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ORIGINAL RESEARCH – QUANTITATIVE

Postnatal and neonatal care after home birth: A community-based study in Nepal

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ABSTRACT

Background: In Nepal, the majority of women who give birth at home do not visit a health facility for postnatal and neonatal care.
Objectives: This study investigated postnatal and neonatal care practices of women who give birth at home in a central hills district of Nepal.
Design: This study is a part of community-based prospective study in the Kaski district of Nepal. Postnatal and neonatal care practices were collected via structured questionnaires.
Setting: Kaski district of Nepal.
Participants: 92 postpartum women who gave birth at home.
Outcome measures: Postnatal care at a health facility and neonatal care practices.
Findings: Approximately 90% (83/92) of women who gave birth at home were assisted by non-skilled birth attendants, and 67% (62/92) received no postnatal care at a health facility within a week post delivery. The main reason for not having postnatal care at a health facility was 'no perceived need' (52/62, 83.9%). With regard to neonatal care practices, 67% (62/92) used a delivery kit, 79% (73/92) washed their hands before handling their babies, 70% (64/92) bathed their babies on the second day of birth, while all dried and wrapped their babies with a cloth within half an hour of the birth. However, only 46% (42/92) reported skin-to-skin contact within one hour after birth.
Conclusions: The results suggest that there is great scope to strengthen community-based postnatal and neonatal care to screen for and identify postnatal and neonatal problems, especially at home birth.
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Summary of Relevance:

Problem

- Postnatal and neonatal care practices of women who give birth at home are not known in low and middle income countries.

What is Already Known

- The majority of women who give birth at home are assisted by non-skilled birth attendants, do not have postnatal care at a health facility and resort to traditional neonatal care practices.

What this Paper Adds

- This study confirms that the majority of women who give birth at home in the Kaski district of Nepal do not have any postnatal care at a health facility within a week after birth mainly because of 'no perceived need.'
- The WHO and country guidelines are not clear about the location of the three postnatal contacts within two weeks of home birth. Making three contacts in a health facility within two weeks after home birth without any issues or concerns about health of mothers or babies is unrealistic in Nepal.
- There has been improvement in neonatal care practices in Nepal compared to previous studies.

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1. Introduction

Neonatal deaths constitute approximately two-thirds of infant deaths in low- and middle-income countries. Three-quarters of all neonatal deaths occur in the first week of life and almost half of all neonatal deaths occur at home.[1] In addition globally, 60% of all maternal deaths occur during or soon after birth.[2] About 65% of the births in Nepal occur at home[3] with the majority of mothers forgoing postnatal and neonatal care until they perceive severe health problems.[4] Postpartum haemorrhage is one of the main causes of maternal mortality in Nepal.[5] In Nepal, while the maternal mortality ratio and infant mortality rate have reduced since 1996, the neonatal mortality has remained largely unchanged.[6] The maternal mortality ratio decreased by 57% from 539 per 100,000 live births in 1996 to 229 per 100,000 live births in 2011. The infant mortality rate decreased by 41% from 79 per 1000 live births to 46 per 1000 live births between 1996 and 2011.[7] Increasing access to birthing services at health facilities, as well as women's awareness, family planning and safe abortion might have played a significant role in decreasing the maternal and infant deaths, but does not explain the unchanged neonatal mortality rate.[8] However, Nepal's current maternal and infant mortality is still high compared to the average 16 per 100,000 live births in developed countries.[9]

Neonatal deaths, defined as deaths occurring during the first 28 days of life, decreased by only 34%, from 50 to 33 per 1000 live births between 1996 and 2006, with no further gains recorded in the National Demographic Health Survey of 2011. The stagnant progress since 2006 might be due to inadequate coverage of community-based neonatal programmes, especially for hard-to-reach populations.[10] Inequality in reduction of neonatal mortality exists across different socio-economic, ethnic and geographical population groups in Nepal.[10] Many of these maternal and neonatal deaths are preventable through access to professional care during and after birth to the mothers and appropriate care to the newborns.[11]

