nurses and midwives would easily identify women with high risk of labor complications and provide treatment in time. Those with complications would be referred to the district hospital for further management and care.

Also the current study revealed that most men appreciated the existence of the facility, as there is availability of electricity and portable water, which some families do not have access to in their remote villages. As a results of availability of those basic essential services most men encouraged their partners to utilize the facilities. This clearly indicates that state of the health care facility plays a key role. The sentiments are in line with a study in Zambia which cited that the state of the MWHs has greater implication on the use of the facilities as inadequate sleeping spaces and bedding, water and sanitary services, deterred women from utilizing MWH (Sialubanje *et al.*, 2015). The Zambia study further reiterates that poor conditions of the MWH led some husbands to forbid their wives from using facilities. This implies that if men perceived

unsuitable conditions within the maternity waiting home, there are high possibilities of their partners not utilizing the MWH on their next pregnancy.

However, despite perceived benefits by men toward utilization of maternity waiting, the study finds that knowledge deficiency among men has a negative impact on the utilization of MWH by their pregnant partners. This finding is supported by review conducted by Penn-Kekana et al. (2017), which eludes that problems of utilization by pregnant women are often due to lack of knowledge and acceptance of the MWH among communities. Unfortunately, with limited information to men who happen to be decision makers in the families, decisions are made blindly without essential relevant facts. Furthermore, the lack of understanding by men on urgency involved on seeking maternal health results in preventable maternal mortalities.

The study was conducted in the midst of the Covid 19 pandemic and the finding suggested that the pandemic might had negative implication towards the utilization of maternity waiting home due to fear of contracting the virus in congested facilities like in maternity waiting homes. The findings are in contrary in terms of the cause of non-use of the facility with study by Akseer *et al.*, (2020) which reiterates that pandemic situation often redirect both human and material resources to response efforts that lead to inadequate delivery of essential health services. As for Opuwo the limited utilization was perceived to be the fear rather than limited service delivery

MWHs were established to bridge the geographic gap in accessing obstetric care from remote areas. The current study findings revealed that pregnant women partners from remote mountains areas find it difficult to access maternity waiting home due to unavailability of transport as well as funds to pay for transport. These findings are in harmony with a study conducted by Penn-Kekana et al. (2017) which highlights that distance and direct and indirect

cost accessing maternal health facility acts as a barrier towards the utilisation of maternity waiting home.

5.5 Conclusion.

Men have a significant role in ensuring support in maternal health through the roles identified as experiences and perceptions resulted from this study. Therefore, recognizing the significance of men's roles will be an important step towards finding the long term solutions towards the underutilization maternal health care services. There is need of redirection and broadening of maternal health Information to men as limited information is available to them, as in the past years the focus was only on women. Men involvement in maternal health care, especially during pregnancy has positive outcome of labor. Robust education should be considered so as to increase men's knowledge and participation. From the perspective of this study, further research is recommended to quantify the level of knowledge among men on maternal health so as to identify the myth and misconception about maternal health by men. Our findings provide crucial evidence that considering the sooner integration of men in maternal health services the greater potential success of the utilization of MWH in Namibia.

5.6 Recommendations:

A number of strategies for the improvement of the utilization of maternal health care services are proposed based on the study findings as follows:

- Promoting the involvement of male partners and to address factors that contribute to non-participation of male partners in maternal health care services. The improvement of MWH utilization, would not be realized until key players like men are fully integrated to maternal health care service. Health promotion activities that involve men are very crucial to increasing awareness about the importance of MWHs in the health system, thus enabling men to recognize the benefits of maternity waiting home and it will enable men to take an active role in household decision-making based on known facts.

