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USING MATERNITY WAITING HOME TO PROMOTE EARLY INITIATION OF BREASTFEEDING WITH IN THE FIRST HOUR OF BIRTH IN NIMULE HOSPITAL, MAGWI COUNTY.

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Abstract.

Background.

Health staff have identified problems with breastfeeding children from 0-6 months especially practicing early initiation of breastfeeding within the first hour of birth in health facilities thus making the need for establishing a Maternity Waiting Home. The aim of this writing was to assess the use maternity waiting home to promote early initiation of breastfeeding within the first hour of birth in Nimule Hospital, Magwi County.

Results.

At least 78% of mothers of Magwi County breastfed their children within the first hour of birth which was a good practice while 22% of mothers breastfed their children after one hour of birth which was not a good practice. All pregnant women who delivered in the MWH had early initiated breastfeeding within the first hour of birth for 328 newborn babies standing at 100%; Maternal outcomes were good showing that 328 live births stood at 100% and no death stood at 0.0%; Immediate neonatal outcomes have shown 327 live births stands at 99.69% with 3 stillbirths stands at 0.91%; Neonatal outcomes have shown that 325 were discharged stands at 99.08%, 1 died stands at 0.30% and some 3 were referred stands at 0.91%.

Conclusion.

Outcomes among the MWH for users had contributed to the observed differences. However, many women with high-risk pregnancies did not use MWH for early initiation of breastfeeding indicating a probable gap in awareness of usefulness, or other inability to stay due to other responsibilities at home. Otherwise, the use of MWH could have improved the maternal outcomes in Magwi County especially for early initiation of breastfeeding within the first hour of birth.

Recommendation.

There is a need to educate mothers and providers on the benefits of the MWH which is the early initiation of breastfeeding with the first hour of birth during the routine ANC.

Keywords: *Maternity waiting homes, Early initiation of breastfeeding, Nimule Hospital, Magwi County.*
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Background.

Globally, only two out of five newborns are put to the breast within the first hour of life (WHO & UNICEF, 2018a) (Mukora Mutseyekwa et al., 2019), and the global recommendation by the WHO is that all infants should start breastfeeding within one hour of birth that is referred to as early initiation of breastfeeding within one hour of birth because breast-milk is the best option for neonates and young infants that provides immunological, psychological, social, economic and environmental benefits Patel et al, (2015). Early initiation of breastfeeding within the first hour of birth is the starting right, no matter where a newborn takes his or her first breath, the desire to give that baby the best start in life is universal thus early initiation is universal. The first hours and days after birth are one of the riskiest periods of a child's life but getting an early start to breastfeeding offers a powerful line of defense. That it is a predetermined factor for early initiation of breastfeeding and exclusive breastfeeding (Lyellu et al., 2020).

The early initiation of breastfeeding is putting newborns with breast milk within the first hour of life is so critical to newborn survival and to establishing breastfeeding over the long term once there is a delay after birth, the consequences can be life-threatening and the longer newborns are left waiting, the greater the risk (WHO & UNICEF, 2018b) and (Getnet et al., 2020). Therefore, the benefits of early initiation of breastfeeding within the first hour of birth have been well documented (USAID, 2020) and it is key to survival and beyond child needs breastfeeding is today the single most effective preventive intervention for improving the survival and health of children. Colostrum, the first milk,

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and breast milk contain a large number of protective factors that provide passive and active protection to a wide variety of known pathogens (WHO Secretariat, 2010) and (Seldu et al., 2020) hence, it justified the reason for the early initiation of breastfeeding within the first hour of birth to every child born alive on earth.

In 2010, South Sudan had an estimated of 50.5% (WHO & UNICEF, 2018e) early initiation of breastfeeding within the first hour of birth. Early initiation of breastfeeding rates can only improve significantly when there are institutional deliveries and that is possible in an organized institution with MWH with well staff trained to perform the practices for both prime gravida and para gravida mothers coupled with paramount sanitation.

Early initiation of breastfeeding within the first hour of life is not an easy feat, a mother cannot be expected to do it alone while they are tired, weak, or in pain right after delivery. They require adequate support and guidance on positioning and feeding their babies (WHO & UNICEF, 2018c) this is true for every new mother and the appropriate care of both newborn and mother in the moments after birth is critical to ensuring that breastfeeding not only begins but continues successful (WHO & UNICEF, 2018d) and for the successful beginning and continuing breastfeeding, it first required early initiation of breastfeeding.

