Barriers and facilitators to seeking postpartum depression care services among postpartum mothers in Jinja Hospital Uganda

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ABSTRACT

Introduction: Postpartum depression (PPD) is a major depression episode associated with childbirth and is common within 4-6 weeks after childbirth. Globally, postpartum depression affects approximately 900,000 women annually with only about 6% of women with PPD seeking psychological help. Despite the availability of PPD services in Jinja Regional Referral Hospital, uptake is still low. We explored the barriers and facilitators to accessing postpartum depression health care among those affected. **Methods:** A facility-based survey was conducted at Jinja Regional Referral Hospital using a qualitative approach. Three focus group discussions and 6 key informant interviews were conducted. All interviews were audiotaped, transcribed verbatim and analyzed using thematic analysis. **Results:** Key barriers to seeking formal care included stigma and lack of social support, low-income levels and availability of other healthcare options like the presence of herbalists. Perceived psychological distress, health education, linkage and psychological support to the mothers facilitated care seeking. **Conclusion:** Mothers failed to access PPD health care due to stigma, lack of transport and money for out-of-pocket expenses at the health facility and lack of support from their families and partners. However, a few mothers took up PPD health care with the help of psychosocial support.

KEYWORDS: Postpartum Depression, Barriers, facilitators, Health seeking, psychosocial support

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RECEIVED
20/10/2022

ACCEPTED
16/04/2024

PUBLISHED
19/04/2024

LINK

www.afenet-journal.net/content/article/7/20/full

CITATION
Dorothy Akongo et al . Barriers and facilitators to seeking postpartum depression care services among postpartum mothers in Jinja Hospital Uganda. J Interval Epidemiol Public Health. 2024 Apr 19; 7(2): 4
DOI:
https://www.doi.org/10.37432/jieph.2024.7.2.111

Introduction

Postpartum depression (PPD) is a major depression episode following childbirth and often coexists with anxiety that creates a disconnection between the mother and the newborn [1]. PPD is associated with poor social support from partners, early gestational age, unemployment, intimate partner violence, unplanned pregnancy history of maternal physical and/or mental illness and hormonal factors. It is also associated with baby factors such as low birth weight and lower engagement in positive behaviours especially during play and feeding time and destruction in interpersonal relationships due to major role transition and regular parenting demands [2,3]. There are a lot of physical and emotional demands on the mothers during the postpartum period, and dysfunction related to depression has a higher chance of interfering with the normal functioning of the mother and interaction with the infant [4] . Postpartum depression can begin as soon as childbirth, but few people can recognize it since it is considered normal to feel sad or exhausted during the first days of childbirth. PPD is normally recognized at four weeks, six weeks, three months or six months after childbirth but can last up to one year of giving birth [4,5] yet proper child development depends on the health and well-being of their parents [6-8]. . Literature indicates that motherhood increases depression and depressed parents increase the vulnerability of their infants including poor cognitive development, low self-esteem, aggressive behaviours, impaired social competence and lower problem-solving skills, poorer school performance and high rates of psychiatric disorders [9-12].

PPD prevalence in Uganda ranges from 6.1% to 43% both in rural and peri-urban studies among women between six to eight weeks, young mothers and HIV-positive mothers [4,13]. McGarry et al found out that 14.7% of Utah women reported having experienced post-partum depression symptoms (PPDS) in 2004 and 60% of these women who experienced PPDS did not seek help. Poor help-seeking behaviour is linked to young mothers, poor social support and low education [13]. In a study conducted among immigrant women in Toronto, Canada, fear of stigma and lack of validation of depressive symptoms by family and society hindered the women´s ability to seek care [14]. Postpartum depression treatment depends on its severity [15] . Mild to moderate PPD may improve with having enough rest, connecting with other new mothers, finding someone to talk to and accepting help from friends and family for short-term effects like baby blues [16]. However, for severe postpartum depression, psychosocial therapy, social support and antidepressant treatment are given and have been successful and proven effective in managing postpartum depression [16].