- Men involvement should be regarded as a key priority and messages should be developed to ensure that men are prepared holistically to understand and support their pregnant partners. This should ideally include information related to ANC, labor, delivery and the post-partum period and well as the psychosocial and financial needs of women.
- Community Health Workers should be used fully to strengthen community-based interventions that have proved successful in countries like Ethiopia, in order to ensure that rural based obstetric women receive the same attention as those in urban areas. Community leaders as the custodians of custom, should be sensitized to come up with deliberate actions which can help in addressing some social-cultural practices so that women can make use of maternal facilities.
- Also community health workers (CHWs) should be encouraged to conduct community outreach villages to disseminate messages about male involvement, and to collaborate with community leaders on how to approach the men.
- To avail mobile clinics and maternity waiting homes with integrated services, which include ANC and postnatal care, should be encouraged at all levels especially in hard to reach areas, to reduce the transport barriers endured by pregnant women in accessing maternal services.
- To avail transport to collect pregnant women in remote areas will be essential intervention measure that will improve the accessibility of the maternity waiting home in places like Opuwo where women face challenges of accessing transport to health facilities.

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Appendices

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Interview guide

Interviewer: Tomas Shapumba
Translator: …….
Date: ……..
Start Time: …… End Time: ….…….

Background information

1. Can you please tell us about yourself which includes the following?
   - Your age?
   - Your educational level?
   - How many children do you have?
   - Were they all delivered in a maternal waiting home?
   - What is your opinion about home delivery/deliveries?

2. Please tell me a little bit about your experiences of your wife being pregnant and giving birth:
   - How did she do in her pregnancy/pregnancies?
   - Who supported her?
   - What role did you play?
   - Who took the decision to send her to the Maternity Waiting Home?
   - How did you travel to the Maternity Waiting Home?

3. How did you hear about the Maternity Waiting Home?
4. What was good and bad about the Maternity Waiting Home? Would you allow your wife to go again for her next delivery?
5. What were the greatest challenges in sending your wife to the Maternity Waiting Homes?
6. What were the greatest benefits?
7. In your experience, why do some men not send their wives to Maternity Waiting Homes?
8. What could be done to improve quality of service in the Maternity Waiting Home?
9. What could be done to improve access?
10. What could we do to convince more men to send their wives to Maternity Waiting Homes when they are close to delivery?

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Otjiurike tjomapuriro
Omupure: Tomas Shapumba

Omutoroke……
Omayuva……
Oiri yokuuta…….Oiri yokupata……

Ondjivisiro yokongotue

Arikana koituraere ouhunga naove omuni ouhunga nambi mavikongorere mba?

- Ozombura zoye:
- Omahongero uoye?
- Una ovanatje vengapi?
- Avehe vakuaterua monganda yomaundjiro uombandukiro?
- Oumune uoye mautjavi ouhunga nombandukuro yoponganda?

2. Turaera katiti ondjiviro yoye ouhunga nomukaendu uoye tjari omutumba natjapanduka;

- Uapandukavi kuye omuni?
- Oune nguemupa oruvara poo okumuvatera?
- Ove otjikuae tjiuaungura?
- Oune nguaeta ondunge yokutja eye usokuyenda konganda yomaundjiro uombandukiro?
- Uayavi konganda yomaundjiro uombandukiro poo uaya puiye?

3. Onganda yomaundjiro uombandukiro ueizuva muiye poo omuune?
4. Otjikuae tjitjari otjiua notjivi ouhunga nonganda yomaundjiriro uombandukiro? Moyenene?
5. Omatokero yene omanene nguaenena okukara nao tjiuahinda omukaendu uoye konganda Yomaundjiro uombandukiro?
6. Omauua yene omanene ngeyapo?
7. Mouripura uoye omena raiye ovarumendu tjiva tjivehahindi ovakazendu vawo konganda Yomaundjiro uombandukiro?
8. Otjikuae tjimatjisa okutjitua okutunduuza ondengu yoviungura ponganda yomaundjiro uombandukiro?
9. Mapesa okutjituavi okuyerurura meero?
10. Otjikuae tjimatjisa okutjitua okuzuvisa ovarumendu kutja vehinde ovakazendu vauo konganda yomaundjiro uombandukiro omayuva uombandukiro tjiiyeri popezu poo tjiyavasa?

