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Barriers to reporting postpartum hemorrhage at different levels of healthcare facilities in Nigeria: A qualitative study

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Abstract

Background: Maternal mortality reduction remains a world health priority. One of the causes of maternal death is bleeding after childbirth. However, little is known regarding barriers to reporting for postpartum hemorrhage care among postnatal women in Nigeria.
Objective: This research aimed to understand the perceived barriers to reporting postpartum hemorrhage care experienced by women and healthcare workers in Birnin Kebbi, North west-Nigeria.
Methods: Qualitative case research was employed in this study with face-to-face interviews among ten postnatal women who experienced bleeding and six healthcare workers. Data were collected from September to November 2021. The interviews were all audio-taped, transcribed verbatim, and analyzed using thematic analysis. NVivo Pro Version 12 was applied to organize further and manage the data.
Results: Six themes were developed: (1) knowledge deficit, (2) poor attitudes, behaviors, and performances, (3) low socioeconomic status, (4) lack of healthcare personnel, (5) cultural norms, and (6) lack of access to healthcare facilities.
Conclusion: The study findings might serve as input for healthcare policymakers and healthcare workers to improve health and reduce maternal mortality. Enhancing knowledge and awareness about reporting process is necessary to improve reporting for postpartum hemorrhage care among women. Training and continuous professional development of health care workers are also highly suggested to enhance the quality of care.

Keywords

maternal mortality; postpartum hemorrhage; maternal death; Nigeria; reporting; barriers, women

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Background

Maternal mortality continues to be a critical threat to the health sector globally. The World Health Organization (2019) indicated that 295,000 women die annually due to childbirth-related problems, most of which are curable and avoidable. Maternal death accounts for 94% of low-resource countries (World Health Organization, 2019), with about 34% of global maternal deaths occurring in Nigeria and India alone (Ope, 2020). Olamijulo et al. (2022) state that Nigeria has one of the worst global maternal mortality ratios (MMR). There is a significant increase in MMR of about 3.4% per annum from 2211 per 100,000 live births in 2007 to 3555.6 per 100,000 live births in 2019 (Olamijulo et al., 2022). The leading causes of direct maternal mortality were hypertension (27.0%), sepsis (20.6%), and hemorrhage (18.7%) (Olamijulo et al., 2022). Primary postpartum hemorrhage (PPH) is usually described as a blood loss of up to 500 ml within the first 24 hours after delivery (Than et al., 2017; World Health Organization, 2012). Despite an increased global effort to tackle women's death following bleeding after childbirth, the problem continues to be a health burden worldwide (Finlayson et al., 2019; Idris, 2022).

The recent findings from World Health Organization (2019) confirmed that less than 50% of childbirths in most developing countries are attended by trained midwives, medical doctors, nurses, or community health workers (CHW). In addition, a survey indicated that about 800 women die from childbirth-related problems worldwide daily, and high maternal mortality (9 out of 10 women) occurs in low-income countries (World Health Organization, 2014).

Evidence suggests that full implementation of PPH standard guidelines helps with PPH-related maternal death. For instance, according to Vogel et al. (2019), the WHO recommended using uterotonics by skilled healthcare workers to prevent severe bleeding after birth in low-resource countries. However, Raghavan et al. (2016) argued that timely uterotonic usage might not be 100% reliable in arresting

bleeding after childbirth. Therefore, World Health Organization (2019) calls on different contributors to revisit their health plans and programs to reduce PPH to reflect the current reality. The needed policies and programs include timely access to health care, training, continuous development programs for health workers, and massive health education for women on the importance of reporting to the hospital (World Health Organization, 2016). Furthermore, World Health Organization (2014) opined that there is a necessity for every individual nation to formulate local policies and programs specific to local needs and consumption in order to address PPH-related challenges.

Different approaches to preventing PPH originate from the commonly used Essential Public Health Operations (EPHO) embraced by individual nations under the auspices of WHO. The EPHO-five aims to prevent disease through different activities across the three stages of health care: primary, secondary, and tertiary health care. All the activities in those levels of health care are within the duties and obligations of health care providers; hence, they play a vital role in disease prevention, such as PPH (World Health Organization, 2019).