WHO guidelines indicate that mental health should be integrated into primary health care as well as maternal and childcare since mothers with no psychological distress have better thinking and caring for their children resulting in better conditions for the proper development of their children [17]. To achieve proper mental well-being of the mothers, the Ministry of Health Uganda has made efforts to provide PPD treatment in Uganda including training primary health care providers to identify and treat depression as well as sensitizing the Village health teams (VHTs) on identification, referral and follow up after discharge, the midwives have also been trained to recognize the depression symptoms. The training is aimed at providing primary-level care at levels where psychiatric clinical officers and psychiatrists cannot be accessed. Despite all these efforts by the government, uptake for PPD care services is still low due to discrimination and poor social support. The health providers also under-detect and under-treat PPD at the health facilities due to inadequate assessment tools, knowledge and poor social support [18].

The government of Uganda acknowledges mental health as a major problem in public health and has executed a few reforms aimed at reinforcing the country´s mental health services [19] . Uganda´s mental health draft policy is composed of desirable reforms that include and not limited to integrating and decentralizing mental health services including postpartum depression care services into primary health care for easy access [20] . Mothers who experience postpartum depression in Jinja Regional Referral Hospital are rarely screened except for those with visible symptoms and the mothers too fear to open up because of the stigma associated with PPD, yet routine screening and openness would help understand the prevalence of PPD. Besides the stigma, the PPD care services at Jinja Regional Referral Hospital are also affected by limited resources, low-trained staff and inadequate standard tools in postnatal and child clinics. Further, mothers who experience symptoms of PPD lack the confidentiality to seek care due to discrimination,

inadequate financial support and perceived stigma. Despite the availability of PPD services in hospitals, most mothers with postpartum depression still fail to access psychological help due to stigma and poor social support. However, the literature indicates that only 6% of the 900,000 women who experience psychological distress seek care [21]. Therefore, we explored the barriers and facilitators to seeking postpartum depression health care among mothers within six months postpartum attending the postnatal and young child clinic in Jinja Regional Referral Hospital. The information generated can help in designing interventions that are tailored towards providing services that give more women the opportunity to access the services.

Methods

Study design

We conducted a qualitative study using narrative inquiry through focus group discussions and key informant interviews to explore the barriers and facilitators to seeking postpartum depression care. Focus group discussions were used to gain a deeper understanding of postpartum depression and factors that limit mothers from accessing care including those factors that encourage them to seek care when they experience psychological distress. Key informant interviews were used to gain the insights of the experts who offer services to the mothers.

Study Setting

The study was carried out at Jinja Regional Referral Hospital, a government health facility which supports up to eight districts in East Central Uganda with basic, emergency, specialist and general care including, antenatal, maternity and postnatal services as well as psychiatric services. The hospital registers over 500 deliveries a month and a daily load of about 100 mothers in the postnatal and young child clinic. The antenatal care package includes among others routine screening for HIV, syphilis, nutritional status, pregnancy-related complications, health education on lifestyle and pregnancy as well as delivery. In every 377 postpartum women, 60 of them present with PPD. The postnatal clinic is managed by the nurses and runs from Monday to Friday. The psychiatrists are attached to the mental health unit and most of the mothers with PPD are missed since the nurses tend to focus on the children and have no standard tool for PPD screening during the visits. Even though PPD is part of the postnatal care package it is not routinely offered service except for mothers who present with severe symptoms.

Study population

The study was conducted among postnatal mothers within six months of delivery attending postnatal and young child clinics and health care providers working at Jinja Regional Referral Hospital.

For the FGDs we included those postnatal mothers who had given birth within six months because they were within the transition period between exclusive breastfeeding and mixed feeds. This is also the period for postnatal routine health facility visits according to the Ministry of Health Uganda guidelines so we expected them at the facility for follow-up.

For the KIs, we recruited healthcare providers who were working in the mental, postnatal and young child clinic including the clinical psychologist, psychiatric nurses, counsellor, and nurses. We included one counsellor, one clinical psychologist, two psychiatric nurses and two nurses. We excluded those who were busy at the time of data collection and did not consent to take part in the study.

