

Utilization of Maternal Health Care Services Among Currently Married Women: A Study in Chidambaram Taluk, Cuddalor District, Tamil Nadu.

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Abstract

Reproductive health is a global concern with significant implications for women's well-being and overall human development. As a crucial component of general health, it directly affects women during their reproductive years. The International Conference on Population and Development (ICPD), held in Cairo in 1994, broadened the scope of reproductive health by emphasizing its multidimensional nature. Within this framework, maternal health—encompassing pregnancy, childbirth, and the postpartum period—plays a decisive role in determining outcomes for both mothers and newborns. Ensuring safe motherhood requires adequate health care practices that safeguard women's health, promote healthy infants, and secure long-term well-being.

According to the World Health Organization (1978), key components of reproductive health include responsible sexual behaviour, family planning, maternal care, prevention of infections, infertility management, elimination of unsafe abortion, and treatment of reproductive organ diseases. Both the Ministry of Health and WHO highlight the importance of early and adequate antenatal care (ANC), recommending a minimum of four visits for uncomplicated pregnancies.

The present study examines the reproductive health status of young, currently married women in rural areas, focusing on the utilization of maternal health care services. It explores three key components—antenatal, intra-natal, and postnatal care—with particular attention to full ANC, place of delivery, skilled attendance during childbirth, and postnatal check-ups. The study was conducted among 500 currently married women aged 18–35 years in Chidambaram Taluk, Cuddalore District, Tamil Nadu. Respondents were selected using a systematic random

sampling method to ensure representativeness of the rural population. Data were collected through a structured interview schedule and analysed statistically. Percentage distributions were used to assess patterns of maternal health service utilization, and Chi-square tests examined associations with socio-economic and demographic factors. The findings provide insights into reproductive health practices and highlight persistent inequalities in access to quality maternal care among rural women. Utilisation of maternal health care services is assessed based on the percentage of the most recent pregnancies that received such services. The analysis of the utilisation of antenatal and intranatal care by current age during the last pregnancy reveals a marked concentration in younger age groups. More than three-fifths (60.4 percent) of the respondents were in the 21–23 years age group, confirming this period as the prime reproductive age in the study area.

Keywords: Reproductive health, safe motherhood, infertility, unsafe abortion, reproductive tract infections, systematic random sampling.

I. INTRODUCTION

Reproductive health is a major global concern that operates at both macro and micro levels. While it constitutes a central issue in international health and development agendas, it directly affects women's physical, mental, and social well-being at the individual level. In recent decades, the reproductive health of adolescents and young women has gained increasing attention among policymakers, researchers, and health professionals, as it is widely recognised as a crucial determinant of gender equality, family welfare, and national development (Bloomfield & Sadler, 2019). Health, in its entirety, is a prerequisite for human well-being and development, and reproductive health forms a vital component of overall health. It contributes significantly to women's empowerment, quality of life, and the broader progress of society.

According to the World Health Organization (WHO, 1985), reproductive health is defined as “a state in which the reproductive process is achieved in a condition of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions, and processes.” This comprehensive definition underscores that reproductive health extends across the life course and encompasses the proper functioning of the reproductive system for both males and females.

The International Conference on Population and Development (ICPD), held in Cairo in 1994, further redefined reproductive health by introducing a

multidimensional perspective to women's health. The ICPD broadened the concept to include fertility regulation, infertility, sexually transmitted infections (STIs), and non-sexually transmitted reproductive tract infections (RTIs). It also introduced the concept of reproductive rights, affirming that individuals have the right to a safe and satisfying sex life, the capability to reproduce, and the freedom to decide when and how often to do so. Furthermore, the ICPD emphasised that both men and women have the right to access safe, effective, and affordable family planning methods, as well as appropriate health care services that ensure safe pregnancy and childbirth (Hildingsson & Sandin-Bojo, 2011).

The World Health Organization (1978) identified the essential components of reproductive health as responsible sexual behaviour, access to family planning services, maternal care and safe motherhood, prevention and control of reproductive tract infections, management of infertility, elimination of unsafe abortion, and treatment of reproductive organ malignancies. These components are interrelated and shaped by a range of biological, social, cultural, economic, and environmental factors that collectively influence health outcomes (Mosley & Chen, 1984).