A study by Finlayson et al. (2019) analyses evidence on the feelings of women and healthcare workers regarding the measures to reduce severe bleeding at healthcare facilities. The evidence has given rise to significant insight into the elements that contributed to successfully applying strategies suitable for preventing PPH. Those elements include the availability of expedient and staff factors (Finlayson et al., 2019).

So, it is pertinent to explore the barriers to reporting PPH among postnatal women in all strata of the health delivery system to improve practice and policy. In addition, the research of Moore et al. (2011) in the assessment of pregnancy and childbirth-related issues among postnatal women in Nigeria indicated that there is defective antenatal and postnatal health care. The study suggests that particular consideration be given to enhanced awareness among women and the provision of basic medical resources. Poor living conditions, inaccessibility to health facilities, deficient information to women, low-grade services, and traditional practices are considered by World Health Organization (2019) as influential element that hinders woman folk from gaining entrance to care during childbearing and childbirth. Inadequate prior details given to women and their relatives were the major barrier to enhanced PPH care (Woiski et al., 2015). In addition, healthcare workers expressed a poor understanding of the guidelines for PPH care, inadequate knowledge, and communication gap among healthcare teams as barriers.

One of the nursing significances in the present research is that the findings will help encourage nurses and midwives to offer patient-centered care, educate patients on recognizing PPH symptoms and risk factors, and overall reporting process. Therefore, it is expected that the findings of this study will be helpful toward capacity building among nurses. Therefore, to provide enhanced quality care toward the prevention of PPH, an in-depth investigation from a different angle is needed to identify influencing factors and much information to apply an action plan towards enhanced quality care (Dupont et al., 2011). Unfortunately, up to date, little is known in Nigeria on the obstacles that affect reporting of women for PPH care from the side of women themselves and health care providers. Therefore, the present study aimed to explore the barriers to reporting PPH among women and health care providers in Kebbi state, North-western-Nigeria.

Overview of the Healthcare System in Nigeria

The healthcare delivery structure in Nigeria spreads through the three administration stages: local authority, state government, and central government, respectively Ministry of Health Nigeria (Ministry of Health Nigeria, 2017). **Figure 1** demonstrates how the healthcare system is distributed across the tears of government with three levels of the healthcare delivery system in Nigeria:

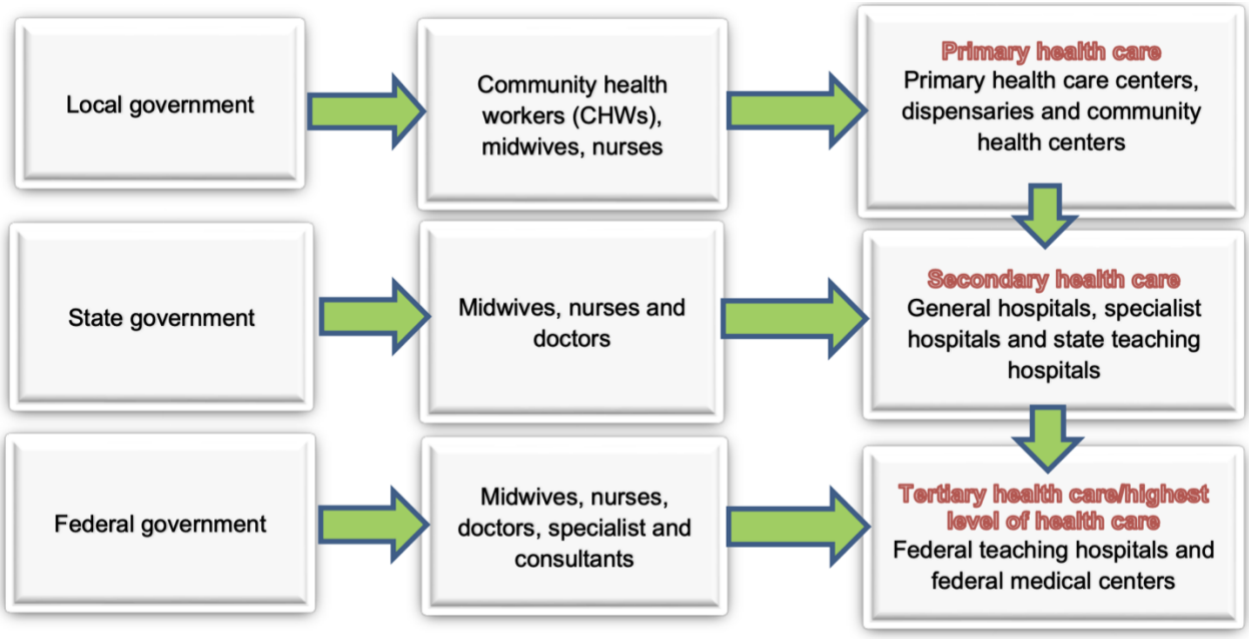

Figure 1 Distribution of levels of health across three tiers of government in Nigeria

(1) Primary health care is located at the community level to cover basic health services, first aid, and referral to a secondary health facility or general hospital. It consists of staff such as community health workers, midwives, and nurses. This level of care is funded and run by the local government as the lowest level of governance in Nigeria; (2) General hospitals functioning at the secondary level of healthcare serves as the middle-class hospital with a number of staff and specialists such as midwives, nurses, and doctors. This level of care receives a referral from the PHC and is funded and run by the state government; (3) Specialist hospitals and University Teaching Hospitals, this level of healthcare services is the third and highest level of healthcare. It receives a referral from the general hospital and provides sophisticated services such as neuro-surgery and transplants. This level of health care is funded and run by the federal or state governments. For instance, Sir Yahaya memorial hospital serves as the expert hospital in Kebbi state Nigeria and is sponsored by the Kebbi state government (Ministry of Health Nigeria, 2019). However, to ensure equal distribution of tertiary health institutions, the Nigerian government recently established federal medical centers in any state with no national teaching hospital. The idea is to facilitate the challenges of delays in the referral of cases that require immediate expert services, such as accidents and obstetric conditions (Ministry of Health Nigeria, 2018).

Methods

Study Design

A qualitative case study was applied in the present study because it serves as a medium through which a complex phenomenon can be studied within a specified context and boundaries. In addition, case study has been widely used in health science research to assess health programs and evolve health interventions (Ritchie et al., 2014).

Participants

The participants in this study consisted of six healthcare providers and ten patients. All the participants were selected using purposive sampling.

Healthcare providers. The six participants were selected from three healthcare facilities: 1) Two CHWs working as an employee of PHC Takalafiya residing in the same community as the women were also enrolled to participate in the present research because they are in control of all the women's health issues. CHWs perform registration of expectant mothers, teach them to report for labor, provide skilled birth services, and, where necessary, accompany them to the secondary health facility for more expert services as a referral process (Ministry of Health Nigeria, 2017); 2) Two midwives from Zauro General Hospital (secondary health facility) as they received PPH women referred from PHC. The midwives provide continuity of care and monitor progress in PPH women's condition, and 3) Two medical doctors from Sir Yahaya memorial hospital (tertiary health facility). The inclusion criteria of the health care providers were 1) being a full-time staff having at least one year of working experience in the maternity section of the facility or hospital; 2) being able to speak and read in the local language (Hausa) or English. All these healthcare providers were selected via their heads/managers. The head was a full-time employee at the time of research in the healthcare facility or hospital. The investigator made a phone call to six health workers eligible to participate in the study.

Patients. The inclusion criteria of the patients were women with experience of PPH three months before the data gathering, being enthusiastic about participating and having the age requirement of 18 years and above. The principal investigator partnering with the in charge of the labor and delivery unit at the research site sorted out bleeding incidences from the birth register. For participants discharged home, the midwives in charge of the unit helped to link the study team with them for selection in their communities. While participants still in the health facility were given an oral invitation by the researchers.