Sampling

The postpartum mothers within six months of delivery were randomly recruited from the postnatal and young child clinics in the hospital. Three groups were conducted, each with six postpartum mothers. The group facilitator highlighted the study overview and the procedures of the FGD in the postnatal clinic triage. In collaboration with the triage nurse, mothers who were interested in the study were identified and grouped according to the age of their children and consent was sought based on their availability and willingness to participate in the study. The mothers' ages ranged from 18 to 49 years, both single mothers and married from both rural and urban settings. The age group of children included 0-1month, 2-3month the 4-6months. Six key informants were interviewed, and these included two nurses from the postnatal clinic, 1 counselor from young child clinic, 2 psychiatric nurses and 1 clinical psychologist from the mental health unit.

Data collection methods

We conducted the FGDs and KIIs during the month of August 2020. The FGDs and KIIs were conducted by two trained research assistants with a background in social sciences and psychiatric nursing. The FGD guides were translated into Lusoga, the language best understood by the mothers and interviews were audio recorded with consent. The first author supervised all the research assistants and the information collected and the discussion lasted between 42 to 58 minutes which encouraged the mothers to air out their views on the subject matter without fear while valuing their time at the facility. FGDs were used to get personal and group´s opinion and provided broader information. The question guide structuring for the barriers and facilitators to accessing postpartum care services were drawn from the health access framework where the demand side involved questions on population characteristics and the supply side involved questions that were based on health system factors.

Quality assurance and control

Research assistants fluent in both English and Lusoga with knowledge of qualitative research were recruited and trained by the principal investigator. These included two social scientists and two nurses. Training was done to help the research assistants understand and comprehend the main objective of the study, sampling procedure, data collection plan, data collection tools and the interview techniques like facility entry, asking questions, probing and audio recording.

Data analysis

During the FGDs and KIs notes were taken and all sessions were audio recorded. The recordings were transcribed verbatim by AKT, translated to English and then back translated to ensure validity. Both recordings and transcribed data were stored in a hard disk ready for analysis. The transcripts were read several times for better understanding by DA, KW and AKT. Text data were read to get better descriptions by highlighting emerging factors based on the understanding of the data by DT, DA and KW. The descriptions were grouped together into meaningful themes in categories of barriers and facilitators: barriers included stigmatization, income levels, health workers' attitudes, partner support, screening, health workers' knowledge and available health care options; facilitators included psychosocial support, perceived psychological distress and health education and linkage.

Ethical consideration

We sought ethical approval from Makerere University School of Public Health Higher Degrees, Research and Ethics committee and permission was obtained from the Jinja regional referral hospital administration. Additionally, we upheld the basic principles of ethics in conducting research and the participants were kept anonymous. We obtained written informed consent from the study participants, and it was made clear to the participants that they were under no obligation to participate in the study, and they were free to withdraw even after giving their consent.

Results

The study participants included mothers who were within six months postpartum. These mothers participated in the FGDs during their routine clinic visits. The KIs included health care providers who attend to the postnatal mothers in different departments. They included the psychiatric nurses, counselor, nurses and clinical psychologist who work closely with these mothers. The key themes that emerged from the barriers included the stigma from both the individuals and the community, poor social support from partner, family and friends, low screening in other entry points of the hospital, poor attitude of the health workers and work overload where health care providers spend less time with the mothers and are unable to screen for psychological distress in the postnatal visits. There were factors that encouraged mothers to seek for care which included their past experience with mental distress, psychosocial support and health education given during the postnatal visits.

Barriers to the uptake of PPD health care services

Stigma is common with mental health issues because most people believe it is a result of witchcraft. Most women who experience PPD are under looked and sometimes their children are taken away from them because they are believed to be incapable of taking

care of their children. Women raised several issues pointing towards stigmatization. They linked it to discrimination and fear of embarrassment. While some mothers choose to seek for care, others are limited by the stigma attached to mental health and they choose to suffer in silence because they want to take care of their own children.

"Yes, family members, instead of helping you, just talk about you with their friends-do you know, these days she is like that, she is like this she is like that. So they are discriminated." (FGD 001)

There are mothers that get help, but some of us are ashamed and scared so we just remain there suffering. I fear that people will say you am a bad mother…. I don´t want to wake up one day when my child has been taken because I can´t take care of them that´s why I keep quiet. (FGD 001)

They start talking about you in the entire village." (FGD 002)

Besides stigma, the reception of mothers at the health facilities is also deterrent. Health workers tend to treat mothers according to how they appear when presenting at the facility. Those who dress well are treated with more concern. The participants mentioned that most health workers do not attend to their needs more especially when they look poor in the appearance. They are ignored and neglected so it becomes difficult to share their psychological distress.

