

Postnatal Care Experiences and Barriers to Care Utilization for Home- and Facility-Delivered Newborns in Uganda and Zambia

Emma Sacks^{1,2} · Tsitsi B. Masvawure^{1,3} · Lynn M. Atuyambe⁴ · Stella Neema⁴ · Mubiana Macwan'gi⁵ · Joseph Simbaya⁵ · Margaret Kruk⁶

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Abstract *Objectives* The objective of this study was to examine experiences with, and barriers to, accessing postnatal care services, in the context of a maternal health initiative. *Methods* As part of a larger evaluation of an initiative to promote facility deliveries in 8 rural districts in Uganda and Zambia, 48 focus groups were held with recently-delivered women with previous home and facility deliveries (6 per district). Data on postnatal care experiences were translated, coded and analyzed using thematic content analysis techniques. Results were categorized into: positive postnatal care experiences, barriers to postnatal care utilization, and negative postnatal care experiences. *Results* Women who accessed care largely reported positive experiences, with Zambian women generally reporting more positive interactions than Ugandan women. The main reasons given for low postnatal care utilization were low awareness about the need, fear of mistreatment by clinic staff, cost and distance. In half of the focus groups, women described personal experience or knowledge of denial or threatened denial of postnatal care due to the birth location. Although outright denial of care was not common,

women frequently described various types of actual or presumed discrimination because of having a home birth. *Conclusions for Practice* While many women reported positive experiences with postnatal care utilization, cases of delay or denial of postnatal care exist. As programs incentivize facility deliveries, the lack of focus on postnatal support may place home-delivered newborns in “double jeopardy” due to poor quality intra-partum care and reduced access to postnatal care.

Keywords Newborn care · Neonatal care · Postnatal care · Maternal health · Disrespectful care · Health services · Qualitative methods · Unintended consequences · Uganda · Zambia

Significance

There are limited data on barriers to postnatal care utilization. Analyses of 48 focus groups of a maternal mortality initiative in Uganda and Zambia indicate that barriers to postnatal care utilization may include actual or threatened denial of care and fear of mistreatment for home-delivered newborns and their mothers. Cost, distance and lack of awareness of need continue to be challenges. Efforts to increase access and improve quality of care should include measures to address possible unintended consequences of interventions, especially those that exacerbate barriers to access for the most vulnerable.

Background

Although great improvements have been made in reducing under-5 mortality (Victora et al. 2015), over 2 million newborns die every year from preventable causes (Liu

✉ Emma Sacks
ers2113@columbia.edu

¹ Department of Epidemiology, Columbia University Medical Center, 722 W 168 Street, New York, NY 10032, USA

² USAID Maternal and Child Survival Program (MCSP)/ICF International, Washington, DC, USA

³ Department of Sociology and Anthropology, College of the Holy Cross, Worcester, MA, USA

⁴ Makerere School of Public Health, Kampala, Uganda

⁵ Institute for Social and Economic Research, University of Zambia, Lusaka, Zambia

⁶ Department of Global and Population Health, Harvard School of Public Health, Boston, MA, USA

et al. 2015). While over half of deaths are attributed to complications of preterm birth and birth asphyxia, which generally require skilled intra-partum care to prevent, almost one-third can be attributed to infection, which can occur after discharge in later days and weeks (Blencowe and Cousens 2013). The World Health Organization (WHO) recommends that every newborn receive a postnatal care visit within 24 h of birth, either in the facility where born, or as soon as possible after a home delivery, with two subsequent visits in the first month (WHO 2013). Additionally, while progress has been made in increasing the percentage of births attended by a skilled provider, from approximately 59 % in 1990 to 71 % in 2014 (UN 2015), postnatal care utilization continues to have the lowest coverage across the continuum of care (Victora et al. 2015). According to recent Demographic and Health Surveys, only 13 % of Ugandan newborns and 24 % of Zambian newborns receive a postnatal care visit within 7 days of birth; among home-delivered newborns, these percentages drop to 10 and 15 %, respectively (StatCom-piler 2015).