Maternity Waiting Homes provide the best environment, best practices, and an avenue to provide adequate, full-time necessary support to these mothers to practice early initiation of breastfeeding within the first hour of birth. Without an organized MWH in place, there will be no collective efforts to press on to the practice of early initiation of breastfeeding within the first hour. This write-up assessed the use of maternity waiting homes to promote early initiation of breastfeeding within the first hour of birth in Nimule Hospital, Magwi County.

Project objectives.

To admit 500 pregnant mothers 14 days before the delivery date in the Maternity Waiting Home in preparation for clean and safe delivery and introduce early initiation of breastfeeding within the first hour of birth. At least transport 320 pregnant mothers from various geographical locations to the site of the Maternity Waiting Home to wait for their due time of delivery 4 weeks before the expected date of delivery for early initiation of breastfeeding within the first hour of birth in 12 months of the project period.

To conduct health education for 450 pregnant mothers who are admitted to Maternity Waiting Homes for early initiation of breastfeeding within the first hour of birth on key selected topics before they are delivered as an integral part of the program for behavior change as they go back to their various geographical locations.

To initiate 495 newborns for early initiation of breastfeeding within the first hour of birth by qualified health service providers according to the birth outcomes in the 12 months of the project with correct documentation and report.

To conduct 3 rounds of training for health workers in the Maternity Waiting Home for early initiation of breastfeeding within the first hour of birth for every live birth and correctly documented and reported in the 12 months of the project period.

To raise awareness and acceptance among family and community members, and integrate culturally appropriate practices into the provision of maternal newborn care at the MWH and health facilities to which they are linked.

Project scope.

Description.

The MWH program is not available in Magwi County for early initiation of breastfeeding within the first hour of birth but there are plenty of human resources for health, The MWH program was established to admit pregnant mothers from various geographical locations to one place so that they can be cared for before, during and after delivery to have clean, safe delivery by well-trained health staff ready to correctly practice early initiation of breastfeeding within the first hour of birth for every child delivered at the MWH.

Deliverables.

Most of the pregnant mothers who lived far from the health facility that prevents them from accessing the services at MWH were provided transports to and from, those who had zeal and on their own paid for their transport were reimbursed and there was a referral for some complications that require specialized health services to ensure that every that passed through MWH was initiated early initiation of breastfeeding within the first hour of birth.

Constraints.

The MWH project was accepted and fully funded by the donor for 12 months, as the needs increase, there will be some extension for the other 6 months but there are some constraints especially in transporting pregnant mothers during the rainy season, cultural norms, and unwillingness by the volunteers to travel to far geographical locations, workload on the few staff that are offering services in MWH for early initiation of breastfeeding.

Assumptions.

As staff for MWH for early initiation of breastfeeding, staff meeting will be organized, training for the staff, recruitment for new staff and shifting of the strategies.

Main activities at MWH.

Health education for the women in MWH on key selected topics like early initiation of breastfeeding, newborn care and other relevant practices during their stay, waiting for the

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delivery their newborns. It was done to keep them busy and boost their morale and make them feel less isolated.

Formation of craft groups so that women could make crafts that could be sold for profits. A craft groups was regarded as preventing social isolation, keeping MWH users occupied as they once more wait for the onset of their labors and offering them cool income while staying at a MWH.

Another proposed activity was operating a vegetable garden that could be maintained by MWH users who were physically able to perform certain tasks. The vegetable garden would provide women with an activity to take in as well as provide food for MWH users.

Some created activities at MWH includes: pregnant women's forums to discuss birth preparation, safe and free institutional child birth; mass mobilization events; awareness campaign on health education, HIV and tuberculosis prevention; counselling and screening for cervical and breast cancer prevention and counselling for income generating activities in women.

Transport provision to and from various geographical locations and transport refund for those pregnant mothers who have used their own money for transport to the site of the MWH purposely established for early initiation of breastfeeding for live birth.

Data Collection and Evaluation: Develop a standardized data collection system and train staff on proper methods of data collection. Implement regular evaluations by clients – i.e. upon discharge. Monthly statistics report by the health facility. Create a strategy for data analysis and feedback for continuous quality improvement.

Project Significance.

