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International Journal of Women's Health

ISSN: 1179-1411 (Online) Journal homepage: www.tandfonline.com/journals/djwh20

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To cite this article: Rachel Luwaga, Joseph Ngonzi, Francis Bajunirwe & Deborah Shindell (2026) Facilitators and Barriers to Discharge Education for Puerperal Sepsis Prevention After Caesarean Section: A Qualitative Study at a Tertiary Health Facility in Southwestern Uganda, International Journal of Women's Health, , 649602, DOI: 10.2147/IJWH.S649602

To link to this article: https://doi.org/10.2147/IJWH.S649602

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Published online: 28 Oct 2026.

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International Journal of Women's Health

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ORIGINAL RESEARCH

Facilitators and Barriers to Discharge Education for Puerperal Sepsis Prevention After Caesarean Section: A Qualitative Study at a Tertiary Health Facility in Southwestern Uganda

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Introduction: Maternal mortality remains a major global health concern, disproportionately affecting low- and middle-income countries. Puerperal sepsis remains an important contributor to maternal morbidity and mortality, with caesarean delivery increasing women's risk of infection. As caesarean deliveries increase, strengthening strategies to prevent puerperal sepsis throughout the continuum of care is increasingly important. Although prevention efforts have focused largely on antenatal and intrapartum care, post-discharge self-care and education remain insufficiently emphasized. Evidence from Mbarara Regional Referral Hospital indicates gaps in women's knowledge and practices regarding post-caesarean self-care, highlighting the need for effective discharge education to support prevention, early recognition, and timely care-seeking for puerperal sepsis. However, the effectiveness of discharge education depends not only on the information provided but also on healthcare providers' ability and willingness to deliver it within the available health-system environment. The COM-B framework provides a useful lens for understanding these influences by examining providers' capability, opportunities within the health system, and motivation to deliver discharge education. Understanding these factors is therefore important for identifying barriers and facilitators that can be addressed to strengthen puerperal sepsis prevention after discharge. The study aimed to explore the facilitators and barriers to the provision of discharge education for puerperal sepsis prevention following caesarean delivery.

Methods: This study employed an exploratory qualitative design at Mbarara Regional Referral Hospital. A total of 12 healthcare providers, comprising six senior house officers and six midwives, were purposively selected, provided informed consent, and participated in in-depth interviews. The interviews were audio-recorded and transcribed verbatim. Thematic analysis was conducted by systematically coding statements from the transcripts, organizing similar codes into subthemes, and subsequently synthesizing the subthemes into overarching themes.

Results: Twelve healthcare providers (six midwives and six senior house officers) participated in the study. Under Capability, knowledge, clinical experience, and awareness of puerperal sepsis and its prevention facilitated discharge education. Opportunity was facilitated by the availability of discharge forms and opportunities to provide education, but barriers included limited post-caesarean-specific information, inconsistent timing and content of instructions, language barriers, inadequate staffing and time, fatigue, limited space and privacy, and gaps in coordination and teamwork. Under Motivation, professional commitment, passion for patient care, and awareness of the consequences of inadequate education facilitated discharge teaching, whereas patient disengagement, heavy workload, and other demotivating factors hindered it.

Conclusion: Discharge education for puerperal sepsis prevention following caesarean section was influenced by interacting provider and health-system factors. While providers' knowledge, experience, commitment, and available resources supported education, workload, staffing constraints, limited privacy and space, language and literacy barriers, inadequate post-caesarean materials, inconsistent timing, and gaps in teamwork constrained its consistent delivery. Strengthening discharge education therefore requires

https://doi.org/10.2147/IJWH.S649602
Received: 18 August 2026
Accepted: 17 October 2026
Published: 28 October 2026

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a multi-level approach that addresses both providers' capability and motivation and the health-system opportunities needed to deliver effective education.

Keywords: maternal, self-care, health education, instructions, health worker, postpartum, infection

Background

Maternal mortality remains a major global health concern, with approximately 260,000 maternal deaths reported in 2023, disproportionately affecting low- and middle-income countries. The postpartum period is particularly important because a substantial proportion of maternal deaths occur in the days and weeks following childbirth, when women may already have been discharged and are managing their recovery at home.[1] Pregnancy-related infections are important contributors to maternal mortality in sub-Saharan Africa, accounting for approximately 11.5% of maternal deaths.[2] Puerperal sepsis is an important postpartum complication and has been implicated in approximately 15% of maternal deaths in a Ugandan tertiary hospital.[3] The postpartum period therefore provides an important opportunity to strengthen education on infection prevention, early recognition of complications, and timely care-seeking.

Caesarean section is an important risk factor for puerperal sepsis globally and in Uganda.[4,5] As the use of caesarean section continues to increase globally, caesarean section rates in sub-Saharan Africa are projected to nearly double from 3.6% to 7.1% by 2030, which could potentially increase the risk for postoperative complications, including puerperal sepsis.[6] Prevention of puerperal sepsis has traditionally focused on antenatal and intrapartum care, including health education, infection prevention and control, aseptic surgical practices, antibiotic prophylaxis, and appropriate wound care. However, prevention also extends beyond the health facility, as women need adequate knowledge and skills to continue appropriate self-care after discharge.

Despite the importance of post-caesarean self-care, discharge education has not been sufficiently emphasized. Evidence from Mbarara Regional Referral Hospital indicates gaps in women's knowledge and practices regarding post-caesarean self-care.[7] Similarly, studies have reported that women may leave hospital without adequate knowledge of essential self-care practices needed during recovery and for preventing or recognizing postoperative complications.[7–9] Effective discharge education is therefore important for preparing women to manage their recovery, recognize potential complications, and seek appropriate care following discharge.[10]

While maternal knowledge and self-care practices have received attention, less is known about the factors influencing healthcare providers' ability to deliver effective discharge education, particularly education focused on the prevention and early recognition of puerperal sepsis. Healthcare providers work within clinical environments where their knowledge and skills, available resources and opportunities, and motivation may influence how discharge education is planned, delivered, and reinforced. Understanding these factors is particularly important at Mbarara Regional Referral Hospital, where puerperal sepsis remains an important maternal health concern.

The COM-B framework provides a useful lens for examining these factors by considering Capability, Opportunity, and Motivation as interacting influences on behavior.[11] In this study, Capability encompassed providers' knowledge and skills related to puerperal sepsis prevention and post-caesarean self-care; Opportunity reflected the availability of time, resources, educational materials, space, and organizational support for delivering discharge education; and Motivation captured providers' willingness, confidence, and commitment to providing this education. Using these domains, this study explored the facilitators and barriers influencing healthcare providers' provision of discharge education for puerperal sepsis prevention following caesarean section at Mbarara Regional Referral Hospital.