Many studies have identified factors affecting utilization of formal facilities for obstetric care (Bohren et al. 2014); fewer have examined factors contributing to non-use of postnatal care (Waiswa et al. 2008). A Ugandan study identified “cultural, financial and geographic barriers”, as well as poor quality of care at facilities (Kyomuhendo 2003). A study in Zambia identified both demand- and supply-side barriers, including the poor relationship between community members and health facility staff, but did not detail explicit discrimination (Mutale et al. 2013). In Nepal and India, postnatal care utilization has been correlated with facility delivery and access to skilled birth attendants, and inversely with low income, low levels of maternal education, maternal age and rural residence (Khanal et al. 2014; Singh et al. 2012). Although a number studies have shown a low awareness of the importance of postnatal care among rural African mothers (Nabukera et al. 2006), newer studies show a changing trend, such as in Ethiopia where 85 % of surveyed women were aware of postnatal care, but only 67 % accessed it (Tesfahun et al. 2014). Reasons given for low utilization included lack of time, long distance to provider, no available childcare and limited availability of health services (Tesfahun et al. 2014).

Increased attention has been given to the quality of obstetric care received by women in health care facilities, going beyond competent clinical care to improving the quality of the interaction between provider and patient, both in industrialized and developing countries (McConville 2014; Warren et al. 2013). In 2014, the WHO called for respectful maternity care and the elimination of abuse during childbirth (WHO 2014). While the statement

focuses on treatment of women and gives little mention to their newborns (Sacks and Kinney 2015), one could expect that a negative experience during antenatal or intra-partum care could also influence the likelihood of care-seeking for postnatal care. Research efforts are underway to document and quantify levels of abuse and disrespect of women during the intra-partum period (Warren et al. 2013), but preliminary results indicate that an experience of discrimination or abuse during childbirth will significantly reduce the chance of having a future facility delivery (Peca 2016).

An increase in access to skilled birth attendance is essential to the goal of reducing unsafe obstetric practices. Safer deliveries can occur in facilities that provide life-saving services and medications should the need arise. Yet, programs to promote institutional deliveries, through the illegalization of Traditional Birth Attendants (TBAs) or prohibition of home birth, may further stigmatize women who deliver at home. Over a decade ago, in Costa Rica, it was demonstrated that with increasing medicalization of childbirth, TBAs stopped providing services; some of their former patients were able to access facilities, but many were not and were then left without skilled or traditional attendants (Jenkins 2003). More recently, a project in Tanzania that promoted pay-for-performance gave health facilities financial bonuses for increasing the number of facility deliveries, allowing health workers to use a variety of strategies to achieve this goal. It was found that these strategies included scare tactics around the risk of contracting HIV, threats of fines, and withholding of a birth certificate or vaccination for the child (Chimhutu et al. 2014). The unintended adverse effects of maternal health programs, including the effects on non-program participants, is under researched and under evaluated. This study represents a preliminary effort to document the postnatal care experiences of women in Uganda and Zambia in districts with a maternal health initiative.

Methods

As part of a larger evaluation of an initiative to increase facility deliveries (“Saving Mothers, Giving Life”), which included an assessment of women’s perceived quality and satisfaction with care, data were collected on women’s motivations for, and experiences with seeking and accessing obstetric and neonatal health care. Data collection took place between November 2012 and July 2013 across four rural contiguous districts in Uganda—Kabarole, Kibaale, Kamwenge and Kyenjojo—and four rural non-contiguous districts in Zambia—Kalomo, Lundazi, Mansa, and Nyimba. Ongoing during data collection was an initiative aimed at increasing facility birth through both demand side incentives and quality of care improvements.

These initiatives included mobilization of community health educators, widespread media campaigns encouraging facility deliveries, sale of subsidized transport vouchers, increased pay for rural physicians, upgrading of facilities to provide surgical and transfusion care, and various training courses for clinicians.

A total of 48 focus groups were held whose participants were women who had delivered in the preceding year and lived within the eight project pilot districts. Women were recruited by community health workers and local leaders. Focus groups were held in private locations, lasted between 45 min and 1.5 h and facilitated by bilingual research assistants fluent in local languages: Bemba, Chitonga and Nyanja in Zambia; Runyoro/Rutooro and Runyunkole/Rukiga in Uganda. Trained facilitators used semi-structured guides, which were translated and back-translated for accuracy. Participants were provided with lunch and compensated for their travel time and expenses.