Maternity Waiting Home acts as a driving force and an avenue to better promote early initiation of breastfeeding as it provides shelter for pregnant women living in remote geographic areas before delivery and this is not a new concept (WHO, 1996). Maternity Waiting for Home dates back to the 1950s (Minkler DH, 1972 and Poovan P & Kwast BE et al, 1990) with examples of their use in multiple continents (Eckermann E and Deodato G, 2008, Ruiz MJ & Garcia SG et al, 2013 and Wilson JB & Tinkorang EK et al, 1997). In the 1960s Maternity Waiting Homes were introduced in developing countries (Satti H & Seung K et al, 2013), They provide skilled delivery, postnatal care referrals, counseling for maternal and newborn care, and early initiation of breastfeeding in the first hour of birth (Lori et al, 2013). Maternity Waiting Home plays a significant role in intervening in the first delays and the second delays including the early initiation of breastfeeding within the first hour of birth (van Lonkhujzen I & van Roosemalen J, 2012).

In 2015, there was a coordinated evaluation effort, the Maternity Waiting Homes Alliance for Zambia was formed between the government of Zambia, donors, implementing partners and university evaluators, and the Saving Mothers Giving Lives project to provide robust data for decision makers on the effectiveness of Maternity Waiting Home, an intervention for improving maternal and newborn health outcomes Lori JR & Kaiser J et al, (2018). but this time the major purpose of this project, the Maternity Waiting Home in Nimule Magwi County was to introduce the element of early initiation of breastfeeding within the first hour of birth into the three domains (i) infrastructure, equipment, and supplies, (ii) policies, management and finances and (iii) linkages and services as reached by consensus on a minimum core model for Maternity Waiting Home in rural Zambia (Lori JR & Boyd CJ et al, 2016, Scott NA & Henry et al, 2018 and Vian T & Scott N et al, 2017).

The assurance of utilizing the Maternity Waiting Home included the prevention of both maternal and neonatal morbidity and mortality while it also has the added benefit of reducing the number of problems, raising healthy generations, and significantly increasing and improving the community's overall health Bekalu G Kassa & Mulugeta D Worke et al, (2021) hence, it serves as a greater opportunity to educate the mothers and users early initiation of breastfeeding within the first hour of birth.

Project Approach.

The approaches to disclosing the decision, involved the decision-making process as a core step within and outside the one's expertise and preference of individual users with legally binding health workers to carry their duties to care for the pregnant mothers at the MWH for early initiation of breastfeeding because it had high medical significance along with some accountability options to disclose the decision.

The decision taken by MWH for early initiation of breastfeeding within the first hour of birth was responsible to individuals while respecting their preferences to represent similar practices in other countries. Importantly enough, multiple potential mediating processes were taken to allow disclosure to affect the outcomes for instance, gaining social support and changes in social information for the smooth running of MWH activities for early initiation of breastfeeding within the first hour of birth. This provided a conceptual framework to clarify the conditions under which disclosure will surely yield beneficial outcomes at MWH for early initiation of breastfeeding within one hour of birth and the types of outcomes were relevant to a given disclosure situation without contradicting the Feedback Loop for long-term outcomes of the disclosure of the decision to implement MWH for early initiation of breastfeeding within the first hour of birth.

The Feedback Loop of eight phases were implemented in sequence to effectively respond to client needs and in brief, the eight phases implemented were Information collection, Information consolidation, Analysis, Reporting, Decision making, Delegation, Communication and Implementation of MWH for early initiation of breastfeeding within the first hour of birth.

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By taking a holistic approach to MWH services for early initiation of breastfeeding within the first hour of birth, MWH had the potential to increase contact with the healthcare system and improve maternal and newborn outcomes.

Project implementation.

Promotion of early initiation of breastfeeding in Maternity Waiting Home were one of the components of a comprehensive approach to instilled behavior change for achieving healthy newborn babies through this project called MWH for early initiation of breastfeeding within the first hour of birth. The goal is to ensure that every pregnant mother brought to Nimule Hospital valued and appreciated the importance of Early Initiation of Breastfeeding within the first hour of birth and practically initiated the newborn baby within the first hour of birth for optimal growth.

Project design.