The direct causes of neonatal mortality worldwide are infections, birth asphyxia, complications of prematurity, and congenital anomalies. The harmful neonatal care practices related to the feeding, hygiene/cord care, thermal control and bathing/skin care can cause infections.[12,13] Use of prelacteal feeds, discarding of colostrum, the use of unsterilised equipment for cord cutting, and bathing immediately after birth are associated with negative health outcomes for the newborns. To address the causes of neonatal mortality, Nepal piloted a Community-Based Neonatal Care Package (CB-NCP) in ten districts in mid-2009, with a plan to cover whole country by 2015.[14] The CB-NCP programme consists of seven components that focus on healthy home behaviours for postnatal and newborn care, and are delivered through female community health volunteers and other community-based health workers including maternal and child health workers and village health workers.[6] In particular, the CB-NCP programme focuses on identification of neonatal problems (e.g. infections, low birthweight, asphyxia and hypothermia) by providing postnatal home visits on days 1, 3, and 7 after birth.[14] Similar community-based interventions in other settings have been shown to be beneficial in improving neonatal care practices to reduce neonatal mortality.[15]

Neonatal care practices and immediate postnatal care within 24 h of birth for women who give birth at home needs to be considered separately to women who give birth in health facilities who receive professional onsite help for neonatal and postnatal care. This study, part of a larger cohort study, investigated the postnatal care and neonatal care practices of women who gave birth at home. Neonatal and postnatal care practices following home births can play a significant role in the reduction of maternal and neonatal mortality and morbidity, as well as being able to guide community-based neonatal and maternal care interventions.

2. Materials and methods

2.1. Study design and participants

Data for this study was drawn from a cohort study conducted in the Kaski district of Nepal between December, 2011 and October, 2012. The study was approved by the Human Research Ethics Committee of Curtin University, Perth, Western Australia (approval number HR 130/2011) and the Ethical Review Board of the Nepal Health Research Council (approval number 88/2011). Characteristics of the study district, study design and sampling of the study participants have been described elsewhere.[16,17]

In brief, the Kaski district is relatively developed, ranking among the top 5 in human development index of the 75 districts in Nepal. Women's literacy is 75%.[18] The majority of houses in urban areas are made of brick and cement while those in rural areas are made of mud and stone. The majority of rural houses use firewood as cooking fuel while those in urban areas use gas. The majority of women (81%) give birth in health facilities.[19] At the time of data collection, CB-NCP had not been implemented in this district; however, a birth preparedness programme had been implemented. Though birth preparedness programmes in Nepal focus on promoting antenatal check-up and institutional birth, they also incorporate counselling about neonatal care practices and the need for postnatal care.[16] The cohort study recruited a representative sample of 701 women with a gestational age of 5 months or more. These women were followed-up until six months after delivery. The present study is limited to the subgroup of 97 women who gave birth at home.

2.2. Data collection and analysis

Fifteen female enumerators conducted the baseline interview at recruitment to seek information on socio-demographic and household characteristics of the participants. These variables are shown in Table 1. Participants' education was divided into 4 categories based on schooling: no education, primary (up to 5th grade), secondary (6th to 10th grade) and higher secondary and above (above 10th grade). Ethnicity was classified as lower caste, janajati, upper caste, and religious minorities, following the government's classification of caste on the health system. 'Upper caste' and 'lower caste' correspond to Indo-Aryan people whereas 'janajati' refers to indigenous Tibeto-Burman people. Household wealth was generated from the first component of a principal component analysis using household assets of the initial cohort. The household assets included cooking fuel, flooring material, television, mobile phone, sofa, cupboard, type of toilet, and type of water source.

The Ministry of Health and Population, Nepal, has developed guidelines for skilled birth attendants.[20] Staff nurses and auxiliary midwives who are trained in midwifery skills are considered skilled birth attendants (SBA). Therefore, community health workers including traditional birth attendants, village health workers, and maternal and child health workers without midwifery training, family members and neighbours are considered as non-SBAs in this study.

The same data enumerators tracked the women to conduct a second interview within 45 days after birth. Questions on postnatal care and neonatal care practices were derived from previous studies in Nepal.[21,22] These structured questions sought information on postnatal care at a health facility within 24 h and within one week of birth, reasons for not having postnatal care at a health facility and new-born care practices related to hygiene, use of a

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