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FACTORS INFLUENCING POSTNATAL CARE UTILIZATOIN AMONG WOMEN IN PERI-URBAN AREAS: A CASE STUDY OF XAITHANY DISTRICTVIENTIANE CAPITAL

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A B S T R A C T :

Postnatal care (PNC) is an essential component of maternal and child health services, playing a vital role in lowering maternal and neonatal morbidity and mortality while enhancing overall well-being (Sacks et al., 2022). However, in many low- and middle-income countries, PNC coverage lags significantly behind antenatal care, skilled birth attendance, and facility-based delivery, resulting in frequent disruptions to the continuum of care during the postnatal period (Sadettan et al., 2025). This qualitative study investigated the determinants of PNC utilization among women in peri-urban areas of Xaithany District, Vientiane Capital, Lao PDR, aiming to identify strategies to enhance care-seeking and continuity. Data were collected across two villages, two health centers, and one district hospital using four focus group discussions, two with mothers (n = 16) and two with community members (n = 9), alongside six key informant interviews with healthcare providers. Findings revealed that PNC utilization is shaped by three main categories of factors: predisposing, enabling, and need factors. Predisposing influences, including maternal education, cultural traditions, family dynamics, and community support, strongly guided care-seeking behaviors. Enabling factors, such as socioeconomic status, transportation, distance, service costs, healthcare workforce shortages, and facility resource limitations, further constrained access and continuity of care. Need factors centered on mothers' perceptions of health risks and their capacity to recognize danger signs; restrictive postpartum practices and reliance on self-assessment often reduced demand for routine PNC, with care sought primarily when acute complications arose. Based on these insights, enhancing PNC utilization requires a multi-faceted approach addressing cultural, systemic, and logistical barriers. Priority interventions include strengthening community-based health education, fostering respectful provider communication, improving village-level coordination and reporting systems, addressing healthcare workforce constraints, and integrating maternal mental health into routine postnatal services to ensure holistic, high-quality care.

Keywords: postnatal care, utilization, continuity, peri-urban, Laos

Introduction

Postnatal care (PNC), the care provided from childbirth through the first six weeks postpartum, is a critical window for safeguarding the health of mothers and newborns. Despite its importance, maternal and neonatal morbidity and mortality remain disproportionately high during this period, leading to frequent missed opportunities for delivering essential health interventions and nurturing care. To address this, the World Health Organization recommends a minimum of four PNC contacts: within 24 hours of birth, at 2–3 days, at 1–2 weeks, and at 6 weeks postpartum (World Health Organization, 2022). Globally, a substantial proportion of maternal deaths occur post-childbirth; between 2003 and 2009, direct obstetric causes accounted for roughly 73% of maternal deaths, with most occurring in the postnatal phase (Say et al., 2014). Neonatal mortality follows a similar trend, peaking during the first week of life, as confirmed across 34 studies (Dol et al., 2023).

In Lao PDR, considerable progress has been achieved in antenatal and intrapartum care, with 71.6% of pregnant women completing four or more antenatal visits and nearly 80% of births attended by skilled health personnel (LSIS III, 2023). However, maintaining continuity of care into the postnatal period remains a major bottleneck. Although 85.4% of women delivering in health facilities receive an initial assessment within the first 24 hours, fewer than half return for the recommended follow-up visits (Sadettan et al., 2025), presenting a persistent challenge for maternal and child health outcomes nationwide. While the national maternal mortality ratio fell from 405 per 100,000 live births in 2005 to 126 in 2020, and the neonatal mortality rate decreased from 33 per 1,000 live births in 2005 to 12 in 2023 (Sadettan et al., 2025), these figures still lag behind regional standards, signaling a need for sustained health system investment. Xaithany District, a rapidly urbanizing area in Vientiane Capital, offers a strategic setting to investigate PNC utilization. As a peri-urban community, it sits at the intersection of geographical proximity to health services, evolving socioeconomic conditions, and deeply rooted cultural postpartum practices. Guided by Andersen's Behavioral Model of Health Services Use (Goodman, 2010) , this

study classifies determinants of PNC utilization into predisposing factors (education, cultural beliefs, family influence), enabling factors (income, physical distance, transport, service quality), and need factors (perceived health status and complications). By examining these dynamics in Xaithany District, this study fills a crucial evidence gap in peri-urban maternal healthcare in Lao PDR and contributes to broader discussions on health equity in transitional settings.