Promotion of early initiation of breastfeeding within the first hour of birth: The expected 90% of pregnant women in the catchment area to deliver at a health facility that is adequately staffed and resourced to provide high-quality care and referral to a higher level of emergency care – unit within the hospital. Before early initiation of breastfeeding within the first hour of birth, women in the catchment area who delivered at home are assisted by trained traditional birth attendants able to practice early initiation of breastfeeding within the first hour of birth. The traditional birth attendants address traditional beliefs and other cultural barriers that might prevent a woman from receiving care at the facility Satti H & Chetane P et al, (2012) and Nhindiri P & Nystrom L et al, (1996).

Maternity Waiting Home Admission Protocol:

The Maternity Waiting Home for this project is intended for all pregnant women living near and far from the health facility or face other geographical barriers like rivers during the rainy season (Partners In Health, 2013a)

Labor and Delivery Protocol:

Maternity Waiting Home is a part of a comprehensive care strategy for antenatal care, labor and delivery, and postpartum care. Other integral components of this strategy are the trained health professionals, referral and transport protocols to ensure that women benefit from this project of Maternity Waiting Home (Partners In Health, 2013b)

Project Tool.

The most important project tools adopted from MAA GRUHA, (no date) are outlined in the project tools, these are the tools included for the successful implementation of the Maternity Waiting Home; 1). Case card of the Maternity Waiting Home to collect the background information, admission details, and the signature of the Coordinator, 2). Counseling record for recording the date, subject matter, and the signature of the Coordinator, 3). The medical record to register the date, complaints, and the prescription and advice, 4). Discharge report to the beneficiary that contains the date of discharge, the total number of days stayed date of delivery, referred or shifted from or to, the outcome of the birth, the sex of the baby, and signature of the Coordinator, 5). Physical and financial progress report, showing the details of the reporting g period, of the project, name of the agency, contact details, and physical progress while other sections are beneficiaries, services offered, submitted amount, etc, 6). Admission register, 7). Monthly reporting format, 8). Case details for validation.

Implementation plan.

Ensure early initiation of breastfeeding within the first hour of birth and Birth Attendance: to better leverage an existing resource as the support of skilled attendance at the moment of birth helps mothers to deliver newborns safely and save lives through skilled birth attendants such as doctors, nurses or midwives to practice early initiation of breastfeeding within the first hour of birth.

To ensure that breastfeeding begins on time, right after birth, the child needs to be placed on the mother's chest within the first hour of birth and help initiate breastfeeding while the birth attendance continues to expel the placenta, early initiation of breastfeeding.

To measure the progress against the recommended practices: the indicators for the current project status are going to be used instead of retrospective assessment over a longer time period in order to reduce errors in accuracy and completeness, especially for practices that can vary on a day to day basis where evidence will be after asking all women who have given birth in the past two years that when did they put their babies to breasts.

To understand how mothers, make the decision of non-initiation and several barriers to breastfeeding initiation in South Sudan across the different cultural norms and myths considering the environment, if it is supportive enough for mothers, medical professionals, and families to non-initiation of breastfeeding within the first hour of birth. Understanding the factors related to previous breastfeeding experience and education for mothers was decisive when it comes to deciding to initiate breastfeeding within the first hour of birth given the proven influence that partners had in decision-making.

To conduct future research, paying much attention to identification of motherhood and to evaluate the level of adaptation to the maternal role and the risk factors for maladjustment to early initiation of breastfeeding within the first hour of birth.

Work plan/Rollout timelines for Maternity Waiting Home.

Activity in the work plan or rollout timeliness for the Maternity Waiting Home for early initiation of

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breastfeeding was Pre-program mostly construction of the Maternity Waiting Home that will run from the first month to the second month of the project, the start of the transitional housing that will run from third month to fourth month, the start of on-site Maternity Waiting Home scheduled to operate from fifth month through twelfth months, community mobilization was to run from the fourth month through the eighth month, community engagement was to run from the fourth month through 12 months, project monitoring and evaluation starts from the first month throughout 12 months and the project end report and handover process will start from eleventh month to twelfth month.

Budget.

During the budget preparation, priorities among the project were made to ensure that the budget fits the organization's policies and priorities. The most cost-effective variants were selected and finally, the means of increasing operational efficiency in the organization was sought to build financial constraints right from the very start of the project. The budget formulation process was considered under the four major dimensions 1). Setting up the targets and the level of expenditures that are compatible with the targets, 2). Formulated expenditures policy for tracking the expenditures, 3). Resources are allocated in conformity with both policies and fiscal targets as the main core process of budget preparation, and 4). Addressed operational efficiency and performance issues.