Methods

Research Question

The study explored the following research question: What are the facilitators and barriers influencing healthcare providers' provision of discharge education for puerperal sepsis prevention following caesarean section at Mbarara Regional Referral Hospital?

Study Design

An exploratory qualitative study design was employed to explore and understand, from healthcare providers' perspectives, the facilitators and barriers influencing the provision of discharge education for puerperal sepsis prevention following caesarean section.

Study Site

The study was carried out at Mbarara Regional Referral Hospital (MRRH), the largest referral hospital in Southwestern Uganda. MRRH serves a population of approximately 4.6 million people living predominantly in rural, agrarian settings, with a catchment area that includes Buhweju, Bushenyi, Mitooma, Kazo, Ntungamo, Kiruhura, Ibanda, Isingiro, Rubirizi, Rwampara, Sheema, Mbarara, and Mbarara City, as well as refugee settlements such as Nakivale and Oruchinga. The hospital has approximately 350 beds and serves as a teaching hospital for medical and nursing schools, including Mbarara University of Science and Technology (MUST). MRRH provides general and specialized care and has diagnostic and therapeutic capabilities. Its clinical departments include outpatient services, obstetrics and gynaecology, anaesthesia, microbiology, pathology, radiology, paediatrics and child health, internal medicine, surgery, pharmacy, and dental services. The obstetrics and gynaecology unit serves women from Mbarara, Bushenyi, Sheema, Rukungiri, Isingiro, Ntungamo, and Ibanda. MRRH has been reported to have a caesarean section rate of approximately 40%, with 865 of 2151 deliveries attributed to caesarean section during a three-month period from 1 January to 31 March 2019.[12]

Study Population and Purposive Sampling

The study population comprised final-year Obstetrics and Gynaecology senior house officers (SHOs) and midwives who had worked in the Obstetrics and Gynaecology/postnatal ward for at least two years. Purposive sampling was used to deliberately select participants with relevant experience in post-caesarean care and discharge education. The two cadres were selected because they have distinct but complementary responsibilities in the care and education of women following caesarean section, allowing the study to capture different perspectives on the facilitators and barriers to discharge education for puerperal sepsis prevention.

All midwives who had worked in the Obstetrics and Gynecology unit for more than two years and final-year senior house officers were eligible to participate. Those who met the eligibility criteria but were unavailable during the study period were excluded.

A total of 12 healthcare providers were interviewed, comprising six senior house officers and six midwives. Participants were recruited until data saturation was reached, defined as the point at which no new information emerged within each professional group.

In-Depth Interviews

Data were collected through individual in-depth interviews. The researcher approached potential participants on the Obstetrics and Gynaecology ward and introduced the study. Those who agreed to participate selected a convenient time for the interview when they were not busy with their hospital duties, and a formal appointment was made.

At the appointed time, participants provided written informed consent and audio-recording consent before the interview. Interviews were conducted in a separate room and lasted between 45 minutes and 1 hour. The interviews were audio-recorded, and field notes were taken. Participants were compensated for their time. Data collection commenced on 24 June 2025 and concluded on 13 August 2025.

The interviews were conducted by a trained research assistant with a midwifery background who was not working in the Obstetrics and Gynecology ward and had no professional supervisory or evaluative role over the participants. Participation was voluntary and confidential.

COM-B-Informed Interview Guide

An in-depth interview guide was developed using elements of the COM-B framework. Guiding questions and probes were developed around the COM-B constructs, including whether healthcare providers were physically and

psychologically capable of providing discharge instructions, whether they had the resources and opportunities required to provide discharge education, and whether they were motivated to provide discharge instructions to mothers who had delivered by caesarean section. The interview guide was developed in English because healthcare providers have a general understanding of the language, as their training in medical schools is conducted in English.

The interview guide was piloted through two initial interviews with healthcare providers. Following transcription and review of these interviews, the questions were refined to improve their clarity, depth, sequencing, and alignment with the study objectives. For example, the question, "What is the relationship between caesarean section and puerperal sepsis?", was used as an opening question to initiate discussion and encourage participants to reflect on puerperal sepsis prevention following caesarean section. Subsequent questions were refined to facilitate deeper exploration of the facilitators and barriers to providing discharge education for puerperal sepsis prevention. The refinement process improved the flow of the interview guide while ensuring that the questions remained focused on the study objectives.

Concurrent Data Collection and Analysis

Data collection and analysis were conducted concurrently. Data saturation was assessed through ongoing coding and thematic analysis during data collection.

Among the senior house officers, the initial interviews (HW001–HW002) generated several new codes, subthemes, and themes, reflecting a wide range of ideas at the beginning of the study. By HW009, only a few new codes and subthemes were emerging, and no new themes were identified, indicating that the data were beginning to stabilize. From HW010 to HW012, no new codes, subthemes, or themes were generated, and the data became repetitive. Saturation was therefore considered achieved after HW010, as no further new information emerged in the final interviews.

Among the midwives, early interviews (HW003–HW004) generated multiple new codes, subthemes, and themes. By HW005, the emergence of new information had significantly reduced and the coding framework had largely stabilized. From HW006 to HW008, no new codes, subthemes, or themes were identified, and the data became repetitive. Saturation was therefore considered achieved after HW005, as no further new information emerged in subsequent interviews.

Thematic Analysis

The audio-recorded interviews were transcribed verbatim by the research assistant. The analysis involved an iterative process in which the transcripts were read repeatedly to identify similarities and patterns in participants' statements. Statements with similar meanings or direction were assigned codes, and related codes were grouped into subthemes. These subthemes were subsequently reviewed and organized into overarching themes (see Supplementary Table S1).

The themes were not predetermined. The COM-B framework was used as a theoretical lens to guide the interpretation and organization of the findings into the domains of Capability, Opportunity, and Motivation. Thus, codes and subthemes were developed from participants' responses, while the COM-B framework guided the interpretation and organization of the emerging findings. Facilitators and barriers to the provision of discharge education for puerperal sepsis prevention were identified within these domains.

To enhance the rigor of the analysis, an independent member of the research team, who was one of the study supervisors and was not involved in conducting the interviews or the initial coding, reviewed the categorization of responses and emerging themes. The review focused on the consistency and coherence of the analysis and its alignment with the study objectives. Areas requiring clarification were discussed within the research team.

Reflexivity and Rigor

The credibility of the study was enhanced through the use of an interview guide with probes that allowed participants to fully express their views. The COM-B constructs provided guidance for formulating the questions and maintaining the direction and focus of participants' responses.