It is noted that the final sample size of sixteen participants was realized after no new information was observed, and it was marked as data saturation points meaning enough information had been collected to achieve the study aims (Ritchie et al., 2014).

Data Collection

After the ethical approval was obtained, data gathering was performed within three months, from September to November 2021, in a quiet meeting room of the three selected study sites. Data were collected using face-to-face, semi-structured, in-depth interviews by the first researcher. All participants opted to be interviewed in Hausa, the main local language in Northern Nigeria. The researcher is a Nigerian national of northern extract; there seem to be no element of dialect and or lifestyle barriers with the study participants.

Interview questions or guidelines were formulated by the researchers based on five components of the Health Belief Model (HBM) to obtain a comprehensive understanding of the participants' perspectives, in particular, barriers to a comprehensive understanding of the participants' perspectives. In addition, the socio-demographic data of participants was also captured via the interview guide. The interview guides were repeatedly translated by an expert translator to ensure that the intention and focus of the questions did not change during the translation procedure from English to Hausa. In addition, the researcher performed the data collection tool validation to confirm its authentication. A pilot test of the questions was done with participants outside the current research but possessing the same inclusion criteria. This procedure helped assess the applicability and suitability of the questions being framed, evaluate wording, and find out any unease or confusion. The results demonstrated that performing in-depth interviews while a woman was still not fully recovered or unstable from the condition was inappropriate for a detailed interview. The women were not ready to talk about issues relating to their conditions or their link with the healthcare system or healthcare workers. As such, in-depth interviews were organized a few weeks after discharge for those women still receiving care at the research site included in this research.

Initially, the principal researcher carried out interviews with ten postnatal women. Then, other rounds of interviews with healthcare workers. Each interview session lasted for about 20-30 minutes to minimize inconveniences. Enhancing an in-depth understanding of the issue through a different dimension, field notes were maintained by the principal researcher all over the data gathering sessions to cover all the

participants' nonverbal gestures and other equally significant data from the non-participant observations.

The interviews were all audio-taped and transcribed verbatim. The principal researcher then listened to the tapes repeatedly to authenticate the accuracy of the transcripts and manually analyzed the transcripts line by line to identify common patterns, categories, and themes. With the number of IDIs described above, interviews were harmonized, and the participants' responses appeared duplicative; as such, it was determined that sufficient data had been achieved, the point of saturation achieved, and further recruitment ceased. **Table 1** shows the number of participants in face-to-face interviews at each health facility selected.

Table 1 Data collection method and location

Location	Participants	Number of interviews	Number of participants
PHC Takalafiya	3 Women and 2 CHWs	5	5
General Hospital Zauro	3 women and 2 midwives	5	5
Sir Yahaya Memorial Hospital	5 women and 2 doctors	7	7

Data Analysis

Data analysis was simultaneously conducted with data gathering, and it commenced following the rounding off of the first interview. In addition to manual analysis, a computer-assisted mechanism, NVivo Pro Version 12, was applied to organize further and manage the data. Analyzing the results in the present research, we adopted six stages of thematic analysis outlined by Braun and Clarke (2006) to ensure the representation of participants' meaning. During this procedure, the researchers scrutinize to find out if the themes work in accordance with the framework of the whole information set and refine the established themes to confirm that they are unique (Maguire & Delahunt, 2017). The transcripts were read and re-read to ensure accuracy for enhanced authenticity of the result. Initially, the researchers read and re-read the transcripts to become conversant with participants' responses and to be acquainted with the information, taking note of initial analytic observations. Secondly, the researchers conducted a line-by-line coding process to explain the pattern with captivating features across the whole information set. A coding process was formed, which proceeded to sub-themes and themes that reflected the same ideas. The research team members described and agreed upon the final themes by means of consensus. In the end, the researchers presented a report on barriers to PPH reporting from the perspectives of women and healthcare workers.