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INFORMATION SHEET

Project Title: The Experiences and Perceptions of Male Partners of the Utilization of Maternity Waiting Home in Opuwo District, Namibia

What is this study about?
This is a research project being conducted by Tomas Shapumba at the University of the Western Cape. I am inviting you to participate in this research project because you have had an experience of Maternity Waiting Homes of Opuwo since your partner / wife had used the facility. The purpose of the study is to find out about male partners' experiences and their thought on the roles they play as head of the family (decision-makers), providers for their partner's healthcare needs during pregnancy and childbirth on the usage of Maternity Waiting Homes. This information will assist to gain knowledge that might help on the interventions to improve acceptance, access and final the use of Maternity Waiting Homes by pregnant women.

What will I be asked to do if I agree to participate?
Once you agree to participate the researcher will inquire on the appropriate date, time and place that is suitable for you. After the date and place is communicated to the researcher, the researcher would come to a place of your choice. Before starting the interview the researcher will ask you if you are still willing to participate and there would not be any repercussions if you have decided not to participate. The interview will take about 40 minutes or less of your time and there would be a translator who will assist us to translate from English to Otjiherero so that you will understand better. The researcher would also request you to allow him to tape-record the interview as it will allow the interviewer to concentrate more on the interview rather writing notes. It will be also ok to deny permission for the researcher to record you during the interview and again there would not be any negative implications by so doing. Then you will be asked some questions about your views, opinions, perceptions and experiences regarding your experiences and perceptions on Maternity Waiting Homes in Opuwo District.

Would my participation in this study be kept confidential?
The researcher will protect your identity and the answers that you have given during the interview. The researcher will hide the identity of participants so that no one can link an interview with a participant. Numbers will be used instead of names on interview transcripts and when analysing data and reporting. The source of information will be kept private, unreal names or numbers will be used when referring to you or your words. I shall keep any other records of your participation locked in the safe at all times, and destroy them after the research project. If an article is written about this research project, your identity will be protected in the same way.

What are the risks of this research?
There are no negative outcomes involved in this study except for your valuable time. This is an opportunity for sharing experiences, so all comments will be welcomed without judgement.

The hiding of names is meant to minimise the linking of information with a particular participant. Assistance will be availed to you if you experienced any traumatizing experience or you need to talk to someone. You will be booked with social worker in Opuwo District Hospital.

What are the benefits of this research?

The research might result change in policy formulation in the government on how the Maternity Waiting Homes should be structured and utilized and this might benefit both the pregnant mothers and their partners.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You are free to choose to participate in this research study. You may refuse to participate or stop participation at any time without penalty. You may also withdraw any time from the discussion if you wish to do so. You may also refuse to answer some or all the questions if you don't feel comfortable with those questions.

What if I have questions?

This research is being conducted by Tomas Shapumba who is a Masters student at the School of Public Health at the University of the Western Cape. If you have any questions about the research study itself, please contact me on the following details:

Telephone: +264-65-272801 or +264-811428899
Fax: +264-65-273022
E-mail: tshapumba@yahoo.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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This research has been approved by the University of the Western Cape's Research Ethics Committee. (REFERENCE NUMBER: to be inserted on receipt thereof)

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ORUPA RUONDJIVISIRO

Epu: ondjiviro nourizuuve uovarumendu ouhanga nomaungurisiro uonganda yomaundjiro uombandukiro yovakazendu morukondua rua Puwo, Namibia.