Maternal health, defined as the health of women during pregnancy, childbirth, and the postpartum period, represents one of the most critical dimensions of reproductive health. It is a key determinant of infant and child survival and has lasting implications for family and community well-being. Despite its importance, pregnancy and childbirth continue to pose significant health risks for many women worldwide. Complications during pregnancy and delivery often result in suffering, long-term illness, and maternal mortality, particularly in low-and middle-income countries. Ensuring safe motherhood therefore requires timely and adequate health care practices that promote maternal well-being, ensure safe delivery, and support long-term health outcomes (Villar & Giuliani, 2015).

Among the major challenges affecting maternal health are reproductive tract infections (RTIs) and sexually transmitted infections (STIs). These infections remain significant public health concerns and constitute major obstacles to achieving reproductive health goals globally. RTIs and STIs are associated with infertility, adverse pregnancy outcomes, and increased maternal morbidity and mortality. In addition, the social stigma attached to these infections often discourages women from seeking timely treatment, thereby exacerbating poor reproductive health outcomes (Sengupta & Dutta, 2020).

Nutrition is another critical determinant of reproductive and maternal health. Nutritional deficiencies during pregnancy pose serious risks for both mothers and infants, including anaemia, low birth weight, and developmental delays. A woman's

nutritional status before and during pregnancy strongly influences foetal growth, lactation, and early child development. Adequate intake of calories and essential nutrients during pregnancy is therefore vital for ensuring healthy maternal and neonatal outcomes and for reducing pregnancy-related complications.

Ghana Demographic and Health Survey (GDHS) highlights that the care a woman receives during pregnancy, delivery, and the immediate postpartum period is crucial for the survival and well-being of both mother and child. One of the most effective strategies for reducing maternal morbidity and mortality is ensuring both the availability and utilisation of maternal health services, particularly antenatal care (ANC).

Antenatal care plays a central role in preventive health care for pregnant women. It involves regular medical supervision, health education, counselling, and screening aimed at early detection and management of pregnancy-related complications. The World Health Organization defines ANC as “care before birth,” emphasising its role in promoting the health of both mother and baby through education, treatment, and guidance. Similarly, the RCH/PHD–GHS annual report defines ANC as health care and education provided during pregnancy to ensure the safe delivery of a healthy baby.

Empirical research by Magadi et al. demonstrates that inadequate antenatal care is closely associated with adverse outcomes such as maternal mortality, low birth weight, and perinatal deaths. The Ministry of Health (MoH) recommends that pregnant women initiate antenatal care early and complete the recommended number of visits throughout pregnancy to maximise its benefits. The World Health Organization advises a minimum of four antenatal visits for women with uncomplicated pregnancies, with additional visits recommended for high-risk cases (Villar et al.). These visits facilitate continuous monitoring of maternal and foetal health and provide opportunities for timely medical interventions.

Despite the recognised importance of antenatal care, access to maternal health services remains limited in many developing countries. A substantial proportion of women receive inadequate or delayed antenatal care due to geographical, financial, and socio-cultural barriers. Consequently, preventable maternal deaths resulting from pregnancy-related complications continue to occur at unacceptably high levels. Antenatal care coverage, measured by the proportion of women who receive care from skilled personnel at least once during pregnancy, is therefore a key indicator of maternal health service utilisation.

While antenatal care is essential for reducing maternal morbidity, mortality, and perinatal complications, its effectiveness depends not only on the number of visits but also on the quality of care provided. The presence of skilled health professionals, availability of essential obstetric services, and a functional referral system are necessary to translate antenatal visits into positive health outcomes. Although global antenatal care utilisation has improved since the 1990s, evidence suggests that the content and quality of care in many low- and middle-income countries remain inadequate.

In India and other developing nations, utilisation of antenatal care services is strongly influenced by socio-economic and demographic factors. Women with higher levels of education, better income, and urban residence are more likely to seek timely and adequate antenatal care. In contrast, rural women, those from marginalised communities, and women with limited education face multiple barriers, including poor access to health facilities, lack of awareness, and gender-based restrictions on mobility. These inequalities contribute to persistent disparities in maternal health outcomes.

In addition to access-related barriers, issues concerning the quality of care and provider attitudes have emerged as significant determinants of service utilisation. Studies indicate that unfriendly treatment by health care providers, inadequate communication, and poor interpersonal relationships discourage women—particularly those from low socio-economic backgrounds—from using maternal health services. Women who perceive health facilities as disrespectful or discriminatory are less likely to complete recommended antenatal visits or seek institutional delivery care, thereby further widening reproductive and maternal health inequalities.