"We are neglected; even when you just call them to give you time, they pretend to be busy and working on others. They just ignore you. When the doctors perceive you to be very poor, they abandon you." (FGD 003)

The participants pointed out financial status as one of the barriers to seeking health care because when they visit the hospitals, most times they part with some money before they are attended to so those with low-income levels are barred from visiting the health facilities.

"Everything is for buying in the hospital, they discriminate you because there is nothing you have given them." (FGD 003)

"Not having money is a barrier to seeking healthcare because I know that when I reach hospital, they might ask for money and yet I don´t have any" (FGD 002)

Key informants indicated that most mothers lack of transport to the health facility is also a barrier. Being financially restrained, mothers fail to access the health facility and yet they need the services.

" … we take it that those mothers who have not come back for review have issues that stopped them and mostly it is lack of transport." (KI 003)

With low income in many families, most partners provide none or little support to their partners. The participants argued that their partners are generally supportive but when it comes to seeking care for psychological distress, they don´t support them because they fear embarrassment from their friends and community. The Covid-19 pandemic came with 'stay at home orders', and most women were locked up with violent partners which could have increased emotional distress and limited mothers from seeking care. The participants stressed that the limited movements during the pandemic increased violence because their partners used that chance to torture them. And the women who felt psychological distress could not seek for care because their partners thought they would report them and get embarrassed.

"Your husband can tell you you are going to embarrass him." (FGD 001)

"My husband is a serial cheater, he brings different women to our house and when I complain he beats me seriously, he refused me from visiting my people and he has one boda boda man (motorcycle taxi rider) who is allowed to ride me and he too reports if I try to tell him to take me to our home or any of my friends. It is not easy." (FGD 003)

Screening for PPD using a standard tool is an important procedure in knowing the number of women suffering from it. However, screening is only done at the mental health unit where the standard screening tool is available. Much as screening for postpartum depression is vital for all women, most mothers who screened positive for PPD during the study had not been screened and were not aware of their situation, except two who had received treatment from the mental unit. However, at the postnatal unit, a few mothers who present with significant symptoms are given counselling and they are linked to mental units for screening and treatment where necessary.

"We really don´t have a standard tool, but maybe check the HB of the mother." (KI from postnatal clinic)

"As a regional referral hospital, we always use our …. We have criteria the DSM5 criteria for depression, we have the clinical guidelines, and we always use the clinical guideline and DSM5 available at the mental unit" (KI from mental unit)

Most of the health workers at the postnatal and young child clinic are not well informed about postpartum depression and do not think its common except for the few who recognize the symptoms of PPD.

"Postpartum depression, is it common in postnatal hmmmm maybe they take long to regain and you can check the hemoglobin levels (HB) and take off blood sample" (KI postnatal clinic)

The health workers have limited time to spend with each mother considering the huge volume of patients they have to attend to, so they normally focus on physical health only.

"While we would love to handle every patient well, this is not feasible because of time constraints. Here we see very many mothers and when you think of giving each one enough time to talk, the numbers pile up and you may not be able to attend to all the patients and accomplish all the day´s tasks. Haaa women are many in this facility" . (KI from postnatal clinic)

Participants noted that most mothers don´t present to the health facility because they opt to seek care from the traditional healers and herbalists within their communities. Also, because there are no formal linkages between mothers who deliver from home and health facilities, most of them tend to visit health facilities only when psychological distress is significant. In addition, given the symptoms of postpartum depression, some people mistake it for something else and they choose inappropriate care.

… they first start with the natives such as herbalists before they come here (KI from young child clinic).