Omerihongero nga ouhunga naiye?
Ongondoneneno ndji momerihongero nga yaungurua i Tomas Shapumba ponganda yomerihongero uokombanda ya University of Western Cape. Ami mekunanga kutya ukare norupa momerihongero nga mena rokutja ove una ondjiviro ouhunga nonganda yomaundjiro uombandukiro yovakazendu, mena rokutja, omukaendu uoye uaungurisa oruveze ndo.Ondando yomerihongero nga okukondja okutjiua ouhunga nouripura uovarumendu ouo otjoviuru vyomatundu kutja veungura iye kovakazendu vauo kouveruke uao ngunda omukazendu eri otjingundi nomuatje tjapandukua komaungurisiro uonganda yomaundjro uombandukiro yovakazendu.ondjivisiro ndji maiungurisiua okuyeta ondunge ndjimai yenene okuvatera okuyerura nokutunduuza okuyeta onganda ndji yomaundjiro nombadukiro yovakazendu kondondo osenina komaungurisiro uovakazendu ovatumba.

Otjikuae tjimesa okutjita indi tjimberi yandjere?
Ove tjiueri yandjere okukara norupa omurihonga mekuupura euyva, noiri noruveze mbiekupuire.
Tjazu nokukuraera eyuva, oirinoruveze .Omurihonge poo omukondonone meya koruveze mdumuazuvasana. Ngunda ehiyauta okupura omapuriro omukondonene mekupura kutja ngundee okuuri movanga okukara norupa nu kakuna ouvi mbumauya kove tjiuatja konakuvanga rukuauo okukara norupa.Omapuriro nga marire oure uozominute omirongo vine (40) poo kehiyanao nu mapekara omutoroke ngumeku vatere okutanaura okuza motji English okutuara motjiherere.Kutja uzuve naua. Omukondonone mekuningire kutja umuyandjere makambure ehungi renu momahina mena rokutja omupure matjimuvatere okuyandja ombango komapuriro pendje nokuyandja ombango kokutjanga. Nunoho marire naua tjiuatja omukondonone akambura ehungi roye momahina tjimapura omapuriro nu kakuna ouvi poo navi ndjimaiyapo tjiuatjiti nao.
Okuzambo mopurua omapuriro ouhunga noumune nourizuve nondjiviro yoye ouhunga nonganda yomaundjiro uombandukiro morukondua ruaPuwo.

Onguae omakarero uandje norupa tjoyesa okurira otjiundijkua?

Omukondonone matjevere kutja ove ohamunikua nainga omaziriro uoye nguuaziri tjiuari amopurua omapurio.Omukondonone mahoreke ovanarupa avehe kutja apehakara ngumakara nomahakaeneno kunauo. Ozonomora ondumaze ungurisiua pendje nomana kungamua tjitjaungurisiua momakondononero nga.

Otjipuikiro tjaindji ondjivisiro ndji matjitizirua peke kehi yomana ngeheri uouatjiri poo ozonomora mavi ungurisiua otja ena roye poo omambo .Ami metizire ngamua atjihe tjitja ungurisiua kovina vloye momakarero norupa motjipuikiro tjapeke povikando avihe nunoho kombunda yaindji ongondononeno poo yotjiungura avihe mavi imbirahiua.
Tjipatjangua ngamua otjaitonga ouhunga naindji ongondononeno ndji ena roye aruhe maritiziua otjotjiundikua momuano otjingeuo.

Ouzeu uaiye mburi Mongondononeno ndji?
Momerihongero nga kamuna ovina ovivi mbirimo pendje noruveze ndu moungurisa .Indu oruveze ruokuhanasana ozondjiviro okutja ongamua tjiunatjo matjiyakurua nokuhina oumune uare.Omahorekero uomana oukutjevera kutja ngamua athihe atji haenene. Atjihe atjihaenene okupita okuyenda kuarue poo.kungamua omunarupa.Ombatero moyenene okupeua tjipekeya kutja ngahino kona kurizuva naua momuinjo okuhakaena kuna omuuungure uondunino yotjiuana komahuhuminino.Ove moyenene okuhakaenisiua kuna omuungare uondunino yo Tijuana motjipangero tjorukondua ruaPuwo.