Achieving equitable and universal reproductive health care requires addressing these disparities through integrated health policies and community-based interventions. Efforts must focus on improving accessibility, affordability, and quality of maternal health services, while also strengthening health awareness, empowering women through education, and promoting respectful maternity care.

Methodology

The present study focuses on various aspects of the reproductive health status of young, currently married women in rural areas. This chapter presents an overview of the methodological framework adopted for the study. It describes the universe of the study, the sampling frame and sample size, the study area, methods of data collection, and procedures of data analysis, including a brief account of the statistical techniques employed.

The primary objective of the study is to examine the various dimensions of

maternal health and the socio-economic factors influencing it among young, Currently Married Women Residing In Rural Areas Of Chidambaram Taluk.

Objectives Of the Study

1. To examine the various gynaecological, obstetric, and postnatal morbidities and their determinants among rural women.
2. To analyse the utilisation of maternal care services during the antenatal, intranatal, and postnatal periods among young, currently married women in rural areas.

Data Collection

An interview schedule was carefully designed in accordance with the objectives of the study. Most items in the schedule were structured and close-ended to ensure uniformity and consistency in responses. The interview schedule was administered through face-to-face interviews to collect primary data from the respondents in a systematic and reliable manner.

Sample Size and Sampling Procedure

The study sample comprised 500 currently married women aged 18–35 years who had experienced at least one pregnancy at the time of the survey. Respondents were selected using a systematic random sampling technique to ensure adequate representation of the rural population. This method minimised sampling bias and enhanced the reliability and validity of the findings.

Data Analysis

The collected Results and Discussion

data were systematically coded, tabulated, and analysed using appropriate statistical techniques. Descriptive statistics, particularly percentage distributions, were used to examine patterns and trends in maternal health indicators. To assess the association between selected variables, the chi-square test was employed to determine statistical significance.

Utilisation of Maternal Health Care Services

The utilization of maternal health care services, particularly antenatal care during pregnancy, delivery care, and postnatal care, constitutes a pivotal domain within the broader spectrum of women's reproductive health. Recognizing its importance, the Government of India initiated several measures to strengthen maternal and child health services as early as the First and Second Five-Year Plans. In 1996, these services gained greater priority through their incorporation into the Reproductive and Child Health (RCH) Programme, and since 2006, they have

received additional emphasis under the National Rural Health Mission (NRHM).

According to the National Family Health Survey–4 (NFHS-4), conducted in India in 2015–16, nearly two-thirds of mothers in Tamil Nadu (62.9%) received antenatal checkups in the first trimester of pregnancy. Slightly more than four-fifths (81%) of respondents had at least four antenatal checkups. Nearly two-thirds of women consumed Iron and Folic Acid (IFA) tablets for 100 days or more during pregnancy, and 96.3 percent of deliveries occurred in health institutions (Ministry of Health and Family Welfare, National Family Health Survey–4,2015–16).

This study examines the utilization of maternal health care services, with a specific focus on antenatal, intra-natal, and postnatal care services. The study also analyses differentials in the utilization of full antenatal care, place of delivery, assistance from trained personnel at the time of delivery, and postnatal checkups among women across various socioeconomic demographic characteristics. Information on the utilization of antenatal care services was collected from currently married women aged 18–35 years who had experienced at least one pregnancy at the time of the survey.

Table -1
Percentage Distribution of Respondents by Utilisation of Maternal Care Services and Women’s Background Characteristics

Sl.No.	Socio-Economic & Demographic Characteristics	LAST PREGNANCY					
		Ante-Natal Care		Intra-Natal Care		Post-Natal Care	
		N	%	N	%	N	%
1.	Current Age (in years)						
	18-20	74	14.8	72	14.66	72	14.94
	21-23	302	60.4	299	60.90	296	61.41
	24-26	76	15.2	74	15.07	70	14.52
	27-29	39	07.8	37	07.54	35	07.26
	30+	09	01.8	09	01.83	09	01.87
2.	Educational Attainment						
	Illiterate	45	09.0	42	08.55	40	08.30

