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# From Coverage to Quality: Managing the Paradox of Safety and Alienation in Maternal Care Systems

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### Abstract

Maternal mortality remains a critical global health priority, frequently exacerbated by the underutilization of essential services despite increased physical coverage. While quantitative metrics track service reach, this study adopts a qualitative phenomenological framework to explore the experiential factors—safety, trust, and alienation—that facilitate or obstruct the maternal care continuum. Through in-depth interviews with 35 participants, the research examines a significant tension between traditional, home-based practices and formal institutional care. Findings reveal that while facility-based delivery is primarily motivated by perceptions of physiological risk, sustained engagement is often undermined by a "transactional" clinical environment that prioritizes measurements over meaningful dialogue. Many women experienced a sense of "invisibility" and alienation when consultations were rushed or culturally insensitive, leading to the critical underutilization of postnatal care (PNC). Conversely, respectful communication and emotional safety were found to significantly enhance service uptake and confidence in the health system. The study concludes that improving outcomes requires a management shift from mere service provision toward woman-centered care. Policy interventions must prioritize the integration of PNC education during the antenatal period and transform clinical environments into inclusive, supportive spaces to bridge the gap between service availability and consistent, high-quality utilization.

**Keywords:** Maternal Health, Healthcare-Seeking Behavior, Woman, Experience, Care

## 1. Introduction

Maternal mortality remains a preeminent indicator of global health disparity, functioning as a proxy for a nation's socioeconomic stability and the structural integrity of its health systems. The death of a woman during pregnancy, parturition, or the puerperium is seldom a discrete clinical event; rather, it represents the culmination of systemic neglect, gender-based inequities, and a catastrophic breakdown in the continuum of care (World Health Organization [WHO], 2025). According to the latest longitudinal analysis by the United Nations Maternal Mortality Estimation Inter-Agency Group (MMEIG), an estimated 287,000 maternal deaths occur annually, translating to approximately 800 deaths per day (WHO, 2023). While the global maternal mortality ratio (MMR) declined by approximately 34.3% between 2000 and 2020, the pace of progress has stagnated significantly. Recent data indicates that since 2016, the annual rate of reduction

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has remained essentially flat, or in some regions increased, threatening the attainment of the Sustainable Development Goal (SDG) target 3.1 of fewer than 70 deaths per 100,000 live births by 2030 (United Nations, 2023; WHO, 2025).

Geographic and economic stratification remains stark: nearly 70% of global maternal deaths are concentrated in sub-Saharan Africa (WHO, 2023). Furthermore, the lifetime risk of maternal death for a woman in a low-income country is 1 in 49, compared to 1 in 5,300 in high-income countries (United Nations Children's Fund [UNICEF], 2023). These disparities have been further compounded by the "polycrisis" of environmental instability, protracted conflict, and the secondary impacts of the COVID-19 pandemic, which disrupted essential obstetric services and widened existing gaps in health equity (United Nations Population Fund [UNFPA], 2024; WHO, 2025).

The discourse on maternal mortality has largely been framed within two dominant paradigms: a biomedical focus on direct obstetric causes—such as hemorrhage, hypertensive disorders, sepsis, and obstructed labor—and a macro-level statistical emphasis on service coverage and mortality ratios. While essential, these approaches often obscure women's lived experiences of navigating maternal healthcare systems that may be formally available yet practically inaccessible, unacceptable, or culturally incongruent (Kruk et al., 2018). The transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs) signaled a shift toward equity, quality, and continuity of care; however, structural disparities persist. Although MDG 5 achieved a 44% global reduction in maternal mortality between 1990 and 2015, progress was uneven, with several regions experiencing stagnation or reversal due to conflict, economic instability, and emerging health threats (United Nations, 2015; WHO, 2023). Achieving SDG target 3.1—reducing the global maternal mortality ratio to fewer than 70 deaths per 100,000 live births by 2030—requires an unprecedented annual decline that cannot be accomplished through infrastructure expansion alone. Evidence increasingly suggests that service availability does not ensure utilization or quality, underscoring the need to understand how women perceive and experience care across the maternal continuum (Kruk et al., 2018; Tunçalp et al., 2015).