The interviews were conducted by a trained research assistant with a midwifery background who was not working in the Obstetrics and Gynaecology ward and had no professional supervisory or evaluative role over the participants. Before data collection, the researcher and research assistant reflected on their prior experiences and potential biases related to providing discharge education and consciously sought to bracket their preconceptions about the discharge process during

data collection and analysis.[13] The research assistant used open-ended and non-judgmental questions and avoided leading questions or expressing personal opinions. Participants' words were quoted directly in the Results, with their meanings interpreted in the Discussion, to enhance the credibility and transparency of the findings.

For dependability, the interview guide was carefully developed and refined following two initial interviews to improve the clarity, sequencing, and depth of the questions. Interviews lasting between 45 minutes and 1 hour allowed sufficient time for participants to provide detailed accounts of their experiences. The researcher and research assistant listened to the audio recordings and compared them with the transcripts to ensure that the transcripts accurately reflected participants' recorded responses.

For confirmability, the researcher remained aware of personal assumptions and potential biases throughout data analysis. Personal feelings, biases, and insights related to participants' responses were recorded as notes after each interview to enhance transparency and minimize the influence of the researcher's personal views on interpretation. The interview guide and probes allowed participants to share their views freely, while clarification was sought where responses were unclear.

Although transferability was not the primary intention of the study, the experiences reported by healthcare providers may have similarities with those of healthcare workers in other regional referral hospitals in Uganda, where discharge processes may have similar characteristics. Therefore, the findings may have some relevance to similar settings within the region.

The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines to promote transparent and comprehensive reporting of the research process and findings.

Data Management

Audio-recorded data were backed up on the researcher's computer immediately after each interview for safety and limited access. Transcripts were stored in soft and hard copy by the researcher. To ensure confidentiality, all audio recordings were transferred from the audio recorder and stored on an external hard drive accessible only to the principal investigator. The recordings will be retained for five years and then permanently deleted. Participants could not be identified or traced, as all data were labelled using unique participant identification codes that were not linked to consent forms or personal identifiers.

Ethics

Ethical approval to conduct the study was obtained from the Faculty of Medicine Research Ethics Committee of Mbarara University of Science and Technology (MUST-2024-1696) on 30 November 2024 and was renewed on 2 February 2026. All participants provided written informed consent and consent for audio recording before participation. The participants consent form included publication of anonymized responses/direct quotes.

Participation was voluntary, and participants were informed that they could decline to participate. No participants withdrew from the study.

Confidentiality was maintained throughout data collection, analysis, and reporting. Participants were assigned unique identification codes, and no personal identifiers were used in the analysis or reporting of findings. Audio recordings and transcripts were securely stored with access restricted to the principal investigator.

Results

Demographic Characteristics

A total of 12 healthcare workers were interviewed, comprising 6 midwives and 6 senior house officers in Obstetrics and Gynaecology. Of the participants, 4 were male and 8 were female. Their ages ranged from 34 to 59 years, with between 6 and 30 years of professional experience, as shown in Table 1.

Summary of Themes and Subtheme

A total of seven themes were generated from the data collected from the participants, as presented in Table 2

Table 1 Demographic Characteristics of the Participants

Participant ID	Designation	Years of Experience
HW 001	Senior House Officer	8
HW002	Senior House Officer	8
HW003	Midwife	30
HW004	Midwife	23
HW005	Midwife	30
HW006	Midwife	11
HW007	Midwife	10
HW008	Midwife	20
HW009	Senior House Officer	7
HW010	Senior House Officer	10
HW011	Senior House Officer	10
HW012	Senior House Officer	6

Table 2 Table Showing the Themes and Subthemes

COM-B Domain	Overarching Theme	Corresponding Subthemes
Capability	**Clinical knowledge and experience**	Extensive clinical experience Knowledge of puerperal sepsis Knowledge of risks for puerperal sepsis Knowledge of prevention of puerperal sepsis following caesarean section
	Physical capability	Physical exhaustion and fatigue
Opportunity	**Health-facility opportunities**	Availability of the discharge form Language and literacy Limited post-caesarean-specific information on the discharge form Availability of educational materials and stationery Time and staffing Ability to gather mothers for group education Space and privacy Availability of mothers and coordination of care Differences in discharge timing between SVD and caesarean delivery
	Social and interpersonal opportunities	Teamwork and shared discharge responsibilities Positive feedback and follow-up between healthcare providers Perceived maternal engagement during discharge education
Motivation	**Professional commitment**	Awareness of the consequences of inadequate discharge information Educating mothers as part of professional responsibility and passion for patient care
	Demotivating factors	Lack of appreciation, negative attitudes Perceived maternal readiness to receive instructions

Narratives from the Responses of the Participants

Twelve healthcare providers participated in the study, comprising six senior house officers and six midwives. The findings are presented according to the three domains of the COM-B framework: Capability, Opportunity, and Motivation. Within each domain, the findings are organized into overarching themes and subthemes. Participants' accounts are presented as findings, followed by brief descriptive synthesis and illustrative quotations.

Capability

Two overarching themes were identified within the Capability domain: clinical knowledge and experience and physical capability.

Clinical Knowledge and Experience

Extensive Clinical Experience

Participants described having several years of experience caring for mothers following caesarean section. They reported that their clinical experience was accompanied by confidence in providing discharge instructions. Experience ranged from approximately six to thirty years.

> Okay, my work experience with mothers, including my years of residency, now I'm coming in my eighth year. HW001, SHO

> Aah! Basically, I have worked for almost 6 to 7 years. Because I worked as a medical officer for almost 5 years before I came back. And now it is my third year, so definitely that is like 8 years. I can give a discharge. HW002, SHO

> I have almost 30 years of experience. Yes, we are confident because we have worked with these mothers for many years and know the information they need. Although some mothers may think they already know what to do, they still value and trust the guidance given by a midwife. HW005, Midwife

> I have worked six years… With the experience I have gained over the years, I feel confident when giving discharge instructions to mothers. HW012, SHO

Knowledge of Puerperal Sepsis

Participants demonstrated knowledge of puerperal sepsis and described its occurrence following caesarean section, associated signs and symptoms, preventive measures, and practices they considered harmful. Their accounts covered the risks of puerperal sepsis, signs and symptoms, preventive measures, and post-caesarean practices that they considered to increase the risk of infection.

Knowledge of Risks for Puerperal Sepsis

Participants described puerperal sepsis as a risk occurring across different stages of caesarean section care, including before surgery, during surgery, during the postoperative period, and after discharge. They also described hygiene-related and cultural practices at home as factors they considered relevant to infection risk. Surgical factors, contamination during surgery, hygiene practices, wound care, sanitary pad use, and application of herbs or other substances to the wound were among the factors mentioned.