	Primary	82	16.4	79	16.09	77	15.98
	Middle	108	21.6	107	21.79	105	21.78
	Secondary	115	23.0	114	23.22	113	23.44
	Higher Secondary	128	25.6	127	25.87	125	25.93
	Degree and above	22	04.4	22	04.48	22	45.64
3.	Educational Attainment of the Husband						
	Illiterate	62	12.4	60	12.22	57	11.83
	Primary	40	08.0	38	07.74	36	07.47
	Middle	105	21.0	102	20.77	100	20.75
	Secondary	100	20.0	099	20.16	98	20.33
	Higher Secondary	160	32.0	159	32.38	158	32.78
	Degree and above	33	06.6	33	06.72	33	06.85
4.	Occupation of the Respondent						
	Housewife	187	37.4	185	37.68	183	37.97
	Employed	59	11.8	58	11.81	59	12.24
	Business	80	16.0	79	16.09	77	15.96
	Coolie / Daily Wages	174	34.8	169	34.42	163	33.82
5.	Occupation of the Husband						
	Employed	102	20.4	102	20.77	102	21.16
	Business	155	31.0	153	31.16	150	31.12
	Coolie / Daily Wages	243	48.6	236	48.07	230	47.72
6.	Household Monthly Income (Rs.)						
	Less than 5000	43	08.6	40	08.15	35	07.26
	5001-10000	189	37.8	186	37.88	184	38.17
	10001-15000	98	19.6	96	19.55	95	19.71
	15001-20000	110	22.0	110	22.40	109	22.61
	20001-25000	39	07.8	38	07.74	38	07.88
	Above 25001	21	04.2	21	04.27	21	04.36

Total	500	100	491	100	482	100
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Utilisation of maternal care services is assessed based on the percentage of the most recent pregnancies that received such services. The analysis of the utilisation of antenatal and intranatal care by current age during the last pregnancy reveals a marked concentration in younger age groups. More than three-fifths (60.4 percent) of the respondents were in the 21–23 years age group, confirming this period as the prime reproductive age in the study area. An additional 14.8 percent belonged to the 18–20 years age group, while 15.2 percent were aged 24–26 years, indicating that almost nine out of ten women were below 26 years of age. By contrast, only 7.8 percent were aged 27–29 years, and a negligible 1.8 percent were 30 years or above. This pattern suggests that childbearing is concentrated in the early twenties, reflecting the persistence of early marriage and early initiation of motherhood. This age distribution has important implications for maternal health programmes, as younger women may require targeted interventions to ensure timely and adequate utilisation of antenatal and intranatal care services.

The distribution of respondents by education during their last pregnancy reveals that the majority had attained middle to higher secondary schooling. About 21.6 percent reported middle-level education, 23.0 percent reported secondary education, and 25.6 percent reported higher secondary education, together accounting for more than two-thirds of the total. At the lower end, 9.0 percent of women were illiterate and 16.4 percent had only primary education, suggesting that nearly one-fourth of the respondents had minimal or no formal schooling. At the higher end, only 4.4 percent had completed a degree or above, reflecting limited access to advanced education. Overall, the data highlight a positive trend in female education, with a concentration in secondary schooling; however, illiteracy and low levels of higher education remain concerns that may directly influence maternal health awareness and service utilisation. The educational profile of the husbands shows a strong concentration at the higher secondary level (37.4 percent), followed by middle (21.0 percent) and secondary (20.0 percent) education. Together, these categories account for nearly four-fifths of the respondents' husbands, indicating a relatively favourable educational background. A smaller proportion of husbands were illiterate (7.0 percent) or had only primary schooling (8.0 percent), while just 6.6 percent had attained a degree or higher qualification. This distribution suggests that most husbands possessed moderate levels of schooling, which is likely to positively influence the utilisation of antenatal and intranatal care services. Education enhances awareness of health needs, improves decision-making regarding maternal care, and is often associated with better economic resources, all of which encourage service use. Nevertheless, the presence of illiteracy and the low proportion of highly educated husbands point to persistent disparities that may contribute to

unequal access to maternal health care among women.

The occupational distribution of the respondents highlights the dominance of housewives (37.4 percent) and daily wage workers (34.8 percent), together constituting more than 70 percent of the sample. These groups represent women who are either financially dependent on their spouses or engaged in insecure, low-income work, conditions that may restrict access to regular and quality maternal health services. By contrast, 16.0 percent of women were engaged in business activities and 11.8 percent were formally employed. These economically active women, though fewer in number, are likely to demonstrate greater awareness, decision-making autonomy, and financial capacity to utilise antenatal and intranatal care services. Overall, the findings indicate that occupation plays a critical role in shaping maternal health service utilisation, with economically secure groups better positioned to access and benefit from such services, while women in vulnerable occupations face significant barriers.