Central to this paradox is the Three Delays Model proposed by Thaddeus and Maine (1994), which conceptualizes maternal mortality as arising from delays in deciding to seek care, reaching an appropriate facility, and receiving adequate treatment once there. While the model has been instrumental in highlighting geographic and financial barriers, the first delay—rooted in women's perceptions of risk, trust, and cultural congruence—remains insufficiently examined. Decisions to avoid institutional care are often rational responses to anticipated mistreatment rather than a lack of awareness. Evidence of disrespectful and abusive care (D&A) has been widely documented; Bowser and Hill's (2010) seminal landscape analysis identified seven forms of mistreatment during childbirth, including physical abuse, non-consented care, verbal humiliation, discrimination, abandonment, and detention. Subsequent systematic reviews confirm the global prevalence of such practices, demonstrating that experiences of physical, verbal, and emotional abuse, stigma, and non-consensual interventions substantially undermine trust in health facilities and deter both facility-based delivery and continued engagement across the maternal care continuum (Bohren et al., 2015).

At the core of the maternal health crisis lies a persistent paradox: the availability of services does not ensure their accessibility, acceptability, or quality. Programmatic success is often inferred from increased facility numbers or rising antenatal care (ANC) coverage, yet robust evidence demonstrates that poor quality of care now outweighs lack of access as a primary driver of preventable mortality. A landmark analysis by Kruk et al. (2018) estimated that in low- and middle-income countries (LMICs), 8.6 million excess deaths from conditions amenable to health care occurred in 2016, with 5.0 million attributable to poor-quality care and 3.6 million to non-utilization. This "know-do gap," wherein evidence-based practices fail to translate into routine care, manifests through stock-outs of essential medicines, informal fees despite nominally free services, prolonged waiting times, and neglectful or disrespectful provider interactions. In response, women may rationally disengage from formal services, perceiving home birth with a traditional birth attendant as safer, more culturally congruent, or more dignified than facility-based care.

The maternal care continuum—comprising antenatal care (ANC), skilled birth attendance, and postnatal care (PNC)—is often experienced as a series of fragmented encounters rather than a coherent, supportive pathway. Although global ANC coverage has increased, the quality of these interactions frequently remains inadequate, with limited

counseling, compromised privacy, and minimal emotional support contributing to disengagement. While poverty intensifies these barriers, healthcare-seeking behavior is mediated by social capital, gender norms, and intra-household power relations. In many patriarchal contexts within LMICs, decision-making authority over women's health rests with husbands or senior family members, constraining women's agency and rendering them structurally invisible within health systems. Evidence from Pakistan demonstrates how economic marginalization intersects with caste hierarchies and gender norms to exclude women from effective maternal care, despite the presence of national programs (Mumtaz et al., 2014).

This social exclusion is compounded by systemic fragility within health services. Encounters marked by supply shortages, informal payments, or dismissive provider attitudes erode trust and fracture the implicit social contract between women and the state. Such experiences have cumulative effects: negative interactions during ANC are strongly associated with subsequent avoidance of PNC, the phase in which a substantial proportion of maternal and neonatal deaths occur. Consequently, the strength of the maternal care continuum is determined less by service availability than by the quality of interpersonal care. Women consistently articulate the need for a holistic sense of well-being and relational continuity, valuing respectful communication, emotional support, and cultural sensitivity alongside clinical safety. A systematic qualitative review by Downe et al. (2018) confirms that across diverse settings, women prioritize a positive birth experience characterized by dignity, autonomy, and involvement in decision-making as integral to quality maternity care.