At least conditions for sound budget preparation were set such as the 1). Early decisions to tackle hard choices to permit smooth implementation of priority project activities and avoid disruption in the project management during execution; 2). considered hard constraints, it was done so to give line ministries a hard constraint from the beginning of the budget preparation to favor a shift from a needs mentality to an availability mentality – organized along the following line from a top-down approach: - defining aggregated resources available for public spending, establishing sectoral spending limits that fit the government priorities, and the spending limits were made known to line ministries, 3). Avoided some questionable budget practices – that widespread certain budgetary practices but inconsistent with sound budgeting, the most considered ones are incremental budgeting, open-ended process, excessive bargaining, and dual budgeting.

Budget Narrative.

The project for promoting early initiation of breastfeeding within the first hour of birth through a Maternity Waiting Home grant total for 12 months was USD 138,045.2 to operationalize the activities of the project of promotion of early initiation of breastfeeding through MWH.

A. Salary & Wages: Total cost – USD 54,818.

The Program Director who was the overseer of the program will spend 100% of his time hiring, supervising, and training staff. This individual's annual salary was USD 26,596.0 and had covered 12 months of the contract.

Program Coordinator had spent 100% of her time providing direct service to the participants, the described services. This individual's annual salary that covered 12 months of the contract totaled to USD 22,000.0.

The program Assistant was a part-time assistant who provided described services. This individual's annual salary was USD 10.0 per hour for 20 hours a week for 34 weeks of the contract year totaled to USD 6,222.0

B. Fringes: Total cost – USD 18,690.0

FICA will be paid for all salaries: USD 54,818.0 x .0756 = USD 4,194.0

Unemployment cost was USD 17,300.0 X 3 X .03 = USD 2,916.0

Retirement for full-time employees: USD 48,596.0 X .06 = 2,916.0

Health Insurance costs for full-time employees were the following:

Director: USD357 X 12 months = USD 4,284.0

Coordinator: USD365 X 12 months = USD 4,380.0.

C. Staff Development: Total cost – USD 13,600.0

The program staff–qualified professionals were trained quarterly at the facility level for CME and social work and administration for 3 quarters. 3 quarters x USD 2,800.0 = USD 8,400.0

Volunteers were trained for 4 times in 12 months. 4 trainings x USD 1,300.0 = USD 5,200.0

D. Travel: Total cost – USD 1,402.2

The staff were expected to travel around the Countywide to mobilize in the communities, conduct meetings, and meet with county partners and families. The agency reimbursement rate was 0.45 and not the government rate of 0.58.

Program Director 300 miles x 0.45 = USD 135. Daily subsistence USD 71.15 X 5 days = USD 375.75. Total USD 510.75.

Program Coordinator 200 mile x 0.45 = USD 90. Daily subsistence USD 71.15 X 5 days = USD 355.75. Total USD 445.75.

Program Assistant 200 miles x 0.45 = USD 90. Daily subsistence 71.15 x 5 days = USD 355.75. Total USD 445.75.

E. Equipment Purchases/Supplies: total USD 22,250.0

Three computers including a printer, scanner, and word program were purchased. One computer was based in the administrative office and was used to develop and maintain client databases in addition to performing administrative work connected to the program. Beds and mattresses were bought for the program and some utensils for cooking.

F. Transportation – Recipients. Total USD 10,600

Due to the lack of transportation services in the county, transportation was provided for families, pregnant mothers

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to the site of the Maternity Waiting Home for early initiation for breastfeeding within the first hour of birth.

Diesel: USD 500 a month x 12 months = USD 6,000.

Insurance: 0 Automobile Liability per year for USD 700

Repair and Maintenance: Routine Maintenance for Toyota Hardtop and Pickup – oil change, tires as needed USD 900.

Van rental for use of County Transportation Vans USD 250 a month x 12 months = USD 3,000.

G. Medical supplies and Expenses: Total USD 250

5 First Aid Kits were purchased in case of a medical emergency. 5 x USD 50 = USD 250.

H. Cost of Space – Non-Residential: Total USD 16,435

The monthly rent and utilities costs were necessary for the site location to provide services and activities. The cost was prorated at 85% for rent and Utilities hence the Department of Maternity Waiting Home Contract covers the other 15% of the cost.