The occupational profile of the husbands indicates that nearly half were daily wage labourers (48.6 percent), while 31.0 percent were engaged in business and only 20.4 percent were formally employed. The predominance of wage-labour households suggests that a substantial proportion of women belonged to economically vulnerable families, where irregular income and financial constraints may hinder consistent use of antenatal and intranatal services. In contrast, women whose husbands were engaged in business or salaried employment are more likely to benefit from economic stability and greater health awareness, enabling better utilisation of maternal care. These findings underscore the importance of husbands' occupations as a key determinant of maternal health service use and reinforce the need for policies aimed at reducing economic barriers and ensuring equitable access for women from wage-labour households.

The analysis of household income reveals that a large proportion of families (37.8 percent) earned between ₹5,001 and ₹10,000 per month, followed by 22.0 percent in the ₹15,001–20,000 group and 21.6 percent in the ₹10,001–15,000 group. Taken together, more than four-fifths of the respondents belonged to households with monthly incomes ranging from ₹5,001 to ₹20,000, indicating a concentration in the lower- to middle-income categories. Only 8.6 percent of households earned less than ₹5,000, representing the most economically vulnerable segment, while 18.6 percent reported incomes above ₹20,000, reflecting relatively better-off families. These income differentials are closely linked to the utilisation of antenatal and intranatal care services, as economic resources strongly influence health-seeking behaviour. Women from low-income households are more dependent on government health services and often face barriers to institutional

care, whereas those from higher-income families are better positioned to afford private care and achieve more comprehensive coverage of maternal health services. This pattern underscores the persistent role of household economic status as a key determinant of maternal health care utilisation.

Table:2
Percentage Distribution of Respondents by Utilisation of Maternal Health Care Services and Related Issues

Sl.No.	Utilization of Maternal Health Care Services	Last Pregnancy	
		N	%
Ante- Natal Care Services			
1.	Month of first ANC checkup		
	Before 2 months	148	29.6
	After 2 months	279	55.8
	3-4 months	70	14.0
	5 and above months	03	0.6
2.	Times of Ante-Natal Checkup		
	Less than 2 times	45	9.0
	3-4times	156	31.2
	5 and more than 5 times	299	59.8
3.	Place of Ante-Natal Checkup		
	Government Hospital	228	45.6
	Private Hospital	188	37.6
	Sub-Centre / PHC	64	12.8
	Home Visits	20	4.0
4.	Taken TT injection		
	Yes	490	98.0
	No	010	2.0

5.	Taken IFA Tablets		
	Yes	478	95.6
	No	022	04.4
6.	Special foods taken at the time of pregnancy		
	Yes	475	95.0
	No	025	05.0

7.	Types food taken at the time of pregnancy		
	Fruits + Green leafy vegetables + Milk	196	38.4
	Green leafy vegetables + Milk + Whole grain powder	150	30.0
	Milk+ Egg + Fish +Vegetables +Chicken + Mutton	154	30.8

Intra- Natal Care Services

1.	Place of Delivery		
	Government Hospital	269	53.2
	Private Hospital	195	39.0
	PHC/ Sub-Center	024	04.8
	Home	012	02.4
2.	Assistant at Delivery		
	Doctors	434	86.8
	Nurse	052	10.4
	ANM /VHN	011	02.2
	Dais /Relatives	003	0.6
3.	Type of Delivery		

	Normal	305	70.0
	Caesarean Section	105	21.0
	Forceps	090	09.0
4.	Delivery Complications		
	Prolonged Labour	164	32.8
	Excessive Bleeding	085	17.0
	Fainted	102	20.4
	Fits / Convulsion	010	02.0
	Malpresentation of the foetus	013	02.6
	No Problem	126	25.2
5.	Number of Birth		
	1	370	74.0
	2 and more than 2	130	26.0

6.	Expenditure on Delivery (Rs.)		
	Less than 10000	55	11.0
	10001-20000	125	25.0
	20001-30000	180	36.0
	30001-40000	112	22.4
	40001-50000	16	03.2
	Above 50001	12	02.4
	Total	500	100
Post-Natal Care Services (Multiple answer)			
1.	Had you gone for check-up after delivery termination (within one month)-If yes	482	96.40
	Had you any problems after delivery, If yes	448	92.95
	Problems of Post natal care		
	Anaemia	88	19.64
	Abdominal Pain and Perineal pain, High rates of backpain	104	21.58
	Infections (Fever, Foul -Smelling discharge & RTP's)	59	12.24
	Excessive bleeding	189	39.21
	Urinary problems & Breast issues	78	16.18
Depression.	184	38.17	