The maternal journey uniquely intersects biological vulnerability with profound social and ontological transitions. The transition to motherhood entails identity reconfiguration, heightened vulnerability, and expectations of recognition, making women particularly sensitive to how care is experienced and interpreted (Mercer, 2004). When healthcare systems reduce women to passive recipients or clinical "cases," they undermine this existential significance, fostering alienation and disengagement from care (Downe et al., 2018). Phenomenology offers a rigorous qualitative lens to examine these dynamics by prioritizing lived experience (*Erlebnis*) and the lifeworld (*Lebenswelt*) over abstract indicators (Husserl, 1970; van Manen, 2016). By bracketing presuppositions, phenomenological inquiry reveals how cumulative encounters with health services shape perceptions of pregnancy, risk, and care-seeking. Decisions regarding antenatal care (ANC), place of delivery, and postnatal care (PNC) are rarely purely instrumental; rather, they emerge from embodied and intersubjective meanings informed by prior interactions, family negotiations, and cultural narratives (Dahlberg et al., 2008).

Interpersonal dynamics are central to this process. Respectful, empathetic communication by providers fosters trust and continuity, whereas neglect, rudeness, or cultural insensitivity discourages engagement—particularly with PNC, which often lacks the perceived urgency of parturition (Bohren et al., 2015). Care-seeking is further embedded within kinship and social networks, where gender norms and collective memories of institutional failures shape decision-making (Mumtaz et al., 2014). Health facilities may be perceived as emotionally unsafe or culturally incongruent spaces when customary practices are dismissed, reinforcing avoidance despite physical accessibility (Davis-Floyd, 2003). Such experiential dimensions remain largely invisible to quantitative metrics, underscoring the necessity of woman-centered qualitative approaches. Accordingly, this study employs a phenomenological framework to explore lived experiences across the maternal care continuum, elucidating the facilitators and barriers to ANC, institutional delivery, and PNC utilization. By foregrounding these narratives, the study advances the understanding essential for shifting from service availability toward respectful maternity care (RMC) that upholds dignity, agency, and holistic well-being (World Health Organization [WHO], 2018).

## 2. Method of the Study

This study adopts a qualitative research design grounded in interpretive phenomenology to address the central research questions regarding how women experience antenatal care (ANC), institutional delivery, and postnatal care (PNC) across the maternal care continuum, and which experiential, interpersonal, and socio-cultural factors facilitate or

obstruct service utilization. Interpretive phenomenology is particularly suited to these inquiries as it prioritizes understanding how individuals make meaning of lived experiences rather than measuring predefined outcomes (van Manen, 2016). Theoretically, the study is informed by the phenomenological traditions of Husserl and van Manen, with an emphasis on *Erlebnis* (lived experience) and the *Lebenswelt* (lifeworld) in which maternal care-seeking unfolds (Dahlberg et al., 2008; Husserl, 1970). This framework conceptualizes the maternal journey as a significant ontological transition involving identity reconfiguration, embodied vulnerability, and relational dependence.

To ensure methodological rigor, the researcher practiced *epoché* (bracketing) through reflexive journaling and continuous self-examination to identify and temporarily suspend prior assumptions about maternal health service utilization. This process supported a faithful interpretation of participants' narratives and the study's aim of capturing women's perspectives on care experiences and decision-making. Participants were recruited using purposive sampling to ensure variation in age, parity, and care pathways among women who had experienced pregnancy, facility-based delivery, and the postpartum period within the preceding 12 months. This sampling strategy ensured the inclusion of women who had engaged with different points of the maternal care continuum. A total of 35 participants were interviewed, with recruitment continuing until data saturation was reached.

Data were collected through in-depth, semi-structured interviews, allowing participants to narrate their experiences of ANC, childbirth, and PNC in their own terms while ensuring coverage of domains relevant to the research questions. Interview guides explored perceptions of care quality, interpersonal interactions with providers, experiences of respect or mistreatment, perceived risk, cultural congruence of services, and the influence of family and community on healthcare decisions. This approach enabled an examination of how cumulative encounters across care stages shaped engagement or disengagement. Ethical integrity was maintained through approval from the relevant institutional ethics committee, written informed consent, confidentiality safeguards, and the creation of a supportive interview environment for discussing sensitive birth-related experiences. By explicitly aligning phenomenological methods with the research questions, this study aims to generate contextually grounded evidence to inform woman-centered and respectful maternity care that acknowledges dignity, agency, and holistic well-being.