Trustworthiness

To improve the rigor of the current research, the following techniques were applied. Firstly, person triangulation was performed where extra participants confirmed the statements made by the main participants. Additionally, other supplementary participants with similar characteristics set out in the inclusion criteria not included in the main participants were also interviewed to validate the main participants' statements. Secondly, time triangulation was also applied, where similar questions were asked at different points in time during the interview. Thirdly, method triangulation was also considered whereby in addition to multiple individual interviews, observation and document analysis were performed to authenticate the findings.

Ethical Considerations

The present research was granted by the Research and Ethics Committee of the Ministry of Health and Sir Yahaya Memorial Hospital Birnin Kebbi, Kebbi state, Nigeria (no. MOH/11/REC). All participants assented to written informed consent before partaking. It was made known to all participants that their enrollment was voluntary and they could withdraw at any point until data collection was done. All participants were fully informed of the purpose of the research. Additionally, participants were informed of the confidentiality and anonymity of their information to uphold ethical principles.

Results

The themes included how women and healthcare workers reflect on PPH and its meaning in this milieu. Thematic analysis of the interviews came out with six themes: (1) knowledge deficit, (2) poor attitudes, behaviors, and performances, (3) low socioeconomic status, (4) lack of healthcare personnel, (5) cultural norms, and (6) lack of access to healthcare facilities (**Figure 2**). An explanation of each theme with illustrative statements is demonstrated below.

Theme 1: Knowledge deficit

This theme incorporated the diverse feelings and convictions related to the reporting of PPH care. It also highlights the need for sufficient information about PPH care and reporting regarding the deficit of knowledge from the women and healthcare workers' perspective, which requires training and continuous development. All the health workers were interviewed regarding familiarity with emergency PPH reporting, which indicated that they were not aware of the existence of an emergency PPH reporting process in Nigeria.

> *I don't really know what it is; I have no idea about the reporting process (CHW 1, community health worker).*

> *I think I heard one of the resource persons talking about the emergency reporting process during our meeting some time ago, but sincerely I forgot the process at the moment (Midwife 1).*

> *I don't have any idea about emergency obstetric care; I cannot remember 1 (CHW 2, community health worker)*

The recipient of services (women) were worst hit by the insufficient knowledge of the reporting process. Interviewed about PPH reporting guidelines, the majority of women replied negatively.

> *No any campaign or educational gathering to that effect in my community. I think even if you want to report, you may not know how to report and be attended to (W1, woman).*

> *Never, never ever (W7, woman).*

Most women were not fully knowledgeable about emergency PPH reporting, evidenced by absent orientation towards the reporting guidelines issued by the Ministry of Health Nigeria.

Emergency reporting … reporting process for PPH care I cannot remember (W7, woman).

However, some interviewees had come across the PPH reporting guidelines by coincidence.

Because I have heard on the radio and saw it on television that no reporting of PPH could lead to the death of a mother, it showed very good information to us, but it never came from any community or primary health center, and I have no exposure on such guidelines and protocols (W7, woman 7).

On the other hand, healthcare providers recommended the need for continuous training of healthcare workers for effective handling of PPH and other emergencies, thereby improving reporting among women.

We need to be updated periodically to gain new knowledge and ideas (Doctor 1).

We need to be offered a free opportunity to participate in local workshops and seminars (Midwife 2)

Theme 2: Poor attitudes, behaviors, and performance

This theme presents two different perspectives between healthcare workers and women but is most likely related to low attitudes, behaviors, and performance of both sides. The following quotes are expressed by the healthcare workers:

Most of the women appear arrogant and don't comply with advice from the health care workers. I believe certainly there is poor compliance . . . specifically for women from the family of moderate wealth and low educational background (CHW 1, community health worker).

Some healthcare workers regarded the women as non-appreciative of their services.

Because women nowadays patronize the services of quacks and untrained health personnel rather than professionals, some of them are non-compliant. They are just arrogant (Midwife 1).

CHWs indicated that their responsibility is to enlighten the women on risk factors only, and it is not their role to assist women in getting to the hospital.

When she is approaching the expected delivery date, it is the responsibility of the relatives and other family members to take her to the hospital to be offered care by a skilled birth attendant (CHW 1, community health worker).