In focus groups, women were asked to describe their most recent delivery, the decision-making process for how they chose the birth location, where they planned to deliver their next child, care seeking experiences for both routine and emergency care and their opinions on the quality of care they received. Women were asked to describe any postnatal care visits they made and their assessment of the quality of postnatal care. Participants were probed about potential delays in seeking care and any consequences of those delays. Participants were also asked how women who have home deliveries are viewed in the communities and were probed for details about any stigma or different treatment due to delivery location.

For this study, data were extracted which covered factors influencing choice of delivery and postnatal care location and descriptions of experiences with obstetric and neonatal care. Focus group discussions were audio recorded, translated into English, coded in NVivo Version 10 (QSR, Australia) and analyzed using thematic content analysis (Creswell 2012). Participants were not asked directly about negative experiences; reports of denials and threatened denials of care emerged spontaneously and were probed. Results were categorized into: positive postnatal care experiences, barriers to postnatal care utilization, and negative postnatal care experiences, including reasons for lack of use of postnatal care. Findings are presented in order of commonality of responses within themes.

This study was reviewed and approved by the Columbia University Institutional Review Board, the Higher Degrees Research and Ethics Committee at the Makerere University School of Public Health College of Health Sciences in Uganda and the Uganda National Council of Science and Technology, and the ERES Converge Research Ethics Committee and the Ministry of Health in Zambia.

Findings

Participants were largely comparable across the two countries (Table 1), with Zambian participants being slightly older and slightly more likely to be married or cohabiting with a partner than Ugandan participants. On average, women had had one to two previous home births and one to two previous facility births. Findings were categorized by key theme: positive postnatal care experiences, barriers to postnatal care utilization, and negative postnatal care experiences.

Women's Positive Postnatal Care Experiences

Although the majority of participants reported not seeking postnatal care, many who did had positive experiences upon arrival. Women in most focus groups in Zambia reported positive experiences, while in Uganda negative experiences were more commonly reported. In both countries, focus group participants who sought postnatal care stated that they did so because community health workers and nurses had taught them the importance of doing so. Many women in Zambia stated that they were pleased with the manner in which the nurses attended to them and their newborns. They reported that they were "received well," examined for possible complications and that nurses' attitudes were generally positive and "welcoming."

When I went to the clinic we found the nurse who was very helpful and friendly. She injected my baby, gave me vitamin A and advised me to exclusively breastfeed my baby for the first 6 months. (Mansa, Zambia)

Table 1 Demographics of women in focus groups

	Uganda	Zambia	Total
Total number of groups	24	24	48
Number of groups (home birth)	12	12	24
Number of groups (facility birth)	12	12	24
Total number of participants	172	221	393
Age (mean)	25.3	27.0	26.3
Years in current village (mean)	9.8	14.4	12.4
Occupation as farmer (%)	83.8	77.8	80.4
Married/cohabiting with partner (%)	84.6	94.5	90.2
Parity (mean)	3.2	3.5	3.3
Total home deliveries (mean)	1.8	1.7	1.7
Total facility deliveries (mean)	1.4	1.6	1.5

Some women in Zambia who had experienced postnatal complications, such as excessive bleeding, also reported being treated well.

I was well looked after. I was laid on the bed in the labor ward and was given one injection to stop the bleeding. I also had my womb cleaned. (Mansa, Zambia)

I was helped at the clinic. I was checked. I was bruised but they stitched me and they also checked my baby too; it was fine. (Nyimba, Zambia)

Although positive experiences were less frequently reported in Uganda, some women reported being satisfied with their postnatal experiences after delivering at home.

While I was giving birth, the placenta could not come out safely, but when I went to the hospital, I was helped by a welcoming doctor who left all what he was doing to come and attend to me. (Kibaale, Uganda)

The care was good because they did not refuse, for as I explained to them, they diagnosed me and gave me tablets. (Kabarole, Uganda)

Women in both countries were also happy when their newborns were examined, treated for complications, immunized and given under five cards.