### **3. Negotiating Antenatal Care: Perceptions, Trust & Engagement**

Negotiating antenatal care (ANC) is a multifaceted process shaped by women's perceptions of risk, trust in healthcare providers, and the depth of their engagement with services, all of which significantly influence health-seeking behaviors and maternal outcomes (Alemu et al., 2022). Pregnant women who possess a strong perception of pregnancy-related risks—particularly those with a history of obstetric complications or knowledge of at least one danger sign—are more likely to accurately appraise these risks. Specifically, women aware of danger signs are 5.22 times more likely to have a high-risk perception (AOR = 5.22) (Alemu et al., 2022).

However, many women perceive ANC primarily as a curative service rather than a preventive one, often seeking care only when they feel unwell or perceive a specific physical threat (Nyathi et al., 2017). This "curative" mindset reflects a low perceived susceptibility to asymptomatic risks and can lead to late initiation or underutilization of services (Alemu et al., 2022; Nyathi et al., 2017). Engagement with ANC is also deeply influenced by socioeconomic factors; even when physical access is comparable, women from more deprived backgrounds often report lower levels of personal connection to their care and fewer opportunities for shared decision-making compared to their more affluent counterparts.

Ultimately, trust and communication serve as the foundation for effective ANC engagement. Respectful, empathetic, and clear interactions foster confidence and encourage women to return for scheduled visits (Kazi et al., 2021). Conversely, inadequate communication—often stemming from provider workload or perceived discrimination—diminishes trust, exacerbates patient anxiety, and creates significant barriers to continued care (Kazi et al., 2021; Attanasio & Kozhimannil, 2015). As one of the respondents expressed:

*“I went for a check-up because everyone said the first months are dangerous. I wanted to know if something is wrong inside.”*

The quality of counseling emerged as a decisive factor in shaping trust and continued engagement. Many participants reported that consultations were rushed and narrowly focused on measurements, with little opportunity for questions or emotional expression. Such experiences contributed to feelings of invisibility and reinforced perceptions of ANC as a transactional rather than relational encounter. Another participant noted:

*“They checked my blood pressure and weight, wrote something, and told me to come next month. No one explained what it meant.”*

One woman explained:

*“I felt like my body was being checked, not me as a person.”*

In contrast, women who experienced respectful communication and clear explanations expressed greater confidence in the health system and a stronger commitment to follow-up visits. These accounts underscore the centrality of interpersonal care in fostering trust, echoing findings from qualitative studies demonstrating that respectful provider communication enhances the perceived value of ANC and continuity of care. As one participant shared:

*“The nurse spoke calmly and explained why iron tablets are important. That day I felt safe, like someone is watching over me.”*

Trust was also shaped by women’s perceptions of provider competence and attentiveness. Several participants interpreted dismissive behavior as a signal that their concerns were not legitimate, often leading them to seek reassurance from alternative sources such as traditional birth attendants, elder women, or private providers. One woman recounted:

*“When I told them I feel dizzy, they said it’s normal and don’t worry. But I was worried because nobody really listened.”*

Social and familial influences played a significant mediating role in ANC engagement. Decisions to attend or discontinue ANC were rarely made independently; instead, they were negotiated within households. Another participant said:

*“My mother-in-law said women in our family never needed so many check-ups. She said going again is unnecessary.”*

One woman added:

*“My husband said unless there is a problem, why waste money and time?”*

Importantly, women’s trust in ANC was cumulative and longitudinal. Negative early encounters had a lasting impact on subsequent engagement, even when services were geographically accessible. As one respondent described:

*“After the first visit, I didn’t feel respected. So even when I knew I should go again, I kept postponing.”*

Conversely, positive ANC experiences were described as empowering and confidence-building. This trust extended beyond ANC, shaping expectations about institutional delivery. Another participant shared:

*“Each time they explained what was happening with my baby, I felt more prepared. I trusted them when they said delivery in hospital is safer.”*

Despite these positive accounts, several women perceived ANC environments as emotionally unsafe or culturally incongruent. Clinical spaces were often described as intimidating, particularly for first-time mothers. One woman recounted:

*“I was afraid to ask questions because they scold women who talk too much.”*

Another added:

*“They don’t like when elders come inside. But I needed my mother with me.”*

Women also evaluated ANC through comparisons with community-based care. Traditional birth attendants were frequently described as more approachable and emotionally supportive. Such comparisons did not necessarily reflect a

rejection of biomedical care but rather a desire for relational continuity and affirmation, consistent with evidence that women value emotional support alongside clinical competence. As one participant noted:

*“The dai listens to me patiently. In hospital they are always in a hurry.”*

These findings suggest that ANC engagement is best understood as a process of meaning-making in which women continually assess whether care encounters affirm their dignity, address their concerns, and align with their social realities. Risk perception alone was insufficient to sustain engagement; instead, trust—constructed through respectful communication, acknowledgment of vulnerability, and cultural sensitivity—emerged as the pivotal determinant. When ANC failed to meet these expectations, women recalibrated their care-seeking strategies, often disengaging or seeking alternatives.

## 4. Institutional Birth Between Safety and Alienation

For most participants, institutional birth was neither an unequivocal refuge nor an outright rejection, but a negotiated decision shaped by biomedical risk, cultural meanings, and cumulative care experiences. Women consistently acknowledged the life-saving potential of facility-based delivery, particularly in the event of complications, yet this recognition was frequently counterbalanced by apprehensions rooted in alienation, loss of dignity, and cultural incongruence. Institutional birth thus emerged as an ambivalent space—associated simultaneously with clinical safety and emotional vulnerability.

Perceived physiological risk was a central motivator for seeking facility delivery. Women who had experienced complications themselves or within their social networks described hospitals as necessary safeguards against uncertainty. As one participant explained:

*“My first baby did not come easily at home. This time I was scared, so I went to the hospital.”*

Another woman noted:

*“Everyone says if bleeding happens, only the hospital can save you.”*

These narratives reflect findings from prior studies showing that women often conceptualize institutional birth primarily as an emergency resource rather than a preferred place for routine childbirth (Gabrysch & Campbell, 2009; Thaddeus & Maine, 1994). Safety, however, was framed narrowly around survival rather than holistic well-being.

Several participants drew a clear distinction between being clinically safe and being treated with dignity. As one respondent reflected:

*“Yes, the baby was safe, but the way they spoke to me still hurts.”*

Another woman added:

*“I felt like an object, not a mother.”*

Such accounts demonstrate that safety is experienced relationally, encompassing respectful communication, emotional reassurance, and recognition of personhood. Similar distinctions have been documented in qualitative studies across diverse settings, where women report that mistreatment overshadows positive clinical outcomes (McMahon et al., 2014; Downe et al., 2018).

Cultural incongruence further shaped women’s ambivalence toward institutional birth. Facilities were frequently described as spaces that dismissed customary practices and social support. One participant described:

*“At home, my mother would talk to me, pray for me, but in the hospital no one even looked at my face.”*

Another woman recalled:

*“They laughed when my family asked if I could sit or squat. They said, ‘This is not village style.’”*

These experiences echo anthropological research showing how biomedical models often marginalize traditional birthing practices, reinforcing feelings of exclusion and powerlessness (Davis-Floyd, 2001; Sargent et al., 2005). For many women, such dismissals translated into emotional isolation during labor. As one participant shared:

*“I knew it was safer there, but I felt very alone.”*

The perception of emotional unsafety was intensified by experiences of disrespect and neglect. Participants recounted verbal reprimands and abandonment during labor, which heightened fear and uncertainty. One woman recounted:

*“When I cried, the nurse shouted, ‘Why are you screaming now?’”*

Another participant added:

*“They left me alone for a long time. I thought something was wrong with my baby.”*

These narratives align with global evidence on disrespect and abuse during facility-based childbirth, including verbal abuse and abandonment of care (Bohren et al., 2015). Such encounters eroded trust and shaped women’s future intentions regarding institutional care.