"Where these mothers deliver from affects their health-seeking behaviour. Because those who deliver from home and experience mental health distress symptoms, may believe that these symptoms are a nonbiomedical illness, they seek care from traditional healers or any other place of their choice" (KI from mental unit)

Facilitators for accessing postpartum care

However, participants indicated that psychosocial support at the postnatal clinic has greatly helped them. Counselling is normally done at the postnatal clinics to the women who seek for help. Women who receive routine psychological support have more reasons to access care because they have backup support. The FGD pointed out that women receive psychosocial support from their partners, families, friends and healthcare providers and this support gives them relief and encourages them to seek for more help when experiencing psychological distress. Most women get relieved when counseled. And the health care providers offer encouragement to the mothers facing psychological distress.

"They counsel you and what was worrying you seems to be lightened. Even when you had something in mind like taking the child to the father and leaving it there, you may change your mind and take care of it" (FGD 002).

"We encourage the mothers to confide in and seek support from their friends and relatives and if they were working, we also talk to their employers" (KI from mental unit)

Health workers give health education in the morning at the postnatal clinic and mothers who show some psychological distress are linked to care for further management. Mothers who present with symptoms of postpartum depression and are noticed by the healthcare workers are linked to the mental unit for screening and treatment where need be. The health care providers in postnatal and young child clinics talk to the mothers´ experiencing psychological distress and link them to the mental health unit for proper care. This facilitates the mothers to seek more care.

"When we talk to the mother and her attendant and then link her to the mental ward, there I think she is managed well, given drugs then sent back home" . (KI from postnatal unit)

Mothers who were experiencing psychological distress and were aware of its effects on them, child and family, normally seek for help in time. Postpartum mothers who experience changes in their moods and normal activities seek for

psychological help because of the changes and situation around them. When they get to know that what they are experiencing is affecting their routine activities like childcaring and other roles, they tend to seek for help.

"The situation I was in and the pain motivated me. I really didn't want to tell anyone, but the pain was too much in my heart and I couldn't help it anymore but pour my heart out to the nurse" . (FGD 001)

Discussion

We found that postpartum depression services were part of the postnatal care package but were not part of the routine postnatal care process. However, a few of the health workers assessed those with significant symptoms and linked them to the mental health unit for better screening, diagnosis and treatment.

Women reported that those with psychological challenges were normally discriminated against and called names that made them feel less like mothers. Most community members discriminated against them and were taken as outcasts. Women who experienced mental breakdown felt that they were bad mothers which led to both self and community or family neglect with little or no support. Postpartum depression is associated with stigma although a few studies on health access have been linked to it [22]. Also, the stigma attached to cultures where PPD is taken as a bad omen hinders women from seeking care [18]. Although family and community stigma play a role, self-stigma equally limits care seeking especially when sufferers do not understand the condition, have not been educated or counselled and the people who would have supported them are also not well informed.

A few of the healthcare providers indicated that some women did not seek PPD healthcare because of their income levels which hindered their transportation to the health facility. Most of the mothers were financially unstable and going for psychological help was a last resort because they lacked transport and other needs. Most mothers indicated that, inadequate finances lowered their chances of visiting the health facilities for psychological help. Most studies have similar findings that a woman´s financial status encourages or discourages her from seeking care [19,20] .

Negative health worker attitudes influenced the number of women accessing psychological help. Edge et al (2010) also reported similar results in their study indicating that how health workers treat the mothers in the health facility determines their care seeking behaviour [23]. Most women experiencing PPD do not open up to arrogant health workers; this is a missed opportunity for timely diagnosis and treatment thus low health care seeking.

Support from partners, family and friends played a great role in seeking psychological help. Women from less supportive families had less ability to seek care and this exposed them more to postpartum depression. Similar studies found that poor partner support lowered the chances of women with depressive symptoms from seeking care [23,24]. Women living with violent partners did not seek psychological help for fear of more violence. Intimate partner violence has been linked to mental disorders [25,26].

Regarding the routine screening process, most mothers were not screened for PPD except for a few with significant symptoms. Georgiopoulos et al (2001) indicated in their study that routine screening identified 35% of women diagnosed with PPD [27]. Screening increases the chances of identifying mothers with PPD. Studies have indicated that short-term PPD is associated with behaviour disorders in children and is linked to poor child development [28]. Regarding the standard tool, a few health workers recognized the availability of a screening tool at the mental health unit while the majority indicated that it was not available. This is in line with the study by Seehusen et al (2005) that indicated only 18% of the health care providers used validated screening tools designed for PPD screening [29]

The women who deliver from home find it hard to visit a health facility in case of psychological distress opting for traditional healers and other health care options within their communities. Women who delivered from the health facility found it easier to approach health workers in case of any psychological distress [27,30]. The presence of traditional healers hindered them from seeking care and they only visited the health facility when the symptoms were significant [31,32]. Most of the women who experienced PPD only visited the

health facility when the situation was alarming and were mostly referred or taken by family members.