Others stated that their main role is if a woman gives birth at home or outside the facility.

If the woman gives birth at home or on the way to the health Centre, my only duty is to administer Misoprostol only, nothing more than that (Midwife 2).

If a woman gives birth at home and later develops PPH, our responsibility is just to prescribe suitable drugs to arrest the bleeding (Doctor 2).

On the contrary, the care recipients (women) highlighted the attitudes and behaviors of the healthcare workers that negatively affect PPH reporting. Some healthcare workers might be doing their best, but some were less concerned. The participants express this:

Some of them are busy chatting and conversing with each other in the hospital (W5, woman).

I am not comfortable with the harsh and unfriendly handling of the Doctors, Midwives, Nurses, and all other health care personnel (W3, woman).

Another issue is the aggressive approach of the health care workers to their patients, the women.

I don't know why; I was at the hospital with my junior sister, who gave birth at home but took me to the hospital to manage PPH. On that day, a nurse was shouting at us, asking us all sorts of questions in such an unfriendly and hostile approach. Why? Why? Am I not a human being like herself? (W3, woman).

However, some women pointed out the low attitude and behavior of the healthcare workers due to their poor welfare. The women expressed this:

Sometimes the staff might maltreat you because they have not been adequately paid and might not get their entitlement from their employers (W10, woman).

I have offered gifts and bribes to the nurse before being attended to in our health center (W7, woman).

Theme 3: Low socioeconomic status

Women's socio-economic status is also an essential factor that affects reporting of PPH among women. Socio-economic status determines the ability of a woman or her family to report for health care services, including antennal and care for PPH. For instance, one woman shared that:

I could not report for PPH care because my husband was a mere community guard whose duty was to serve as chief security at the palace of a village head day and night; as such, I do not have time for such (W1, woman).

The income of the family influences the utilization of health care services, including reporting for PPH care, and low socio-economic status negatively affects the ability to access public health care services. For example:

No, I don't have to report for PPH care because I am from a small village. My husband cannot afford that; all we can do is invite a traditional birth attendant for my care (W2, woman).

Therefore, women's socio-economic status was a vital indicator of the inequalities and imbalances of the reporting for PPH care and other health care services among women.

Theme 4: Lack of healthcare personnel

The limited number of certified healthcare workers in labor and childbirth care was identified as an impediment to reporting process for PPH care. The participants expressed this:

I don't believe it is a good experience to be in the hospital or any health center because there are not enough personnel to handle a number of women for PPH care (W4, woman).

I think I cannot cope with the long waiting in the queue (W5, woman).

It is very terrible one stay in the hospital for up to sunset only to be told to come back tomorrow (W6, woman).

Theme 5: Cultural norms

Some respondents stated that cultural norms against care during childbirth could also influence the reporting of PPH care.

I was about to report to the health facility when my mother-in-law asked me to stay at home for some traditional practice (W9, woman).

One older woman in our neighborhood insisted that I should be subjected to room perfumes made up of pepper smokes, which made me cough, sneeze, and have watery eyes ((W7, woman).

Theme 6: Lack of access to healthcare facilities

The transportation system is another factor identified to influence the reporting. The participants express this:

It seems difficult for me to be in the health facility from my village as there is no road network (W8, woman).

A respondent explained that there was an obstacle to free access to the health center.

My village is not far from the health center, but we have to go by water canoe and boat as there is riverine water all over (W10, woman).