Literature Review

Postnatal care (PNC) is widely recognized as a critical stage in the continuum of maternal and child health, with the World Health Organization recommending at least four structured contacts within six weeks postpartum to safeguard survival and promote well-being (WHO, 2022). Despite global progress, PNC coverage remains uneven, particularly in low- and middle-income countries where restrictive cultural practices, socioeconomic barriers, and health system limitations intersect to shape utilization (Barennes et al., 2009; Sadettan et al., 2025). In Lao PDR, maternal and child health outcomes have improved through financing reforms, expanded midwifery training, and strategic partnerships with development partners; nevertheless, continuity of PNC remains weak, with fewer than half of mothers receiving two or more recommended follow-up visits (Bunde et al., 2025) . Perceptions and cultural beliefs play a decisive role in care-seeking: many women view clinical care as necessary only when acute complications arise, while traditional practices such as "hot bed" confinement and restrictive postpartum diets are regarded as essential for recovery, practices that can contribute to maternal nutritional deficiencies and child stunting (Quayle, n.d.; Xayyabouapha et al., 2022). Key facilitators of PNC include antenatal care attendance, institutional delivery, maternal education, breastfeeding knowledge, active family involvement, and community outreach (Sakuma et al., 2019; Sychareun et al., 2016). Conversely, major structural barriers encompass geographic distance, inadequate transportation, low household income, service quality gaps, and limited health provider availability (Sacks et al., 2022). Addressing these multifaceted challenges requires culturally sensitive health education, strengthened facility-based delivery practices, the integration of maternal mental health services, and respectful, person-centered care aligned with global quality frameworks (Wojcieszek et al., 2023).

To synthesize these complex determinants, several theoretical frameworks offer valuable insights. Public health governance literature emphasizes collaborative structures and institutional accountability (Carlson et al., n.d.; Emerson, 2018), while health services theory highlights the importance of care integration, trust, and patient-centered environments (Piquer-Martinez et al., 2024). More specifically, Andersen's Behavioral Model categorizes determinants into predisposing, enabling, and need factors (Alkhawaldeh et al., 2023; Goodman, 2010), whereas the Health Belief Model explains care-seeking behavior through perceived susceptibility, severity, benefits, barriers, and self-efficacy (Carpenter, 2010; Janz et al., n.d.). Together, these empirical and theoretical perspectives position PNC in Lao PDR as a complex issue shaped by cultural traditions, systemic constraints, and individual beliefs, pointing to the need for integrated strategies that ensure mothers and infants not only survive, but thrive.

Research Methodology

Study Design and Setting: This study employed a qualitative research design to explore the determinants of postnatal care (PNC) utilization in peri-urban Xaithany District, Vientiane Capital. The qualitative approach emphasized context, depth, and participants' lived experiences, ensuring trustworthiness through data triangulation and participant validation(Abdalla et al., 2026). Fieldwork was conducted between March and May 2026 across two peri-urban villages (Hatkieng and Somesamai), two health centers, and Xaithany District Hospital.

Sampling and Data Collection: Participants were selected using purposive sampling to capture diverse perspectives. Target groups included mothers with children under two years of age from Hmong and Lao-Tai communities, key community stakeholders (village health volunteers, village leaders, and Lao Women's Union representatives), and healthcare providers from local facilities. Data collection combined four focus group discussions (FGDs) and six key informant interviews (KIIs), guided by semi-structured topic guides that were pre-tested and refined for cultural appropriateness. All sessions lasted between 40 and 60 minutes, were conducted in local languages, and emphasized voluntary participation. Qualitative data were captured through detailed field notes and digital audio recordings obtained with participant consent.

Data Analysis and Ethical Considerations: Data analysis followed Braun and Clarke's six-step thematic analysis framework (Braun & Clarke, 2006), supplemented by in vivo coding to preserve participants' exact phrasing and nuances (Manning, 2017). Qualitative data management and coding were facilitated using QualCoder software (Blumenthal, n.d.). Primary themes centered on structural barriers to access, family and community support networks, and tensions between traditional postpartum practices and clinical medical advice. Ethical safeguards were strictly implemented: written or verbal informed consent was obtained prior to data collection, personal identifiers were removed, transcripts were fully anonymized, and digital files

were securely stored on password-protected servers scheduled for deletion following project completion. Together, these methodological procedures ensured cultural authenticity, analytical rigor, and credible evidence to inform strategies for strengthening PNC continuity.