> I know that mothers who have undergone a caesarean section are at a higher risk of developing puerperal sepsis because the surgery involves opening the tissues, which can allow pathogens to enter the wound, surrounding tissues, and even the abdominal cavity. HW009, SHO

> And also the fact that during the caesarean section, if there is contamination of the, maybe meconium stain liquor, into the peritoneal cavity, that mother may be at higher risk of getting puerperal sepsis, compared to mothers who have a vaginal delivery. HW010, SHO

> What usually comes to my mind is that some mothers, after undergoing a caesarean section, maintain good hygiene while others do not. When a mother fails to maintain proper hygiene—such as cleaning her private parts, washing her hands regularly, and changing her sanitary pads frequently—she becomes more susceptible to infection. HW006, Midwife

> Some cultural beliefs and practices can increase the risk of puerperal sepsis. Mothers who are not well informed may apply herbs or other substances to the incision site, increasing their risk of infection. HW010, SHO

> You may also find that some mothers clean the rest of their bodies but neglect the wound, keep it covered all the time, avoid bathing, or fail to change their sanitary pads regularly, which can contribute to infection. HW010, SHO

Knowledge of Prevention of Puerperal Sepsis Following Caesarean Section

Participants described several practices that they communicated to mothers as measures for preventing puerperal sepsis following caesarean section. These included hygiene, medication adherence, nutrition, wound care, ambulation, follow-up, and recognition of danger signs. Participants also described avoidance of sexual activity during the recommended period and preoperative hygiene practices.

> So, I have to emphasize the need to take the antibiotics as prescribed and finish the whole dose. I explain the things that can increase their risk of getting an infection, such as poor hygiene. I also tell them about the danger signs to look out for and advise them to come back to the hospital if they notice any of these signs. HW010, SHO

> When we are discharging these mothers, we tell them about diet, how to keep the scar clean and dry. Also the changing of pads as expected, taking the prescribed medications, doing exercises and to avoid sex with their husbands because some may not be feeling any pain and may think it is okay yet it's not. HW005, Midwife

One participant also described preoperative hygiene practices:

> When these mothers with their labor, they move in dust, even they are not from a clean environment, at least we should encourage them to first bathe. We used to do that, encourage them, give them soap and water. Because we used to have a warmer in a sluice room. So, those mothers used to bathe and they go to theatre when they are clean. HW005, Midwife

Physical Capability

Physical Exhaustion and Fatigue

Participants described physical exhaustion and fatigue during periods of high workload. They reported caring for large numbers of mothers while also undertaking other clinical and administrative responsibilities. Hunger, tiredness, multiple responsibilities, and completion of discharge documentation were mentioned in these accounts.

> Like you find yourself overwhelmed! 13 mothers are waiting and it is coming to 2 p.m. You're hungry and haven't even had anything to eat. So you think to yourself, let me leave them, they will go and sort themselves because you are tired and overwhelmed. HW007, Midwife

> The senior residents (final year SHOs) conduct the ward round, after the last patient everyone runs away and leaves all the work to the interns. Then the intern has to write like 10 discharge forms and at the end of the day he also fails to educate the mothers because he is also already tired, he will just write, give to the mothers and they go home. HW009, SHO

Opportunity

Two overarching themes were identified within the Opportunity domain: health-facility opportunities and social and interpersonal opportunities.

Health-Facility Opportunities

Availability of the Discharge Form

Participants described the discharge form as an available resource used during the discharge process. They reported that it contained prompts covering selected areas of health education, including hygiene, diet, family planning, danger signs, return dates, and other discharge instructions.

> Yes, one is the discharge form itself. It includes prompts that remind you of what needs to be discussed with the patient. For example, it highlights key areas such as family planning and danger signs, which are clearly stated on the form. This helps to remind and encourage us to cover these topics during discharge education. HW009, SHO

> We use a standardized printed discharge form for all mothers, including those with normal deliveries. The form contains key instructions that must be provided, as well as a section for any special considerations for the mother. It outlines issues such as hygiene and diet, and includes danger signs for both the mother and baby that require a return to the hospital. It also indicates the return date, which is given on an individual basis. HW007, Midwife

Language and Literacy

Participants described language and literacy as challenges associated with the use of the discharge form. They reported that the form was written in English while some mothers spoke Runyankole or other languages and some could not read. Participants described difficulties communicating discharge information when mothers could not read the form or when the language used by the healthcare provider differed from that spoken by the mother.

> We use a discharge form, but the patient often does not understand the information written on it. Most of our patients are illiterate. HW001, SHO

> The form is written in English, yet most mothers speak Runyankole. As a result, they often view it simply as a document confirming discharge. They may only focus on the treatment given, while the other information does not receive much attention. Therefore, those who do not understand English miss out on important instructions. HW009, SHO

> For mothers who cannot read, we still write the information and give them the discharge form to take home. However, we mainly focus on telling them the return date. Other instructions, like what signs to watch for such as fever after discharge, are not always clearly explained. That is the challenge we face. HW002, SHO

> Personally, I think language barrier is a major challenge. We see patients from Rwanda, Burundi, and Congo. For example, I cannot speak Congolese languages, and many of them speak French, which I do not understand. In such cases, I end up relying on written instructions. However, communication becomes very difficult because although I know what I want to explain, I cannot effectively convey it using language or signs. This greatly hinders patient education. HW012, SHO

Limited Post-Caesarean-Specific Information on the Discharge Form

Participants described the discharge form as being used for both vaginal and caesarean deliveries and reported that it did not contain detailed information specific to post-caesarean self-care. They described gaps concerning hygiene, stitch removal, catheter removal, and some cultural practices.

> One challenge we have is that our discharge form is not specific for mothers who have had a caesarean section. We use the same form for both normal delivery and caesarean section, so there is nothing special written for caesarean mothers. Even though the form helps guide what we should talk about, some important points for caesarean mothers can be missed because everything is general for all mothers. HW009, SHO

> Maybe before the doctor signs, there could be a space to include detailed information about hygiene. The form could also have a section for specific details, such as stitch removal and catheter removal, because currently these are not included. HW008, Midwife

> Another problem is that the form does not include some cultural practices. If we do not talk about them, patients may think they are okay. For example, some people put herbs on wounds, but this should be explained as not good. HW011, SHO

Availability of Educational Materials and Stationery

Participants described occasional shortages of stationery and difficulties obtaining printed discharge forms. They reported that shortages of printing materials and the absence of a printer sometimes resulted in mothers being asked to photocopy discharge forms.