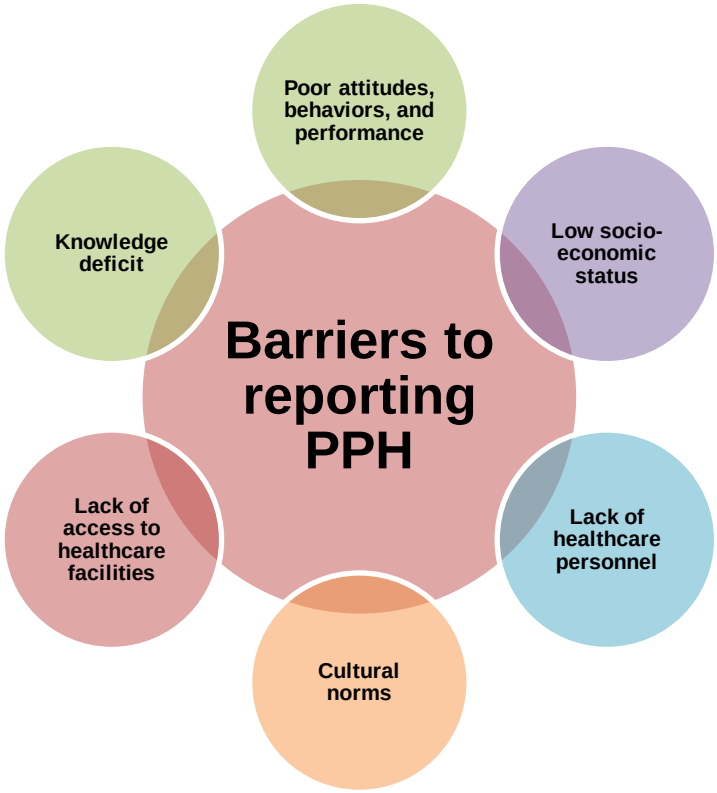

Figure 2 Thematic findings

Discussion

The present study explored barriers to PPH reporting from the perspectives of (women) and health care providers (CHWs, midwives, and doctors) in Northern- Nigeria. The study presents an in-depth view of the women and healthcare workers at different levels of healthcare facilities obtained at the three facilities in Kebbi state, northern Nigeria. The interview with women and healthcare workers in the present study is an intentional approach applied by the research team to inform how the entire process of PPH reporting and the hospital stay could be redesigned and realigned to meet the demands of women and stakeholders.

The first theme is related to deficit knowledge of the PPH reporting process in both healthcare workers and women, which therefore has a potential risk of being exposed to PPH-related problems. However, no established mechanism stimulates women to report for PPH care and prevention. In addition, the results of the present study showed evidence that even though respondents exhibit some degree of understanding about the effects of excessive blood loss during childbirth. However, they have little knowledge about the benefit of early reporting and care, which may be due to a lack of training and education. This is similar to the findings by Moore et al. (2011), suggesting that the lack of intensive teaching and awareness campaigns against PPH during antenatal visits contributes to the poor reporting of PPH care among women in Nigeria. Training, education, and policy to improve awareness, knowledge, and understanding of the risk associated with bleeding after birth, physical and psychosocial, are necessary for this context (Finlayson et al., 2019; Ndirangu et al., 2021; Ricbourg et al., 2015). Training programs for all personnel to reduce bleeding after birth have been identified to empower healthcare workers towards early reporting, thereby, early detection of the risk (Finlayson et al., 2019).

The second theme highlights conflicting perspectives between healthcare workers and women, reflecting a poor relationship between the two. However, this is a critical barrier to be solved. The findings indicated that the healthcare providers were unable to provide sustainable and quality care due to the non-application of ethical principles and

personalization of care. This made it worst as the healthcare workers regarded women as unappreciative and arrogant. This should be noted that a patient is a king when they become a customer (Basheer, 2019); thus, they should be treated well. Therefore, the communication role is critical in this matter.

Additionally, it is noteworthy that a defective interaction between women and health workers contributes to poor reporting, low compliance among women, and an inability to express their health needs during pregnancy and childbirth. Furthermore, women exhibited feelings of discomfort and emotions when interacting with hostile and unfriendly healthcare workers; this might further increase an obstacle to the positive interaction necessary for the reduction of bleeding cases. In addition, the women also noted the causes of poor interaction, which are likely associated with a busy workload of health workers and poor welfare, as seen from the staff collecting bribes and gifts from the women and their relatives. This will affect the principles of equity and fairness to all patients (Tunçalp et al., 2015). However, further studies are needed to confirm this initial conclusion.