Results

Study Context: This research was conducted in the Lao People's Democratic Republic (Lao PDR), a lower-middle-income nation in Southeast Asia where maternal and child health (MCH) remains a key development priority under Sustainable Development Goal 3. While targeted national strategies have steadily reduced maternal and child mortality in recent decades, maintaining continuity of care throughout the postpartum period remains a persistent challenge for the national health system. Healthcare delivery in Lao PDR is structured across four administrative levels: central, provincial, district, and health center tiers. At the primary care level, health centers and district hospitals rely on community actors, including village authorities, village health volunteers (VHVs), and the Lao Women's Union (LWU), to coordinate basic health outreach. However, healthcare utilization is shaped by a complex interplay of household socioeconomic status, geographic access, cultural beliefs, and perceived medical need. Although national health surveys report substantial gains in antenatal care (ANC) and facility-based deliveries, routine postnatal checkups drop off sharply after discharge. This drop-off points to structural and behavioral bottlenecks that extend beyond physical access alone. Xaithany District in Vientiane Capital was selected as the research setting due to its rapid urban expansion, demographic diversity, and peri-urban characteristics. The district presents a setting where physical proximity to primary and referral health facilities exists alongside deeply rooted cultural practices. Applying Andersen's Behavioral Model of Health Services Use in tandem with the Health Belief Model provides a dual framework to evaluate these dynamics, capturing how individual perceptions of disease severity, benefits, and self-efficacy interact with enabling community resources and cultural traditions. Examining these dynamics through community narratives offers grounded insights into how urban transition and ethnic diversity influence continuity of care. Ultimately, the findings from Xaithany District aim to inform national MCH policy by identifying practical approaches to improve health equity, community awareness, and PNC service uptake across transitional peri-urban populations.

Study Setting and Participant Demographics: Xaithany District is among the largest and most rapidly expanding administrative areas in Vientiane Capital. The district's population grew from 99,473 in 1995 to 234,938 in 2020 (CityPopulation, 2020), with urbanization rates reaching nearly 67% (Lao Statistics Bureau, 2015). This demographic shift reflects a transitional environment that blends urban infrastructure with rural social networks. The fieldwork was conducted across three public healthcare facilities: Xaithany District Hospital, Hatkieng Health Center, and Huikiem Health Center, alongside two target villages located within the catchment areas of the health centers: Hatkieng Village and Somesamai Village.

The two study villages present distinct accessibility and ethnic profiles:

- Hatkieng Village: Located approximately 35 km from the city center with paved road access. It features an ethnically diverse population of Lao-Tai (Lao Loum), Hmong, and Khmu communities.
- Somesamai Village: Situated roughly 50 km from the city center, with a population that is predominantly Hmong (~95%).

Both villages lie within 5 km of their nearest health center, providing reasonable physical access to primary care. Khmu community members were excluded from this study sample as they reside in a physically separate zone of the village. In Hatkieng, focus group participants belonged to the Lao-Tai group, whereas in Somesamai, discussions focused primarily on Hmong women. A secondary focus group with community leaders in Somesamai included two key informants (both serving as deputy village heads and VHVs, one Hmong and one Lao-Tai).

Participant demographics across the three qualitative cohorts are detailed below.

Participant (women): A total of 16 women participated in the focus group discussions, representing Hatkieng village (n = 10) and Somesamai village (n = 6). Participants ranged in age from 23 to 40 years. Ethnicity closely aligned with geographic location: all participants from Hatkieng village identified as Lao-Tai, whereas all participants from Somesamai village were Hmong. Educational backgrounds varied across the sample; the majority had completed secondary school (n = 12), while individual participants reported primary education (n = 1), high school (n = 1), a bachelor's degree (n = 1), or no formal schooling (n = 1). Parity ranged from 1 to 4 children per woman. Regarding delivery characteristics, all 10 Lao-Tai participants from Hatkieng village and 3 Hmong participants from Somesamai village delivered their last child at a healthcare facility, while 3 Hmong women from Somesamai village reported delivering at home without a skilled birth attendant (SBA).