> Even the basic supplies are sometimes inadequate. For example, this morning we had to ask a mother to go and photocopy a discharge form. Some mothers do not have money. We may have a system, but it does not have a printer. In such situations, we are unable to provide a discharge document, yet we cannot send a mother home without one. HW003, Midwife

Time and Staffing

Participants described limited staffing and competing responsibilities during discharge periods. They reported large workloads, multiple roles, and limited time for explaining discharge information.

> I think basically it could be an issue of man power, because we are having a lot of work to do. So they will not concentrate on proper explanation of what is on the discharge form. HW002, SHO

> When a midwife is working alone and doing many roles, such as escorting, working on the ward, and doing discharges, there is often no time to give proper education. They may just give the discharge form to mothers without explaining it well. Because of this, some mothers go home without drugs and later come back sick with infection. HW003, Midwife

> We are very few staff, so teaching is usually done in a general way. When there are about 20 mothers, only a few may get clear information. I would prefer to teach each mother one by one, but because of few staff, this is very difficult. HW007, Midwife

Ability to Gather Mothers for Group Education

Participants described gathering mothers together for group health education before discharge. They reported that these sessions covered areas such as diet, care of the mother and baby, and follow-up.

> Yes. At discharge, mothers are gathered together and given health education on diet and care of the mother and baby. We also give them a return date for check-ups at the hospital or nearest health center. This is done whether they have stitches or not."HW006, Midwife

Space and Privacy

Participants described limited physical space and privacy during group health education sessions. They reported that education sometimes took place in corridors or crowded areas where mothers were breastfeeding, caring for babies, or surrounded by people moving through the area.

> There is pressure to free up space, so sometimes it does not matter whether the mother has been educated or not. The main concern becomes discharging her so that another mother can be admitted. HW009, SHO

> Another challenge is the lack of proper space where mothers can sit comfortably and receive health education. Currently, we use a corridor, which is open and busy, with people passing by. In such a setting, mothers cannot concentrate well or ask questions freely. Those who do not understand find it difficult to seek clarification because there is no privacy. HW009, SHO

> There is a lack of good space. There should be a proper room where mothers are received and taught, but this is not available. Instead, mothers sit in corridors in large numbers, some breastfeeding and others with crying babies. This makes it very hard to give health education. If you are not personally motivated, you may even stop trying."HW012, SHO

Availability of Mothers and Coordination of Care

Participants described situations in which mothers were temporarily away from the postnatal ward because they were attending to babies admitted to the neonatal intensive care unit. Participants reported that some mothers were absent when discharge education was conducted because they were attending to their babies in other wards.

> Another issue is that mothers sometimes miss health education because they are busy with their babies in the NICU. Because of this, they miss important information, including details about infections. HW004, Midwife

> … some mothers have babies in the pediatric ward. After being reviewed and told they are ready for discharge, they rush to breastfeed their babies. By the time they return, the health talk has already been done, and they are only informed that they have been discharged and given the discharge form. HW009, SHO

Differences in Discharge Timing Between SVD and Caesarean Delivery

Participants described differences in the timing of discharge education for mothers who had spontaneous vaginal delivery and those who had caesarean delivery. They reported that vaginal delivery mothers were commonly gathered for health education earlier in the day, whereas caesarean mothers could be discharged later following medical review.

> I have noticed that mothers who deliver normally (SVD) get more health education than those who have caesarean sections, who may need it more. SVD mothers are usually gathered early in the morning and given health talks before discharge. Later, during ward rounds, attention shifts to other duties. Caesarean section mothers are discharged later by doctors, and by that time midwives are often busy or not available. As a result, these mothers miss health education and important information. HW009, SHO

Social and Interpersonal Opportunities

Teamwork and Shared Discharge Responsibilities

Participants described discharge as a collaborative process involving SHOs and midwives, with each professional undertaking different responsibilities. Participants described SHOs as assessing mothers and completing discharge documentation, while midwives commonly provided discharge education and follow-up information.

> My first role is to assess the mother and determine whether she is ready for discharge. Once I confirm that both the mother and baby are well, the wound is healing appropriately, and there are no major concerns, I make the decision to discharge her. I then complete the discharge form and, before she leaves, discuss the necessary discharge instructions with her. HW009, SHO

> The midwives play a central role in providing discharge education because they interact with mothers more frequently than doctors. While doctors may offer counselling to mothers with complicated cases, such as those who experienced severe maternal complications, most mothers receive discharge information from midwives. After I complete the discharge documentation, the midwife usually conducts a group health education session before the mothers leave the facility. HW012, SHO

> As a midwife, my role begins after the doctor has reviewed the mother and recommended discharge. I educate the mother about the instructions in her discharge plan, including when to remove stitches or a catheter, the medications she needs to take and for how long, and any follow-up care required. I also explain the danger signs to watch for and provide guidance on how to continue caring for herself at home after discharge. HW007, Midwife

Positive Feedback and Follow-Up Between Healthcare Providers

Participants described healthcare workers reminding one another about incomplete discharge documentation and ensuring that mothers received discharge information. They reported that healthcare workers reviewed discharge documentation, identified missing information, completed gaps, and followed up on mothers who were ready for discharge.

> … our role begins once the doctors complete the discharge documentation. We review the forms to ensure all necessary information is included. We fill in any gaps where necessary and explain the discharge instructions to the mother to ensure she understands the information before leaving the facility. HW003, Midwife

> Midwives will remind you that a patient who is ready for discharge does not yet have a discharge form. Even when the patient is discharged, the process may not be completed, so they follow up to ensure the discharge form is written. After that, they also ensure the mother is properly talked to and given the necessary discharge information. HW012, SHO

Perceived Maternal Engagement During Discharge Education

Participants described differences in mothers' attention and willingness to remain during discharge education. They reported that some mothers talked to others, breastfed, waited for transport, or left before the discharge process was completed. Participants described mothers' attention, patience, availability, and willingness to remain during discharge education as varying across discharge encounters.

> When you give them enough time, they usually listen and follow instructions. But sometimes we do it quickly and gather about 15 mothers at once. While you are talking, some are talking to friends or breastfeeding, so they are not paying attention. HW003, Midwife

> The number of patients also makes it difficult. You may be discharging about 40 mothers, and they may not be patient enough to wait for the process to finish. Some leave before completing the discharge and even leave the discharge forms behind. Others are already waiting for transport and cannot stay longer. HW003, Midwife

> You find that some people are not paying attention, so they miss important information. Others are very excited and just want to go home, so they do not listen to what you are saying. They just want to be told that their discharge letter is ready so they can go home. HW009, SHO

Motivation

Two overarching themes were identified within the Motivation domain: professional commitment and demotivating factors.

Professional Commitment

Awareness of the Consequences of Inadequate Discharge Information

Participants described their awareness of complications associated with puerperal sepsis as a reason for providing discharge education. They referred to infection, sepsis, prolonged hospital stays, hysterectomy, and other complications when describing why they considered discharge education important.