After my delivery, the baby's umbilical cord was not properly tied. The baby bled and was taken to health facility where I got the medicines that stopped the bleeding. (Kyenjojo, Uganda)

Reasons for Non-use of Postnatal Care

Participants gave a range of reasons for not accessing postnatal care after the delivery. The lack of importance was the primary reason given in all of the focus groups. However, fears about mistreatment at health facilities, along with barriers associated with distance and cost were also mentioned in almost all of the focus groups. While reasons given were similar in both countries, more women in the Zambian focus groups identified problems with cost and distance and more women in the Ugandan focus groups expressed fears about mistreatment and previous negative experiences with the health system.

Lack of Importance

Women in both Uganda and Zambia reported reluctance to seeking formal postnatal care if the new mother did not experience any symptoms of illness postpartum. Dizziness or excessive bleeding, which were considered serious, were the most commonly reported reasons for women to seek

postpartum care for themselves, while less serious conditions were often treated at home. They stated that any complications with the newborn warranted a visit to a health facility.

For us, when the mother is fine and child, you do not go... I took the baby when it became unwell after some days; the baby was given medicine to stop pneumonia. (Kyenjojo, Uganda)

My baby and I had no complications, so I saw no reason of going to the health facility. (Lundazi, Zambia)

Fear of Mistreatment by Clinic Staff

Many focus group participants reported that they did not seek postnatal care because they were afraid of mistreatment by health providers due to the fact they had delivered at home. This fear was most often based on previous negative experiences with health providers, although a minority of women held this perception because of stories or predictions from other women.

No we did not go to the hospital [for postnatal care] because if they notice that you delivered from the village ... she [the nurse] can easily beat you. So it is better I go to the old lady in the village because I know she will treat me well. (Kamwenge, Uganda)

Women reported fear of mistreatment from health care providers that included being made to wait, being yelled at or criticized and being physically abused.

Cost and Distance

Many women cited long distances to health facilities and lack of money for transportation or for an under-five card as their reasons for not seeking any postnatal care for themselves or their newborns.

My baby was born safely, but then the clinic is too far, that is why I sat back, because I didn't have money. (Lundazi, Zambia)

Although this was reported by participants in both countries, this reason was much more common in Zambia than in Uganda.

Women's Negative Postnatal Care Experiences

In approximately half of focus groups in each country, women described experiencing some form of direct denial of care, discouragement from seeking care, or fear of being turned away. We identified two large categories that

women had experienced: denial of postnatal care due to home delivery and threatened denial of postnatal care due to home delivery.

Denial of Postnatal Care Due to Home Delivery

Women in very few focus groups experienced outright denial of care due to having a home delivery. More focus group participants in Uganda reported outright denial of care than those in Zambia. Focus group participants in two districts in Uganda reported that they had been turned away because of the fact that they had delivered at home.

I had already bought a card which was supposed to give me access to services at the health centre. But during that time [after the birth], they told me that I would not be given anything because I did not deliver from there. (Kamwenge, Uganda)

The truth is if you deliver from home they [the health care staff] don't view you well... you deliver your baby but [after the birth], it will never get any help. (Kabarole, Uganda)

Some women in Uganda said that health workers told them that they would be a lower priority to receive medical attention or prescription medications because they had delivered at home.

Me, after delivering I spent 1 week when I had no problem; even the baby was suckling and sleeping well. After 3 days she got fever and she was really badly off. I said let me take her to the facility, maybe I would be helped. They told me the medicine is not there for me [because I had delivered at home]. (Kabarole, Uganda)

Me, they didn't [attend to me] because on Monday I took my baby up to Kazingo and nurses told us that 'those who delivered on the way, go home; when we get more drugs that is when you will come back and immunize.' And so I left without being checked. (Kabarole, Uganda)

Women described being directly turned away because there were insufficient resources and they were a lower priority to receive them because they had delivered at home rather than at a facility. Women were told that those who had delivered in the facilities would receive resources and medications first; thus, they perceived that they were receiving punishment for having delivered at home.