Health education encourages women to understand themselves and the changes that come with motherhood. A few health workers indicated that they provided health education to women. Women who receive health education had better decision making when it comes to accessing care because of the health benefits. A few women indicated that they were aware of the depressive symptoms and would freely open up to friends and family. Studies have found that knowledge of PPD helps in accessing care among women[33-35].

In addition, social support is vital towards accessing health care for PPD. Mothers who received social support from their families and friends took up PPD health care without struggles or fear. We found that poor partner support limited mothers from accessing care because their partners feared embarrassment. This is in line with others studies that found inadequate social support as a limiting factor to accessing PPD health care [36,37] . Women who perceived themselves to have had psychological distress tended to seek health care. Women who accessed care knew the results of PPD on themselves, their children, and their families. We found that women who were aware of their psychological distress as being PPD, were able to uptake PPD health care services. Studies have found that postnatal distress leads to poor child cognitive development and mothers who are aware of this tend to access care promptly [38,39].

The majority of the studies focus on 4 to 6 weeks´ post-partum neglecting the transition period from exclusive to mixed feeding which is a critical period for mothers to adjust on the frequency or weaning off children from exclusive breastfeeding. We faced a few limitations; the response largely depended on the participants´ which may have been subject to social desirability bias because some of the study aspects were sensitive among postpartum mothers. However, confidentiality and privacy were ensured during data collection to facilitate openness. Our study design did not allow us to determine causality nor quantify the magnitude of the identified barriers and facilitators to seeking PPD care. We recommend a cohort study in future to mitigate this.

Conclusion

Key barriers to mothers accessing PPD health care were stigma, ignorance of PPD, lack of transport and money for out-of-pocket expenses at health facility, and availability of other healthcare options like the presence of herbalists. The barriers at facility level were inadequate PPD awareness among the health care providers, inadequate screening at facility level, poor health worker attitude and inadequate social support- these resulted in missed opportunities for proper diagnosis and timely treatment of PPD for sick mothers who contacted the health system. The factors that facilitated/encouraged women to seek care for PPD were mothers' perceived psychological distress and self-awareness of PPD and its management, psychosocial support, health education and referral to mental health clinic. Male involvement was critical to proper PPD management. Therefore, healthcare providers should work hand in hand with the women to bring their partners on board during both antenatal and postnatal care for proper mother and childcare education hence improving social support and reducing partner violence. The health education sessions should also cover income-generating activities for women to improve their income levels so that they are able to support transport and other needs to access PPD health care when needed.

What is known about this topic

- Postpartum depression affects women globally but is high in low- and middle-income countries yet it is under-detected and treated
- Postpartum depression affects the woman's ability to cope with routine activities thereby limiting her interaction with her child and thus poor cognitive development

What this study adds

- The knowledge base of postpartum depression on barriers and facilitators to inform policy on the best intervention to improve maternal and child health outcomes
- Knowledge of missed opportunities for proper and timely diagnosis and treatment of PPD mothers who contacted the health facility

- Male involvement as a critical support system in healthcare delivery

Competing interests

The authors declare no competing interests.

Authors' contributions

DA conceptualized the study, did the analysis and wrote the original draft of the manuscript in addition to reviewing the subsequent manuscript drafts. VG and PW reviewed and edited drafts of the manuscript. AKT and KW did analysis, reviewed and edited drafts of the manuscript. DT, conceptualized and reviewed drafts of the manuscript. ANK reviewed manuscript drafts. JN reviewed the initial reports and provided technical guidance during the conceptualization of the study.

Acknowledgments

We would like to appreciate the hospital administration for the clearance and are grateful to the study participants who accorded us their time. We would like to acknowledge AFENET for the support given during the manuscript writing workshops.

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