Rent: USD 750 a month – prorated 85% of usage USD 637.5 x 12 months = USD 7,650.

Utilities: USD 500 a month – prorated 85% usage USD 425 X 12 months = 361.25.

Repair/Maintenance: USD 120 a month x 12 months = USD 1,440.

Sanitation Supplies: USD 350 a month x 12 months = USD 4,200.

Liability/Property Insurance: USD 3,275 per year prorated 85% = USD 2,783.75

Total: USD 138,045.2

Project Monitoring & Evaluation.

The monitoring and evaluation depend on six factors that influence a woman's decision and ability to access a Maternity Waiting Home 1). Distance and accessibility, 2). Transportation issues, 3). Financial costs, 4). Physical aspects of Maternity Waiting Home, 5). Cultural practices/restrictions and 6). Unfamiliarity about the existence of Maternity Waiting Home.

Routine monitoring and evaluation.

Several women stay at Maternity Waiting Homes and the absence of an ambulance that could provide transport for women from Maternity Waiting Homes to the nearest local hospital or higher health care center that can provide secondary health services.

Several women may require permission from their husbands to stay at a Maternity Waiting Home until the period of their stay in the facility for better birth outcomes.

Those women who lack the means of transport and prevented them from reaching to Maternity Waiting Home to use the available Maternity Waiting Home services. And those who are affected by geographical location.

Those women forgo staying in the Maternity Waiting Home during pregnancy for the reason that they cannot afford the costs of food and supplies they are required to bring with them for the duration of their stay.

Women who expressed concerns over a lack of supervised care while staying at a Maternity Waiting Home as well as poor sanitary conditions at the facility and the absence of meals provided to Maternity Waiting Home.

Frequent monitoring and evaluation.

Poor sanitary conditions of the Maternity Waiting Home worsened by the presence of pests like mosquitoes, ants, and fleas. Lack of privacy, staff behavior – rudeness of midwives towards the Maternity Waiting Home users, inconsistent care with some midwives who are not coming to facility to check on the welfare of women staying at the facility.

Provision of financial incentives to encourage the use of Maternity Waiting Home facilities. The instance the Maternity Waiting Home fee included the cost of hospital birth and was half of the fee typically charged to a woman who presented directly to the hospital in labor.

Women who face a travel time of greater than 60 minutes from their homes to the Maternity Waiting Home utilize Maternity Waiting Home.

Women who have found it difficult to stay away from home for 2-4 weeks (the average length of a Maternity Waiting Home stay) before their due date. And those who found it hard to rely on family or other community members to watch and care for their other children while they were away from home.

The number of facility based births and distance to the health facility are inversely related to the fact that women who are staying or lived within the proximity of hospital are most likely to stay at the adjacent Maternity Waiting home than women who lived further away.

Change management process.

The change management for this project was a proactive process in order to get the tangible success as judged retrospectively, the effectiveness of the change management has occurred in the organization through the developed change initiative with due implementation of the initiative, the organization have achieved the positive outcomes.

As adopted from Tuskegee University, the efficiency and effectiveness of the change management process for the project were successful due to several considerations like reasons for the change i.e. user requests, emergency, enhancements, service call/incident/problem fixing, procedures/training improvement were well planned; number of successful changes were recorded; number of failed changes were also recorded; number of changes backed-out together with the reasons e.g. incorrect assessment, bad build were recorded; number of incidents traced to the change and the reasons; number of implemented changes were reviewed, and the size of review backlogs; data from previous periods i.e. the last period, last

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year were recorded for comparison and number of changes were grouped into categories.

The change management process flow and the process procedure - change request was made, there was review and acceptance of the change, assessment for the technical and risk was done, the change was approved for build, the change was built and tested, the implementation impact schedule was confirmed and risk reviewed, the change for implementation was also approved, change was implemented and validated then lastly the change was closed officially and while in the review, the change management process was found to conform to what was published by Fruition, Yale University.

Models were used to bring about the changes intended to happen, the models used were the Transition models by William Bridges; the Change process model by Kubler-Ross; the Change Process model i.e. Indicators and Strategies by Kubler-Ross (Berkeley University of California, no date).

Management of the resistance.