In Zambia, women who delivered at home reported that they were either refused under-five cards (a pediatric medical record chart), made to pay for them when they should have been free or were made to wait for a month before receiving them.

Nurses at the hospital refuse to give under-five cards and send us back home and tell us to come back when we have reasons for delivering at home. So we are punished for that and told we did it [delivered at home] willingly. (Nyimba, Zambia)

Women in focus groups in all four of the districts in Zambia reported being penalized for delivering at home and in two of the districts, women were discouraged from seeking care or sent away due to inability pay for pediatric health cards for their newborns.

I didn't go [for postnatal care] because I didn't have ZMW5¹ to pay for the card. (Lundazi, Zambia)

Threatened Denial of Postnatal Care Due to Home Delivery

In both Uganda and Zambia, women had heard rumors or information that they would not receive postnatal care because of delivering at home. This was widely reported across the focus groups. In Zambia, this translated more commonly to women stating that they would "comply" with the program directive to deliver in facilities for their next pregnancy.

"I will deliver at the hospital because when I went for under-five [clinic], the nurse almost refused to attend to me and I was told that it's not good to deliver from home because you can die or the baby can die if there is any complication upon delivering." (Nyimba, Zambia)

"They tell us to come back when we can explain ourselves to see if they are satisfied with the explanation [for having delivered at home]." (Nyimba, Zambia)

In both countries, women reported not seeking postnatal care because they feared the repercussions or they believed they would be turned away based on statements made by either providers or community members. In Zambia, some women reported not wanting to go for postnatal care for fear of being chastised for having a home birth.

My question is that we deliver from the village yet we are meant to deliver from health facilities. And the health workers do not give any care to us especially when it comes to immunization. Is it right and should it be taken that those who deliver from homes should not receive immunization from health facilities? They do not even care about us.

(Kamwenge, Uganda)

¹ Five Zambian Kwacha (ZMW) was approximately equal to USD 1 at the time of the study.

In Uganda, more women disagreed with this practice or were upset about their treatment. In Zambia, women more readily accepted the threat of postnatal care denial as a reason to deliver in facilities in the future.

Discussion

Our study finds a mix of positive and negative postnatal care experiences once accessed, but a myriad of challenges to accessing postnatal care. These barriers include cost and distance to access care, and lack of knowledge of the importance of postnatal care, but also fear of mistreatment by health care workers, fear of denial of postnatal care or actual denial or delay of care. Women perceived that their newborns were being denied care or given lower priority for care due to having been born at home. The category of “home born” newborns has not previously been identified as a possible group experiencing discrimination in accessing postnatal care.

Postnatal care utilization continues to be low globally, although it has been estimated that universal coverage and uptake of key interventions could avert over half of current neonatal deaths (Bhutta et al. 2014). Like their counterparts who deliver in facilities, women who deliver at home face barriers to postnatal care utilization including a lack of recognition of its importance, cost and distance. However, women who deliver at home may face an additional challenge of stigma and discrimination when attempting to access postnatal care at health facilities. Amidst reports of positive experiences, some women described the fear of mistreatment, including both verbal and physical abuse, as well as the threat of being turned away, as reasons for not seeking care. Women may be dissuaded from utilizing facilities based on experience, hearsay or unfounded fears developed during the antenatal or intra-partum period. Globally, utilization of antenatal care is consistently much higher than postnatal care utilization (Victora et al. 2015); it would be worth exploring messages that women receive about the need for postnatal care when they attend antenatal care. With the increased number of maternal health initiatives designed to encourage facility birth, there is limited understanding about the effect these have on mothers who continue to deliver at home, in terms of social stigma, opportunities for emergency intra-partum care, or their postnatal care utilization.

A related analysis in Zambia examined the reported frequency and perception of penalties for home delivery (Greenson et al. 2016), which showed some acceptance of the punishments for not delivering in facilities, be they financial penalties or denial of future health care (Chimhutu et al. 2014). However, not all women believed these penalties to be fair (Greenson et al. 2016). Further, financial

penalty or denial of services to families who already have difficulties reaching care will only serve to increase the health care access gap between the advantaged and not (Barros et al. 2012).