Mongondononero ndji muna ouua uaiye?
Ongondononero mapeya aiyeta ondanaukiro nomirari viomaungiriro viohoromrnde kutja onganda yomaundjiro uombandukiro maisa okukaravi nokuungurisiuavi, nu ihi matjiyeta ouua kovakazendu ovatumba nomapanga uawo motusuvero.

Mesa okukara muindji ongondononeno ndji poo mesa okuzako okukara norupa tjamua oruveze?
Omakarero uoye norupa mongondononeno nidi okouharupu uoye kove omuni. Ove uri kamuaha okukara norupa .Ove moyenene okupanda okuhina okukara norupa tjamua oiri nakuhina ndjo okupeua. One moyenene okurinanununa tjamua oruveze mehungi ndi tjimovanga nao. Ove moyenene okupanda okuzira omapuriro tjiva poo aehe indu omuinyo uoye tjiuhina okukuyandjera okuzira.

Mapetjituavi ami tjimbina omapuriro?
Ongondononero ndji yaungurua i Tomas Shapumba eye omuhongua ngurihonga ondondo o master posikore youveruke uotjiuana ponganda yomerihongero uokombanda po University ya Western Cape. Tjiuna omapuriro ouhunga naindji ongondononeno oini, hakaena kunaami kozonomora nda;
Ongoze: +264 -65-272801 poo + 264 -811428899
Ofax +264 -65- 273022
Email:tshapumba@yahoo.com
Tjuna epuriro ngamua ouhunga nomerihongero nga nousemba uoye otjomunarupa mui ndji ongondononeno poo tjimovavanga okurapota ngamua ouzeu mbuuamunu momerihonero nga poo ngatjama nomerihongero nga arikana hakaena kuna:
Pro Uta Lehmann
School of Public Health
otjiuru otjikaendisa tjoviungura po University ya Western Cape.Ondjatu yoposa *17 Bellville 7535
Prof Anthea Rhoda
Dean: Faculty of Community and Health Sciences
otjiuru otjikaendisa tjoviungura po University ya Western Cape.Ondjatu yoposa *17 Bellville 7535
E-mail: chs-deansoffice@uwc.ac.za

Ongondononeno ndji yaakurua ko University ya Western Cape, Ko komiti yongondononeno yongaro ombua yokuhupa.

Committee. (REFERENCE NUMBER: BM 21/02/06 to be inserted on receipt thereof)

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office

New Arts Building,C-Block, Top Floor, Room 28

University of the Western Cape,

Private Bag X17,

Bellville 7535

UNIVERSITY OF THE WESTERN CAPE
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South Africa Tel: +27 21-959 2809 Fax: 27 21-959 2872
E-mail: soph-comm@uwc.ac.za

CONSENT FORM

Title of Research Project: The Experiences and Perceptions of Male Partners of the Utilization of Maternity Waiting Home in Opuwo District, Namibia

The study has been described to me in a language that I fully understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.
The researcher has requested to record the interview with me. This will make it easier to accurately capture everything that is said during the discussion, and will facilitate transcription. The recordings will be identified using a numbers or codes, not my name. They will be stored on a computer which is password protected and on a memory stick which is kept in a safe box. Only the researcher will have access to them. The files will be kept for duration of the research period, after the research has been finalized the recording will be deleted. However, you can ask that the interview will not be recorded.
__ I agree to be audio recorded during my participation in this study.
___ I do not agree to be audio recorded during my participation in this study.
My signature below says that I am willing to participate in this research study.

Name……..Signed……/ Finger print……
Date…….at…….