Voluntary theories were one of the theories used but with much emphasis put on Agency theory as it acts as an agency relationship as a contract under which one or more persons – the principals to engage another person – the agent to perform some services on the behalf of the organization that involved delegating some decision making authority to the agent (Jensen and Meckling, 1976) because conflicts are expected to arise when there is incomplete and asymmetric information between principal and agent in the implementation of the project.

Political process theory was also one of the theories under Voluntary theories used by regulators to suggest that decision-making was based on the information disclosed by firms (Watts and Zimmerman, 1986) and to minimize political costs hence the political and competitive environment also influence the level of information disclosed (Mora and Rees, 1996). Disclosure was measured by self-constructed indices that were used commonly for such voluntary information or mandatory information that cut across environmental and social or forward-looking information (Beretta and Bozzolan, 2005).

Project limitation.

The expected obstacles and barriers to maternity waiting homes are social cultural issues, geographical background or location, and the fear of distance to travel to and those mothers with more than three children might not use the maternity waiting home early initiation of breastfeeding within the first hour of birth. Other obstacles and barriers are lack of family and community support, food insecurity, the cost of staying at maternity waiting homes, distance, and lack of knowledge about the maternity waiting home in addition to that are the lack of basic social and healthcare services, inadequate sleeping space, beddings, water and sanitary services and lack of visits to mothers by the family members.

The protocols to manage the maternity waiting home and admission and discharge criteria are not available elsewhere that means there is need that the Ministry of Health should prepare guidelines for the establishment and management of admission and discharge criteria and monitoring and quality control mechanism.

Lack of male partner involvement in the process of their wives to stay in the maternity waiting home, like there was scenario drawn from Abe, Maternity Waiting Home Auxiliary Nurse that men do not accept wives to leave their homes and mother-in-law also narrated that when they were pregnant during their times, they did not seek for help from the health facilities and another barrier were the economic factors linked to public transport systems and the cost of the stay in the Maternity Waiting Homes making it not sustainable and in addition to that the reluctance from the Nurses and Midwives, they don't refer pregnant mothers to the nearest health facilities with Maternity Waiting Home facilities.

Conclusion.

Element MWH for early initiation of breastfeeding within the first hour of birth is put into the three domains (i) infrastructure, equipment, and supplies, (ii) policies, management, and finances, and (iii) linkages, and services that have added benefit of reducing the number of problems, raising healthy generations, and significantly increasing and improving the community's overall health.

In one communication study, disclosure decision was used as a framework and tested model therefore, Maternity Waiting Homes have also been assessed as part of an integral package of strategies seeking to link families and health facilities) and it contributes a lot, especially in reducing the second delay of the three-delay model. The traditional birth attendants are to address traditional beliefs and other cultural barriers that might prevent a woman from receiving care at the Maternity Waiting Home designed for early initiation of breastfeeding.

Globally, out of 140 million live births in 2015, only 77 million newborns had to wait too long to be put to the breast that was representing only 45% of newborns - less than half of the newborns were put to the breast within the first hour of life.

The approaches to disclosing the decision involved the decision-making process as a core step within and outside the one's expertise and preference of individual users with legally binding health workers to carry their duties to care for the pregnant mothers because it had high medical significance along with some accountability options to disclose the decision. It was responsible to individuals while respecting their preferences representing similar practices in other countries. Importantly enough, multiple potential mediating processes were taken to allow disclosure to affect

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the outcomes like gaining social support and changes in social information.

This provided a conceptual framework to clarify the conditions under which disclosure will surely yield beneficial outcomes and the types of outcomes that will be relevant in a given disclosure situation without contradicting the Feedback Loop for long-term outcomes of the disclosure of the decision to construct Maternity Home. The Feedback Loop of eight phases are going to be implemented in sequence to effectively respond to client needs and in brief, the eight phases to be implemented are Information collection, Information consolidation, Analysis, Reporting, Decision making, Delegation, Communication, and Implementation.

The implementation plan for Maternity Waiting Home is to get the trends in the early initiation of breastfeeding, intensify efforts, and check if there is progress and what are other actions needed to ensure that every newborn benefits from this simple and effective practice. Feeding newborns in the first days of life: to remove the myth that newborns needed more than breast milk in the first day of life. This is linked to traditions, cultural norms, family practices, and health system policies and procedures where most of them are not grounded in evidence. For instance, in some traditions, colostrum is dangerous and the previous substance is discarded. Timing of initiation: to avoid delay in the first critical contact of the newborn with the mother. The evidence shows that the longer the delay in breastfeeding initiation, the greater the risk of death.