This study begins to address the category of “home delivered newborns” as a group that may experience discrimination in receiving postnatal care as their mothers are chastised or penalized for having had a home rather than facility delivery. Participants with home delivered newborns in both Uganda and Zambia reported experiencing threatened denial of postnatal care. If experienced during antenatal care, this could influence delivery locations, but the experience during intra-partum or postpartum care could impact their future delivery location choices. In both countries, women expressed a desire to avoid being chastised for having a home birth. It is possible that women are being in fact being castigated, but they may also be interpreting providers’ diagnostic efforts toward understanding the medical events around the birth as critique. This suggests that messaging to encourage facility births should be carefully phrased so that women who deliver at home still seek postnatal care.

Preliminary studies suggest that humiliation during intra-partum care is common, and women’s experiences include multiple types of disrespect and abuse (Abuya et al. 2015). A study in southeastern Nigeria found that 98 % of women in one teaching hospital had experienced at least one form of disrespectful or abusive care stemming from prejudices during childbirth (Okafor et al. 2015). A recently published framework on respectful maternity care categorizes types of disrespect and abuse into those actions widely deemed to be harmful, to those that are normalized, to care that is simply not accessible or available (Freedman and Kruk 2014). Definitions of respect and abuse can change over time and, as expectations, power dynamics and resource environments change, so too do constructions around ideas of respect and abuse (Irvine et al. 2002; Korbin 1991; Shwalb and Shwalb 2006). In May 2015, in a landmark ruling, the Ugandan courts awarded financial compensation to the family of a woman who died during childbirth as a result of “neglect of duty” by health workers at a health facility (France-Press 2015).

Building on this framework for addressing disrespect during childbirth (Freedman and Kruk 2014), it can be argued that respectful maternity care must not end at facility discharge, but extend beyond the intra-partum and immediate postpartum period. Programs to increase healthcare-seeking behavior should be careful to not inadvertently encourage or tacitly accept withholding of health care as punishment; women and families should be encouraged to seek care for newborns regardless of the location or situation of birth. This study found that, in districts with an ongoing maternal health program,

potentially disrespectful or negligent care was occurring, possibly as a result of the program's focus on increasing facility deliveries. Such unintended consequences of targeted health programs require further study.

The newborns that are being threatened or denied care are likely the same newborns that experience multiple and interactive forms of disadvantage due to geography, maternal education, ethnicity, rural residence and poverty (Wirth et al. 2006). These mothers and newborns face the compounded risk of having poor access to intra-partum care and then poor or no postnatal care, widening the equity gap in maternal and child health (Barros et al. 2012). Special attention should be paid to the most vulnerable. In Indonesia, infants of high birth order and those perceived to be small were found to be less likely to receive postnatal care, despite needing it most (Titaley et al. 2009) and in Zambia, HIV-exposed infants were found to have more obstacles to accessing postnatal care than their non-exposed counterparts (Sacks et al. 2016). Providing services across the continuum from antenatal through childcare requires recognition of abuse and neglect even in the form of absent or withheld postnatal care. In many situations, infants born at home are already at increased risk due to being without a skilled attendant immediately postpartum and different strategies may be needed to reach them in later days and weeks (WHO 2004). Programs should make concerted efforts to reach home-delivered newborns for postnatal care, rather than creating extra barriers for these newborns.

This study had limitations, as it relies on women's reports and could be complemented in future work with observational methods. Because this was not designed to be a prevalence study, it is not broadly generalizable. However, the fact that similar themes emerged in both countries studied indicates that these challenges and incidents are not isolated to a single region or country. Future studies on disrespect and abusive care of newborns should examine the prevalence, and should attempt to collect observational data beyond reported experiences.

Conclusions

Failure by the health system to provide care when sought should be considered a serious violation of the rights of women and their newborns. Programs seeking to increase facility deliveries should be careful to avoid or mitigate unintended consequences, especially for those individuals or communities who do not participate. Programs that do not anticipate the potential stigma or reduction of services to the most marginalized may be increasing their risk: those who are unable or unwilling to reach facilities may also be

denied postnatal care, putting their infants in "double jeopardy."

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