Participant (community members): A total of nine community key stakeholders participated across the focus group discussions, representing Hatkieng village (n = 7) and Somesamai village (n = 2). Participants ranged in age from 31 to 54 years and included five females and four males. In

terms of ethnic composition, eight participants identified as Lao-Tai, while one participant from Somesamai village was Hmong. Educational backgrounds were predominantly at the secondary school level (n = 7), with individual participants holding a high school diploma (n = 1) or a bachelor's degree (n = 1). The participants held various local leadership and community support roles, including deputy village heads (n = 4), Lao Women's Union representatives (n = 3), a head of household unit (n = 1), and a village health volunteer (n = 1).

Participant (KII): A total of six healthcare providers participated in key informant interviews, representing Hatkieng Health Center (n = 2), Huikiem Health Center (n = 2), and Xaithany District Hospital (n = 2). All participants were female and identified as Lao-Tai, with ages ranging from 24 to 53 years. Educational qualifications varied across professional disciplines, including technical diplomas in nursing (n = 1) and midwifery (n = 1), higher diplomas in midwifery (n = 1) and pharmacy (n = 1), a bachelor's degree in midwifery (n = 1), and a master's degree in family medicine (n = 1). Regarding administrative and clinical responsibilities, participants held roles as heads of health centers (n = 2), technical staff members (n = 3), and an academic/technical lead in maternal and child care (n = 1).

Predisposing Factors: Postnatal care utilization is significantly influenced by a combination of maternal education, cultural traditions, and family and community support structures. While demographic trends show that Lao-Tai women generally achieved higher levels of formal education than Hmong women, educational attainment alone did not determine health-seeking behavior, as financial difficulties, sudden nighttime labor, and physical transport barriers led several educated women to deliver at home without skilled birth attendants. Maternal health knowledge was gathered through institutional guidance, digital media such as YouTube, and informal peer networks, with mothers, sisters, and experienced relatives acting as the most trusted and influential sources of guidance. Cultural traditions strongly dictated postpartum recovery; following discharge, Lao-Tai mothers typically observed strict hot-bed confinement and drank boiled herbal water for up to a month, whereas Hmong mothers practiced shorter daytime confinement, though both groups adhered to strict dietary restrictions out of fear of Phid Kam (postpartum dietary taboos). These traditional practices were reinforced by community elders, leading healthcare providers to focus on offering safety guidance, such as avoiding excessive heat, rather than discouraging cultural norms outright. Finally, family roles played a crucial part in care decisions, with husbands providing essential practical and logistical support and mothers-in-law guiding confinement rituals, while formal community support remained limited due to strict loan criteria and debt reluctance regarding village development funds.

Enabling factors: Postnatal care utilization across the study sites is shaped by a complex interplay of socioeconomic conditions, geographic accessibility, and health system readiness. Household financial security directly dictates care-seeking behaviors; while direct facility fees are relatively manageable for stable families, low-income households reliant on agriculture, factory work, or seasonal plantation labor face severe financial strain, often prioritizing immediate livelihood needs over routine checkups due to lost daily earnings during postpartum recovery. High population mobility among plantation workers and limited social health insurance coverage further heightens financial vulnerability and disrupt care continuity. Geographic accessibility presents additional hurdles, as families living 35 to 50 km from secondary or tertiary hospitals face significant travel risks during rapid labor, relying heavily on private vehicle ownership, neighbors, or village health volunteers for transport, a barrier that frequently leads poorer households to give birth at home. Finally, service availability varies sharply across facility tiers: higher-level hospitals provide 24-hour observation, whereas local health centers suffer from critical workforce shortages, a lack of delivery rooms and basic diagnostics, frequent pharmaceutical stockouts, and absent maternal mental health screening, prompting many women to bypass primary care facilities entirely.