> We know that mothers who undergo caesarean section are at risk of infection, and some return with surgical site or sepsis. In some cases, they even end up losing their uterus. This is a serious problem. That is why it is important to provide clear information, because if patients understand, they can help prevent major complications. That is how I see it, and it strongly motivates me. HW002, SHO

> Knowing the dangers that can occur if a mother is not educated is a strong motivation to talk to her. You know that if you do not, there may be no one else to give her the information. This alone drives you to communicate verbally about what she should and should not do after a caesarean section, even if it is not written down. HW012, SHO

> I do not like seeing mothers with sepsis on the ward because they stay longer and sometimes occupy beds for months. Given the shortage of beds, this pushes me to educate mothers so as to prevent complications and reduce the chances of them coming back. HW007, Midwife

Educating Mothers as Part of Professional Responsibility and Passion for Patient Care

Participants described discharge education as part of their professional responsibilities and referred to their interest in caring for and educating mothers. They described professional responsibility, enjoyment of their work, passion for patient education, and concern for mothers as reasons for providing discharge education.

> I love my work and I feel happy really to be managing these mothers. I have the knowledge; why shouldn't I give it out? Because we are here for these mothers. The first thing, if you love your work, nothing will stop you from doing what you are supposed to do. HW004, Midwife

> So what drives me? To me I feel it is part of my job description. So if I'm called here and I do not give what I'm supposed to do then I feel I'll be blamed. I have to give what I'm supposed to like finding a mother outside asking a fellow mother or another stranger outside about a discharge form. It will actually make me feel bad. So I'll find myself giving all this comprehensive care because it is part of my job description. HW007, Midwife

> Aa! For me the education instructions are about my passion. So for me, most of the mothers that I work on, especially in the private setting where you have few, I have time, I can sit and talk to these mothers. HW009, SHO

> In such situations, passion drives the care of the mother because you want the best for the patient. With low staffing levels, you are guided by passion, knowing that if you do not do it, there may be no one else to do it. HW011, SHO

> What motivates me is that I like mothers. I enjoy taking care of them and seeing them go home with their baby. That alone motivates me to go and support that mother. HW010, SHO

Demotivating Factors

Lack of Appreciation, Negative Attitudes, and Perceived Maternal Readiness to Receive Instructions

Participants described circumstances that they perceived as reducing their motivation to provide discharge education. These included perceived lack of appreciation, negative attitudes, workload, and mothers' readiness to receive information. Participants described situations involving pressure, limited appreciation, Competing maternal priorities and limited engagement during discharge education

> Patients are often tired from waiting and may even blame you. There is no appreciation because they have also experienced a difficult situation. They just want to go home, and they do not understand that you may be working alone. This becomes overwhelming, and under pressure you may just decide to let them get their things and leave. HW007, Midwife

> I think it may be an issue of attitude. Ideally, we all have the knowledge and skills needed to provide adequate discharge education, but it is not always being done. Some people may feel they have many other responsibilities and view discharge education as less important. As a result, it is often overlooked. HW002, SHO

> Others may decide to do the work and finish and forego health education. HW004, Midwife

Overall Findings

Across the three COM-B domains, participants described factors relating to Capability, Opportunity, and Motivation in the provision of discharge education following caesarean section. Under Capability, participants described clinical experience, knowledge of puerperal sepsis, knowledge of its risks and prevention, and physical exhaustion. Under Opportunity, participants described the availability and limitations of discharge forms and educational materials, language and literacy, staffing and time, group education, space and privacy, mothers' availability, discharge timing, teamwork, communication, and perceived maternal engagement. Under Motivation, participants described awareness of complications, professional responsibility, passion for patient care, and circumstances associated with reduced motivation to provide discharge education.

Discussion

This study explored the facilitators and barriers influencing healthcare providers' provision of discharge education for the prevention of puerperal sepsis following caesarean section. Using the COM-B framework, the findings show that the delivery of discharge education was influenced by factors related to healthcare providers' capability, the opportunities available within the clinical environment, and their motivation. Although participants generally recognized discharge education as an important part of post-caesarean care, they described several challenges that limited the time, resources, privacy, coordination, and consistency with which education could be provided. At the same time, providers' knowledge, experience, commitment to mothers' well-being, and availability of some educational materials supported the provision of discharge education.

Physical Capability

Participants described high workload and physical fatigue as barriers to providing comprehensive discharge education. They reported that caring for large numbers of mothers reduced the time available for education and sometimes meant that only information considered essential was provided. This finding is similar to previous research showing that high workloads and staffing pressures can increase physical and emotional strain among healthcare workers and may affect their ability to perform tasks consistently.[5,14,15]

However, the relationship between workload, fatigue, and quality of care is not always straightforward. High workload does not necessarily mean that care is poor, but it may reduce the time and attention available for activities such as individualized education. Participants in the present study specifically described discharge education as an activity that could be shortened when workload was high. This suggests that the main concern may not be the absence of discharge education, but reduced opportunity to provide detailed and individualized information. Strategies such as adequate staffing, appropriate distribution of workload, reasonable working hours, and opportunities for rest may therefore help providers maintain consistent discharge education.[16]

Psychological Capability

Knowledge, confidence, and clinical experience were identified as important facilitators of discharge education. Participants described how repeated experience caring for women after caesarean section increased their confidence and practical knowledge. They also emphasized the importance of understanding caesarean section, puerperal sepsis, postnatal care, and common challenges faced by mothers. This knowledge was perceived to help providers tailor information to mothers' individual needs.

These findings are consistent with evidence that healthcare providers' knowledge, skills, confidence, and self-efficacy are important for competent and quality obstetric care.[17] However, the present findings add that experience may be particularly important in helping providers identify the practical concerns that mothers may face after discharge. This suggests that discharge education may benefit from combining theoretical knowledge with practical experience and opportunities for providers to discuss common post-caesarean concerns.

Continuing professional development, standardized guidance, and practical learning opportunities may therefore strengthen providers' psychological capability to provide discharge education. However, participants' knowledge was not objectively assessed in this study, and the study did not independently assess the clinical accuracy of all information provided. The findings should therefore be understood as providers' perceptions of the knowledge and confidence they considered important for discharge education.

Opportunity

Availability of Educational Materials

The availability of educational materials was identified as an important facilitator. Participants described the discharge form, which included information on puerperal sepsis danger signs, as useful both as a reminder for healthcare providers and as written information that mothers could refer to after leaving the hospital. However, participants perceived the

available materials as insufficiently specific to the needs of women recovering from caesarean section, particularly in relation to hygiene, mobilisation, wound care, catheter care, and other aspects of recovery.