In contrast, respectful interactions markedly transformed women’s experiences. One participant noted:

*“The midwife kept saying, ‘You are strong, I am here.’”*

Another woman explained:

*“She explained everything before touching me. I was not afraid.”*

These accounts illustrate how empathetic communication and respectful maternity care foster trust, cooperation, and a sense of safety, reinforcing findings from systematic reviews emphasizing the centrality of relational care to positive birth experiences (Downe et al., 2018). Decision-making around institutional birth was rarely an individual process. Women’s choices were negotiated within kinship networks and influenced by collective narratives surrounding hospitals. As one respondent said:

*“My mother-in-law said hospitals cut women unnecessarily.”*

Another participant explained:

*“People say the hospital is only for when something goes wrong.”*

Such beliefs often delayed facility use or framed institutional delivery as a last resort, consistent with studies demonstrating how gender norms and community memory shape maternal health behaviors (Mumtaz et al., 2014). Even when outcomes were favorable, women reported lingering ambivalence. One woman reflected:

*“They told me at least your child survived.”*

Another participant added:

*“Next time, I will think many times before going.”*

These reflections suggest that while survival mitigates immediate regret, experiences of alienation have lasting effects on trust and future engagement, reinforcing the quality–utilization gap identified in LMIC health systems (Kruk et al., 2018).

Institutional birth emerged as a contested terrain where women balanced biomedical safety against emotional harm and cultural erasure. Women did not reject institutional delivery outright; rather, they sought environments that acknowledged vulnerability, respected cultural identity, and affirmed dignity. When such conditions were absent, alienation overshadowed safety, undermining trust across the maternal care continuum. These findings underscore the imperative to move beyond coverage metrics toward embedding respectful, woman-centered care within institutional childbirth services, as emphasized in global frameworks for respectful maternity care (WHO, 2018).

## 5. Postnatal Period: Disengagement, Continuity, and Missed Care

Across participants, postnatal care (PNC) was frequently described as the most neglected phase of the maternal journey. While women often attended antenatal visits and sometimes opted for facility-based delivery, follow-up in the postnatal period was sporadic. PNC was rarely experienced as a continuous or supportive encounter; instead, it was perceived as optional or only necessary in the event of complications, highlighting a critical disconnect between service

availability and meaningful utilization. Many women interpreted PNC as unnecessary once the infant appeared healthy. As one participant reflected:

*“After my baby was born healthy, I thought, why should I go back? Nothing can happen now.”*

Another woman explained:

*“They told me to come for a check-up, but I felt fine, so I stayed home.”*

Such perceptions of low risk align with evidence from LMICs, where women often undervalue PNC relative to antenatal or intrapartum care (Say et al., 2014; Tura et al., 2013).

Women’s prior experiences during ANC and delivery strongly influenced PNC engagement. Negative or impersonal encounters reduced the likelihood of follow-up, whereas supportive interactions encouraged continued care. As one participant recounted:

*“The nurse scolded me during my first visit, so I didn’t want to see her again.”*

Another woman shared:

*“After my first delivery, the midwife explained danger signs. That helped me come back for the second baby.”*

These experiences illustrate how cumulative encounters shape the maternal care continuum, consistent with van Manen’s (2016) phenomenological emphasis on the lifeworld, where past experiences inform future behaviours. Relational care emerged as a critical determinant of PNC engagement. Women emphasized trust, empathy, and recognition of both maternal and infant needs. As one participant noted:

*“The nurse smiled and asked about my well-being, not just the baby. I felt cared for.”*

Another woman explained:

*“When they ignored me after delivery, I thought, why go again? I felt invisible.”*

These narratives align with prior research indicating that respectful, supportive interactions enhance follow-up and maternal satisfaction (Downe et al., 2018; Bohren et al., 2015).