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E-mail: soph-comm@uwc.ac.za

Epu rotjiungura tjongondononeno

Ozondjiviro nourizuve uovarumendu komaungurisiro uonganda yomaundjiro uombandukiro morukondua ruaPuwo, Namibia
Omerihongero nga mbahandjaurirua naua meraka ami ndimbuzuva nawa.Omapuriro uandje ouhunga nongondononeno ndji yazirua. Ami mbazuu omakarero uandje norupa marire ouhunga naiye nu ami mbaitevere okukara norupa kuami omuni. Ame mbazuu kutja omakarero uandje norupa kaena kutjiukisiua kungamua omundu.Ami metjiua kutja meyenene okurinanununa momerihongero nga tjamua oruveze nokuhina okuyandja epu nokahina okutira kutya ngahino makuya ouvi poo ombandjerero yotjina kaani.
Omukondonone uaningire okupura omapuriro kunaami. Ihi matjirire otjipupu okukambura ehungi arihe naua tjimatuhungire nu mahandjaura oviungura avihe.
Ngamua avihe mbiaungirisiua mavituua ovizemburukiro viozonomora kamana. Ovio omavitizirua mo Computer ndjina po ndjimaipatua no nomora oundikua nu ndjatjaverua nu oukarata oumemori mautizirua motjipuikiro tjapeke poo Otjikesa tjapeke .Omukondonone erike ongumayanene okuhita poo pkuyenda po. Oviungurisiua avihe mbiaungurisiua mongondononeno ndji tjiyaanda mavizemisiua Tjaue ove moyenene kutja omapuriro tjimapurua ayekamburua momahina.
Ami meitavere kutja eraka randje ngarikamburue mozomahina ngunda mbina orupa mongondononeno ndji.

Ami hina kuriyandjera kutja ehungi randje ngarikamburue ngunda mbiri momerihongero nga.
Ekutuana randje kehimba mariraisa kutja ami mberiyandjera okukara norupa mongondononeno yomerihongero nga.

Ena…….Ekutuana……..
Omayuva…….Oruveze……

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UNIVERSITY of the WESTERN CAPE

60 YEARS of hope, action & knowledge

14 April 2021

Mr T Shapumba
School of Public Health
Faculty of Community and Health Sciences

Ethics Reference Number: BM21/02/06

Project Title: The Experiences and Perceptions of Male Partners of the Utilization of Maternity Waiting Home in Opuwo District, Namibia

Approval Period: 13 April 2021 – 13 April 2024

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report annually by 30 November for the duration of the project.

Permission to conduct the study must be submitted to BMREC for record-keeping.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Director: Research Development
University of the Western Cape
Private Bag X 17
Bellville 7535
Republic of South Africa
Tel: +27 21 959 4111
Email: research-ethics@uwc.ac.za

NHREC Registration Number: BMREC-130416-050

REPUBLIC OF NAMIBIA

MINISTRY OF HEALTH AND SOCIAL SERVICES

Ministerial Building
Harvey Street
Private Bag 13198, Windhoek

OFFICE OF THE EXECUTIVE DIRECTOR

Tel: No: 061 -203 2507
Fax No: 061-222 558
Andreas.Shipanga@mhss.gov.na

Ref: 17/3/3/TS00001
Enquiries: Mr. A. Shipanga

Date: 04 June 2021

Mr. Thomas Shapumba
PO Box 3003
Opuwo

Dear Mr. Shapumba

Re: The experiences and perceptions of make partners of the utilization of martenity waiting home in Opuwo District, Namibia

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
   - 3.1 The data to be collected must only be used for academic purpose;
   - 3.2 No other data should be collected other than the data stated in the proposal;
   - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
   - 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
   - 3.5 Preliminary findings to be submitted upon completion of the study;
   - 3.6 Final report to be submitted upon completion of the study;
   - 3.7 Separate permission should be sought from the Ministry for the publication of the findings.
4. All the cost implications that will result from this study will be the responsibility of the applicant and **not** of the MoHSS.

Yours sincerely,

EXECUTIVE DIRECTOR
MINISTRY OF HEALTH AND SOCIAL SERVICES

.....

BEN NANGOMBE
EXECUTIVE DIRECTOR

All official correspondence must be addressed to the Executive Director.

My NAMIBIA MY COUNTRY. MY PRIDE

10/1/2044