This finding is consistent with a scoping review of discharge instructions following caesarean section in sub-Saharan Africa, which found considerable variation in the information provided to women and identified gaps in the content and consistency of discharge instructions.[8] Similarly, technical consensus guidelines developed for post-caesarean care in rural Africa emphasize the need for clear and standardized information on normal recovery, danger signs, wound care, medication, hygiene, and physical activity.[18] These studies support the participants' view that discharge education should extend beyond general information on danger signs and address the practical needs of women recovering from caesarean section.

The findings therefore support the development of standardized and comprehensive educational materials that complement verbal education and remain available to mothers after discharge. Such materials should be understandable, practical, and individualized where possible. Importantly, their content should be based on current evidence-based clinical guidance rather than solely on practices described by participants, particularly because recommendations for some aspects of post-caesarean self-care may differ across settings.[19]

Language and Literacy

Participants identified limited literacy and difficulty understanding English as barriers to discharge education. They perceived that mothers who could not easily read or understand the language used in written materials might have difficulty accessing and retaining the information provided. This finding is consistent with previous research emphasizing the importance of providing maternal health information in forms and languages that women can understand.[20]

The finding is particularly relevant in the study setting, where women may have different levels of literacy and may speak different local languages. Written English materials alone may therefore not meet the needs of all mothers. The use of local languages, simple wording, pictures, demonstrations, and opportunities for questions and clarification may make discharge information more accessible.

This does not, however, demonstrate that mothers with limited literacy failed to understand the education provided. Mothers' comprehension and retention were not directly assessed in this study. The finding therefore reflects healthcare providers' perceptions of communication challenges during discharge education. Future interventions could assess whether locally appropriate language and visual materials improve mothers' understanding and recall of post-caesarean self-care information.

Perceived Maternal Engagement

Participants also described maternal engagement as an important consideration during discharge education. They reported that some mothers appeared less attentive when preparing to leave the hospital or when they were concerned about their infants, particularly when the infant was receiving care elsewhere. These accounts should be interpreted as providers' perceptions rather than objective evidence that mothers were unwilling or unable to engage with discharge education.

The finding may reflect the circumstances in which discharge education is delivered. Women may be recovering from surgery, experiencing fatigue or discomfort, preparing for discharge, or dealing with concerns about their newborns. These circumstances may make it difficult to concentrate on lengthy or complex information. This supports the need to provide important information more than once and to use simple, practical messages that can be reinforced throughout the care process.

The present study did not directly assess mothers' motivation, understanding, or willingness to receive discharge education. Therefore, the findings should not be interpreted as evidence of maternal non-compliance or lack of interest. Instead, they highlight the need for discharge education approaches that take account of mothers' circumstances and provide opportunities for questions and clarification.

Timing of Discharge Education

Participants differed in their views about when discharge education should be provided. Some described education as occurring mainly at the point of discharge, whereas others felt that it should begin earlier, including before caesarean

section or soon after the procedure. This variation suggests that there was no consistently applied approach to the timing of discharge education.

Previous studies have similarly described different points at which maternal health education may be provided, including antenatal care, admission, and discharge.[21,22] However, providing important information only at discharge may be challenging because women may be tired, anxious, focused on returning home, or preoccupied with their newborns.[23] The findings from the present study therefore support an approach in which discharge education is introduced earlier and reinforced at different stages of care.

For women undergoing caesarean section, education could begin during antenatal care or before surgery, continue during the postnatal period, and be reinforced before discharge. Such an approach would provide repeated opportunities for women to receive information, ask questions, and clarify concerns. It may also reduce the amount of information that needs to be delivered at a single point immediately before discharge. However, this study did not compare different education schedules and therefore cannot determine which timing strategy is most effective for improving maternal knowledge or outcomes.

Space and Privacy

Limited space and inadequate privacy were identified as barriers to discharge education. Participants described situations in which conversations could be overheard and perceived that this might make mothers less comfortable asking questions or discussing concerns. Similar concerns have been reported in Uganda, where limited physical space has been described as interfering with women's privacy, while high patient loads and limited time have been identified as barriers to providing individualized postpartum care[24,25] The similarity between these findings suggests that the physical environment is an important part of the opportunity available to healthcare providers to provide individualized education. However, the present study adds that providers viewed the lack of privacy as affecting not only general postpartum care but also the process of communicating discharge information. Where dedicated education spaces are not available, quieter areas, reduced interruptions, and individual or small-group education may provide more suitable environments for communication.

Nevertheless, these findings represent healthcare providers' perceptions. Mothers' actual experiences of privacy during discharge education were not assessed, and therefore the study cannot establish the extent to which lack of privacy affected their participation or understanding.

Availability of Mothers and Length of Hospital Stay

Participants also described the availability of mothers as an important consideration. Variation in the timing of discharge and the length of hospital stay meant that healthcare providers did not always have the same amount of time or the same opportunity to provide education. This concern is related to the timing and workload issues identified in the study, because discharge education must often be provided within a limited period before a woman leaves the hospital.

Evidence from Uganda similarly indicates that limited time and high patient loads can hinder individualized postpartum care.[24] Evidence from a separate Ugandan qualitative study of hospital discharge planning for older adults also identified understaffing, workload, and insufficient time as barriers to effective discharge planning.[26] Although the latter study focused on older adults rather than post-caesarean women, its findings highlight the broader influence of the clinical environment on healthcare providers' ability to undertake discharge-related activities. Together, these findings suggest that discharge education is influenced not only by providers' knowledge and capability, but also by whether the clinical environment provides sufficient time and opportunity for them to deliver it.[24,26]

This supports the need for discharge education to be integrated into the care pathway rather than left entirely to the final moments before discharge. Early and repeated education may be particularly useful where hospital stays are short or discharge times vary. However, the present study did not objectively measure length of stay or determine how it affected the amount or quality of education provided.

Staffing and Workload

Participants perceived staffing levels as insufficient in relation to the number of mothers requiring care. They described high workload and limited time as reasons why providers sometimes prioritized essential information rather than

providing comprehensive education. Similar findings have been reported in Uganda, where understaffing, high patient loads, insufficient time, and competing clinical responsibilities have been identified as barriers to individualized postpartum care and discharge planning.[24,26]

The findings also suggest that the issue was not only the number of healthcare workers available but also the lack of a clearly designated person responsible for discharge education. When responsibility is not clearly assigned, discharge education may depend on individual providers' availability and workload. Standardizing responsibilities and incorporating discharge education into routine clinical processes may therefore improve consistency.