Social and household norms also shaped PNC utilization. In many cases, decisions were mediated by husbands, mothers-in-law, or extended family. As one participant said:

*“My husband said, ‘You don’t need to go. The baby is fine, you’re fine.’ I had to obey.”*

Another woman added:

*“My mother-in-law said, ‘Women recover at home. Only go if bleeding happens.’”*

Such dynamics demonstrate how gendered power relations and social hierarchies influence maternal health behaviors, consistent with findings from Pakistan and other LMICs (Mumtaz et al., 2014; Titaley et al., 2010). Facility environments further influenced engagement. Negative impressions of crowded, impersonal wards discouraged return visits. One woman recounted:

*“The ward was noisy, crowded, and no one explained anything. I left quickly and didn’t come back.”*

Another participant noted:

*“During my stay, they didn’t let my mother visit. I felt alone and afraid.”*

Conversely, supportive environments encouraged follow-up. As one participant explained:

*“They allowed my sister to stay, explained breastfeeding, and checked both of us gently. I wanted to return.”*

These accounts reinforce that environmental and relational dimensions are inseparable in shaping perceptions of safety and value (WHO, 2018; Tunçalp et al., 2015).

Women also highlighted the prioritization of infants over maternal care, contributing to disengagement. One participant observed:

*“They checked the baby but never asked how I felt. I thought my health doesn’t matter.”*

Another woman added:

*“After delivery, everyone focused on feeding the baby. No one cared about my stitches or my pain.”*

This supports the concept of the “forgotten fourth trimester,” wherein maternal risks remain significant postpartum but are often neglected (Miller et al., 2016).

Structural barriers compounded relational and perceptual challenges. Distance, transport costs, and household responsibilities impeded follow-up. As one participant described:

*“The clinic is far, and I had to carry the baby. It was too much work.”*

Another woman explained:

*“I had chores and no one could accompany me. So I missed the postnatal check-ups.”*

These findings reflect the “Three Delays Model,” showing that availability alone is insufficient when social and logistical barriers persist (Thaddeus & Maine, 1994). Despite these challenges, some women proactively sought PNC through trusted providers or community health workers. As one participant shared:

*“The community health worker visited me at home, explained danger signs. I felt safe and went for the follow-up.”*

Another woman noted:

*“I called the nurse who helped me during labor. She told me what to watch, and I returned for my check-up.”*

These narratives illustrate that relational continuity and personalized guidance can bridge gaps in formal care, emphasizing the value of supportive, woman-centred approaches (Bohren et al., 2015; Downe et al., 2018). PNC is often undervalued due to perceptions of low risk, prior negative encounters, relational neglect, and socio-cultural constraints. Engagement depends on emotional safety, cultural sensitivity, trust, and household support—not simply physical access. Addressing these factors is essential to strengthen continuity of care, reduce disengagement, and improve maternal and neonatal outcomes. Woman-centered interventions that integrate relational care, cultural congruence, and household engagement can transform postnatal services from a neglected phase into a critical, affirming component of the maternal care continuum.

## 6. Conclusion

Across the maternal care continuum, women’s engagement with health services is a negotiated process influenced by biomedical risk, socio-cultural norms, and the quality of relational encounters. While institutional birth is recognized for its life-saving potential in managing complications, it is often experienced as an ambivalent space where the promise of clinical safety is counterbalanced by emotional alienation, disrespect, and a disregard for customary practices. These experiences of mistreatment, even when clinical outcomes are favorable, erode trust and contribute to a significant “quality-utilization gap” that leads to disengagement in subsequent stages, particularly during the often-marginalized postnatal period. Consequently, physical access alone is insufficient for sustained utilization; true safety must be redefined as an experiential construct that integrates technical competence with respectful, culturally congruent, and woman-centered care. To bridge the gap between service availability and meaningful utilization, health systems must move beyond quantitative coverage metrics to embrace care models that prioritize the dignity, agency, and holistic well-being of the mother.

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