Importantly enough, we are seeking for opportunities for birth attendants to better support the early initiation of breastfeeding within the first hour of birth, measure the progress against the recommended practices, understand how mothers make decision of non-initiation and several barriers to breastfeeding initiation in Magwi County across the different cultural norms, and myths considering the environment, if it is really supportive enough for mothers, medical professionals and the families to non-initiation of breastfeeding within the first hour of birth and besides that, to understand the factors related with previous breastfeeding experience and education for mothers were decisive when it comes to making decision to initiate breastfeeding within the first hour of birth, given the proven influence that partners had in decision making and to conduct future research, paying much attention to identification of motherhood and to evaluate the level of adaptation to the maternal role and the risk factors for maladjustment to early initiation of breastfeeding within the first hour of birth.

The monitoring and evaluation of the project depend on the six factors that could easily influence the woman's decision and ability to access a Maternity Waiting Home Distance and accessibility, transportation issues, financial costs, physical aspects of Maternity Waiting Home, cultural practices/restrictions and unfamiliarity about the existence of Maternity Waiting Home and there will be routine and frequent monitoring and evaluation on different activities that were planned.

As adopted from Tuskegee University, the efficiency and effectiveness of the change management process for the project was successful due to several considerations like reasons for the change i.e. user requests, emergency, enhancements, service call/incident/problem fixing, procedures/training improvement were well planned; number of successful changes were recorded; number of failed changes were also recorded; number of changes backed-out together with the reasons e.g. incorrect assessment, bad build were recorded; number of incidents traced to the change and the reasons; number of implemented changes were reviewed, and the size of review backlogs; data from previous periods i.e. the last period, last year were recorded for comparison and number of changes were grouped in categories.

Theories like Voluntary theories, Agency theory, Political process theory, and Disclosure theory and Models were used to bring about the changes intended to happen, the models used were the Transition model by William Bridges; the Change process model by Kubler-Ross; Change Process model i.e. Indicators and Strategies by Kubler-Ross.

The change management process flow and the process procedure like change request was made, there was review and acceptance of the change, assessment for the technical and risk was done, the change was approved for build, the change was built and tested, the implementation impact schedule was confirmed and risk reviewed, the change for implementation was also approved, change was implemented and validated then lastly the change was closed officially and while in the review, the change management process was found to conform to what was published by Fruition Yale University.

Recommendations.

- Continue building the capacity of the Maternity Waiting Home staff for early initiation of breastfeeding within the first hour of birth that is as part of the health system in Nimule Hospital, Magwi County to ensure that there is space, inventory, and staff to meet the needs of women.
- Continue to build linkages between chiefs for communities and facilities to ensure programs are in place to enable women to reach Maternity Waiting Homes for early initiation of breastfeeding within the first hour of birth through affordable transport services and can pay for ancillary services upon arrival at Maternity Waiting Home.
- Increase linkages between Maternity Waiting Homes and labor wards to promote provider-client engagement and build trust in labor wards among clients.

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- Support providers to identify opportunities for improving client awareness of danger signs of postpartum hemorrhage after birth as well as providing other health education to clients.
- Attention to the functional health care systems and the community health service systems in orienting the advantage of Maternity Waiting Home at the preconception level are highly needed.

List of abbreviations.

ANC	Antenatal Clinic.
ART	Anti-Retrovirus Therapy.
IEC	Information, Education and Communication.
IRNA	Initial Rapid Needs Assessment.
MCH	Maternal Child Health.
MIYCN	Maternal, Infant and Young Child Nutrition.
MWH	Maternity Waiting Home.
OPD	Outpatient Department.
RMF	Real Medicine Foundation.
TB	Tuberculosis.
TV	Television.
UN	United Nations.
UNFPA	United Nations Population Fund.
UNICEF	United Nations Children's Fund.
USD	United States Dollar.
WHO	World Health Organization.

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Availability of data.
Data used in this study is available upon request from the corresponding author.

Authors contribution.
EK designed the study, reviewed the literature, cleaned and analyzed data, and drafted the manuscript, JFN supervised all stages of the study from conceptualization of the topic to manuscript writing and submission, and DK & EO supported in study conceptualization general supervision and mentorship.

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