On the third theme, "low socio-economic status," women reported an obstacle of living with financial constraints, which sometimes causes a delay in reaching the health center. Empirical literature states that donor agencies such as UNICEF can help mitigate the menace of PPH through the provision and distribution of essential drugs and a massive campaign to create awareness among women on the importance of PPH reporting. This helps to reduce the non-reporting issue related to PPH in less developed countries to gain access to standardized services in a timely manner (Lalonde et al., 2012; Vogel et al., 2019).

The fourth theme highlighted that a limited number of healthcare workers discourages many women from reporting for PPH care. The findings of the present study corroborate the guidelines established by the Ministry of Health Nigeria, suggesting that healthcare workers are needed to closely monitor expectant mothers (Ministry of Health Nigeria, 2017). Therefore, it is pertinent to enhance the awareness of women regarding the importance of reporting for PPH care to achieve early detection and identification of PPH-associated risk.

On the fifth theme regarding cultural norms against care during childbirth, the findings indicated that culture and belief significantly affect reporting for PPH care. This finding conforms with Finlayson et al. (2019) found that women understand the aftermath of a severe PPH but, in some instances, opt for traditional and cultural means to take care of potential birth-related problems. Although our findings indicated that respondents have some insights about the possible consequences of severe bleeding after birth, some women believe that PPH might be related to spirit attacks. In some cases, family members, especially mothers-in-law, contribute to stopping women from reporting to health facilities for PPH-related care by enforcing traditional herbs. Cultural makeup negatively affects pregnancy and childbirth in developing and low-resource countries. This prevents women from reporting and seeking medical intervention for the prevention and care of PPH.

With regard to the last theme, "lack of access to health care facilities," the findings indicated that far distance and Water Rivers (Riverine areas) were the major obstacles to the accessibility of health facilities. Accessible means of transportation to the health facility are highly recommended in this theme. This is similar to the findings by Bohren et al. (2017) highlighted that women's decision to report for PPH care could be affected by their distance to the facility.

Implications of the Study for Nursing Practice

There are several implications of this study for nursing practice: First, the healthcare managers need to provide training and reorientation among all healthcare workers (nurses, midwives, doctors) to increase their knowledge and competencies in handling women for smooth PPH care, achieving proper informational flow, and creating report with women, and overall postnatal services. Second, the healthcare workers are suggested to improve the interactions and relationships with the women by advancing the role of communication to translate positive attitudes and encourage women for timely reporting of PPH. Third, providing healthcare interventions by considering the cultural norms (involving community leaders) is necessary, especially emphasizing the importance of timely referral and avoiding obstetric complications. Last, strategies to improve access to healthcare facilities and employee welfare are deemed essential, as indicated in this study.

Strengths and Limitations of the Study

The strength of the current research is its approach of using different perspectives (Connelly, 2016) applied to gain credible information on the barriers in reporting for PPH care. However, the overall findings might not fully represent the condition in Nigeria. Thus, further studies are needed to validate and generalize the study results.

Conclusion

Six themes were developed in this study perceived as barriers in reporting for PPH from women's and health care providers' perspectives. Lack of knowledge, attitude, behavior, performance, socio-economic status, and lack of health care personnel, as well as cultural norms, should be addressed in order to improve PPH reporting. Massive awareness campaigns, information sharing with women and family members, and regular training of health care workers could promote more reporting and access to health care services. However, more research is needed to support enhancing reporting for PPH care to reduce PPH-related death.

Declaration of Conflicting Interest

The authors declare no conflicts of interest with respect to the authorship and publication of this article.

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Authors' Contributions

All authors had notable contributions during this project, including the study aims, formulation and finalization of the methodology and design, data gathering, analysis, and interpretation of the results. SM was responsible

for the proposal development, ethical considerations, data collection, initial data analysis, and subsequent manuscript drafts. LK, RP, IZ, and SNG assisted with research proposal development, data analysis, and drafting and refining the final manuscript. All authors read and approved the final manuscript for publication.

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Data Availability

All data generated or analyzed during this study are included in this published article.

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