Strengthening staffing, distributing workload appropriately, providing standardized discharge guidance, and clarifying responsibilities among members of the multidisciplinary team may support more consistent discharge education. However, staffing adequacy was not independently measured in this study, and the study did not assess whether staffing limitations resulted in adverse maternal outcomes.

Teamwork and Coordination

Teamwork and coordination also emerged as important considerations. Participants reported that midwives were primarily responsible for providing discharge information but were not routinely involved in joint assessment or review with the obstetric team. They perceived that this could limit opportunities to tailor discharge education to individual maternal needs.

This finding is consistent with Ugandan studies emphasizing the importance of communication, coordination, and teamwork in the delivery of quality maternity and postpartum care.[24,25] The present findings further suggest that coordination between professional groups may be relevant to discharge education because different providers may hold information that could help tailor education to a woman's clinical condition and recovery needs.

However, clinical handovers and multidisciplinary communication were not directly observed in this study. Therefore, the findings should be interpreted as participants' perceptions rather than as an objectively demonstrated failure of teamwork. Further research using observation could provide a better understanding of how different healthcare providers contribute to discharge education.

Participants also pointed out that completion of a discharge form does not necessarily mean that a mother understood the information provided. Documentation confirms that information was provided, but does not by itself demonstrate comprehension. The teach-back approach, in which patients explain health information in their own words, provides an opportunity for healthcare providers to assess understanding and clarify or reteach information when comprehension is not demonstrated[27] Incorporating questions, clarification, and assessment of understanding into discharge processes may therefore strengthen the quality of discharge education.

Motivation

Participants described commitment to mothers' well-being, passion for their work, and concern when mothers returned with puerperal sepsis as important motivators for providing discharge education. These accounts suggest that providers were motivated by both professional responsibility and concern for the well-being of mothers. Participants also described feelings of guilt or concern when mothers returned with puerperal sepsis, which they perceived as reinforcing their commitment to provide education.

These findings are consistent with evidence from East Africa showing that intrinsic factors, including altruism and professional commitment, can motivate healthcare workers, while organizational factors such as working conditions, recognition, support, and relationships also influence motivation[28] The present study therefore shows both sides of motivation: providers may be strongly committed to caring for mothers, but their ability to act on this commitment may still be affected by the environment in which they work.

Conversely, participants identified heavy workload, lack of appreciation, and negative attitudes as factors that could reduce their motivation or capacity to provide comprehensive discharge education. This is also consistent with the East African evidence, which shows that poor working conditions, limited organizational support, and inadequate recognition can reduce healthcare-worker motivation.[28] Thus, improving discharge education may require more than encouraging

individual providers to be committed to their work. Supportive working environments, recognition of staff contributions, manageable workloads, clear responsibilities, and adequate resources are also important.

Importantly, participants' concerns about mothers returning with puerperal sepsis should not be interpreted as evidence that inadequate discharge education caused these readmissions. Maternal outcomes and the actual content or quality of education received by individual mothers were not assessed in this qualitative study. Rather, these experiences illustrate how providers perceived the importance of discharge education within their clinical practice.

Conclusion

The findings in this study show that discharge education is influenced by interacting provider and health-system factors rather than by healthcare providers' knowledge or motivation alone. Providers described having knowledge, experience, commitment, and some educational resources that supported discharge education. At the same time, high workload, limited staffing, lack of privacy and space, language and literacy challenges, inconsistent timing, limited post-caesarean-specific materials, and gaps in teamwork and coordination constrained the opportunity to provide education consistently and comprehensively.

These findings suggest that strengthening discharge education should involve changes at more than one level. Providing educational materials alone may be insufficient if providers do not have adequate time, space, staffing, or organizational support to use them effectively.

Strength of the Study

This study has several strengths. First, it provides in-depth perspectives from both midwives and senior house officers involved in obstetric and postnatal care, offering complementary views of discharge education. Second, the exploratory qualitative design enabled detailed examination of contextual barriers and facilitators that may not be captured through quantitative approaches. Third, purposive selection of participants with relevant clinical experience ensured that participants had direct experience with the discharge education process.

The study also used the COM-B framework as a structured lens for interpreting factors related to Capability, Opportunity, and Motivation, while allowing themes to emerge from the data. The interview guide was piloted and refined following the initial interviews, and data collection and analysis were conducted iteratively. Together, these approaches strengthened the depth and relevance of the findings.

Limitations of the Study

Researcher bias was considered a potential concern because the researcher had prior professional contact with healthcare workers in the Obstetrics and Gynaecology ward, which could have influenced participants' responses.

To reduce the potential influence of the researcher's role and prior relationship with participants, an independent midwife who was not working in the Obstetrics and Gynaecology ward and had no supervisory or evaluative role over the participants was recruited and trained to conduct the interviews. The research assistant also reviewed the transcripts and emerging findings for inconsistencies, while the researcher and research assistant reflected on their preconceptions throughout the data collection and analysis process.

Social desirability bias may have influenced participants' responses, as healthcare providers were discussing their own discharge education practices and may have been inclined to present these practices positively. However, participants also openly described several challenges affecting discharge education, including workload, staffing constraints, limited educational materials, and gaps in coordination.

Implications for Practice

Health facilities should strengthen discharge education for women following caesarean section through a standardized, evidence-based education package covering puerperal sepsis prevention, wound care, hygiene, medication adherence, mobilisation, danger signs, and follow-up. Education should be introduced earlier in the care pathway and reinforced before discharge, using simple language, local languages, visual materials, demonstrations, and teach-back to

accommodate differences in literacy and communication needs. Clear roles should also be established among midwives and obstetric clinicians to ensure consistent delivery and documentation of discharge education.

At the health-system level, improving discharge education requires attention to Opportunity and Motivation, in addition to provider Capability. Facilities should strengthen workload distribution, staffing, availability of educational materials, suitable space and privacy, and coordination among healthcare providers. These measures would create a more supportive environment in which providers can consistently apply their knowledge and professional commitment to discharge education. Together, these strategies provide a practical approach to strengthening post-caesarean education for puerperal sepsis prevention.

Data Sharing Statement

The qualitative data generated from interviews with healthcare workers are not publicly available in a data repository. However, the de-identified data is available from the corresponding author upon request.

Acknowledgments

I sincerely thank Dr. Grace Namboozi for her encouragement and support throughout this study. I am grateful to the staff and management of Mbarara Regional Referral Hospital and the participating healthcare workers for their cooperation. I also thank Ms. Sarah Mwijukye for her assistance with data collection. Finally, I am deeply grateful to my family and friends for their unwavering support throughout the study.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

Funding

This study received no specific funding from any public, commercial, or not-for-profit organization. The study was conducted using the researchers' own resources.

Disclosure

All authors declare no conflict of interest.

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