Need factors: Care-seeking behaviour during the postpartum period is predominantly driven by subjective self-assessments and the emergence of acute medical complications. Most mothers evaluated their recovery based on personal perceptions of well-being, prioritizing physical rest, adequate nutrition, and traditional confinement practices over routine clinical check-ups. When no immediate danger signs were observed, formal postnatal visits were generally viewed as unnecessary, leading many women to forgo scheduled follow-up care. While traditional beliefs such as fear of *Phid Kam* (violating postpartum dietary taboos) heavily influenced recovery routines, younger mothers expressed an increasing desire to align with modern health guidance, though often constrained by elder expectations. Consequently, formal health facility visits were rarely preventive; mothers sought clinical care almost exclusively when facing clear physical complications, such as severe vaginal bleeding, surgical suture breakdown, mastitis, or infant illness, often managing these through a combination of traditional rituals and medical treatment.

Possible approaches to improve PNC utilization: To enhance postnatal care (PNC) utilization and continuity, a multi-faceted approach addressing both community-level dynamics and health system capacities is required. First, strengthening community health education by leveraging outreach programs, village leadership, and family networks acts as a crucial predisposing factor to align traditional practices with formal care delivery. Second, improving interpersonal communication and providing respectful, compassionate care serves as a high-impact, low-cost strategy to build patient trust and motivate facility return visits. Third, strengthening village coordination and local reporting systems, through active engagement of village authorities and health volunteers, improves data accuracy for home births and transient populations while reinforcing referral pathways. Fourth,

addressing workforce shortages and upgrading primary care facility infrastructure enhances enabling conditions, instilling community confidence in health centres. Finally, integrating maternal mental health into routine PNC via standardized screening, provider training, and community-based support addresses a critical unmet need, ensuring a holistic model of postnatal care that aligns with global health guidelines.

Discussion

The findings from Xaithany District demonstrate that despite policy commitments and high rates of initial facility delivery, continuity of postnatal care (PNC) remains constrained by a complex interplay of cultural traditions, socioeconomic barriers, and perceived health needs. Theoretical integration through Andersen's Behavioral Model and the Health Belief Model underscores how predisposing factors, such as elder-enforced confinement rituals (*Yu Fai*), traditional dietary taboos, and reliance on peer networks, interact with enabling resources like household income, transport, and facility service quality. Even within peri-urban settings where health facilities are physically accessible, mothers frequently bypass primary health centres due to resource limitations, while routine follow-up visits are rarely utilized unless acute physical complications or infant illnesses arise. Furthermore, essential components of global MCH frameworks, particularly routine screening and psychosocial support for postpartum depression, remain completely unintegrated at the primary care level. While national policy initiatives like the RMNCAH Strategy (2020–2025) and the revised Healthcare Law (2023) aim to expand universal health coverage, bridging the continuity gap requires moving beyond physical access alone toward culturally sensitive community engagement, family involvement, and strengthened primary healthcare governance.

Conclusion and Recommendations:

This qualitative study explored the factors shaping postnatal care (PNC) utilization and continuity among mothers in peri-urban Xaithany District, Lao PDR. Grounded in Andersen's Behavioral Model and the Health Belief Model, the findings demonstrate that care-seeking decisions are driven by an interplay of predisposing, enabling, and need factors. While formal education provided a foundation for health literacy, elder-guided confinement traditions (Yu Fai), dietary taboos (Phid Kam), and peer networks remained the primary drivers of postpartum recovery. Financial strain, loss of daily earnings, high seasonal migration, and transport barriers further hindered continuous facility use. Consequently, health centre visits were rarely preventive and occurred almost exclusively when acute physical complications arose, while maternal mental health needs remained completely unaddressed.

To improve postnatal care utilization, health system interventions must address these multi-dimensional gaps. Community health education should be delivered through collaborative networks involving village authorities, traditional clan leaders, and families to align traditional customs with safe, modern medical practices. At the facility level, expanding health workforce staffing, upgrading basic diagnostic equipment, and training providers in respectful, empathetic communication are essential to rebuild community trust. Furthermore, local tracking systems managed by village health volunteers must be strengthened to capture home births and mobile populations, alongside formally integrating routine postpartum depression screening into primary care.

Future research should build on these insights to inform national maternal and child health strategies. Comparative studies across different provinces and longitudinal research tracking mothers and infants over time are recommended to better understand regional variations and long-term health outcomes. Additionally, dedicated studies exploring the prevalence of postpartum depression, the influence of social media on health choices, and the impact of respectful maternity care training for primary healthcare workers will provide crucial guidance for health policy and governance reforms.

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