Utilisation of Antenatal Care Services during the last pregnancy, more than half of the respondents (55.8 percent) received their first antenatal check-up after the second month of pregnancy, while 29.6 percent reported undergoing their first check-up within the first two months. Only a very small proportion (0.6 percent) had their first antenatal visit at five months or later. With regard to the frequency of

antenatal visits, nearly three-fifths of the respondents (59.8 percent) reported attending five or more antenatal check-ups during their last pregnancy, while 31.2 percent had three to four visits. Only 9.0 percent reported fewer than two antenatal check-ups.

In terms of the place of antenatal care, 45.6 percent of the respondents received care from government hospitals, followed by private hospitals (37.6 percent) and sub-centres or Primary Health Centres (PHCs) (12.8 percent). Home visits accounted for only 4.0 percent. Almost all respondents (98.0 percent) reported receiving tetanus toxoid (TT) injections during pregnancy, while 95.6 percent consumed iron and folic acid (IFA) tablets. Consumption of special foods during pregnancy was widely reported. About 38.4 percent of respondents consumed fruits, green leafy vegetables, and milk, while a larger proportion (60.8 percent) reported consuming a more diversified diet that included milk, eggs, fish, vegetables, chicken, mutton, and whole-grain powder. This indicates a generally favourable pattern of nutritional practices during pregnancy.

Utilisation of Intra-natal Care Services during the last pregnancy, regarding the place of delivery, more than half of the respondents (53.2 percent) delivered in government hospitals, followed by private hospitals (39.0 percent). A small proportion delivered at PHCs or sub-centres (4.8 percent), while only 2.4 percent reported home deliveries. The majority of deliveries (86.8 percent) were assisted by doctors, followed by nurses (10.4 percent), auxiliary nurse midwives or village health nurses (2.2 percent), and traditional birth attendants or relatives (0.6 percent).

In terms of the type of delivery, most respondents (70.0 percent) had normal deliveries, while 21.0 percent underwent caesarean sections and 9.0 percent had forceps-assisted deliveries. With respect to delivery-related complications, nearly one-third of respondents (32.8 percent) experienced prolonged labour, followed by fainting episodes (20.4 percent) and excessive bleeding (17.0 percent). Smaller proportions reported convulsions or fits (2.0 percent) and malpresentation of the foetus (2.6 percent), while 25.2 percent reported no complications during delivery. The majority of respondents (74.0 percent) had only one child, whereas 26.0 percent had two or more children.

Analysis of delivery expenditure reveals that most households incurred moderate costs. About 36.0 percent reported expenses between ₹20,001 and ₹30,000, followed by 25.0 percent who spent between ₹10,001 and ₹20,000. Another 22.4 percent incurred costs ranging from ₹30,001 to ₹40,000. At the lower end, 11.0 percent of households spent less than ₹10,000, reflecting deliveries conducted mainly in government facilities or under subsidised schemes. Only a small proportion reported higher expenditures, with 3.2 percent spending ₹40,001–50,000 and 2.4 percent spending above ₹50,001. These

findings highlight economic disparities in delivery-related expenditure, which directly influence access to and utilisation of maternal health care services.

Utilisation of Post-natal Care Services during the last pregnancy, postnatal care services refer to the health care provided to women and newborns immediately after childbirth and throughout the postnatal period. These services are crucial for monitoring physical and psychological well-being, identifying and managing postnatal complications, and ensuring healthy neonatal development. Effective postnatal care includes regular health check-ups, nutritional counselling, breastfeeding support, family planning guidance, and education on newborn care. Globally, approximately one in five mothers (20 percent) experiences postpartum depression. In India, studies estimate that between 22 and 28 percent of mothers suffer from postpartum depression, with higher prevalence reported in rural and socioeconomically disadvantaged communities due to underdiagnosis and underreporting.

The findings of the study indicate a high level of health-seeking behaviour with regard to postnatal care. A substantial majority of respondents (96.4 percent) reported attending a postnatal check-up within one month of delivery. Despite this high coverage, a large proportion of women (92.95 percent) experienced health problems during the postnatal period, underscoring the vulnerability of mothers after childbirth. The most commonly reported complications were excessive bleeding (39.21 percent) and depression (38.17 percent), highlighting both physical and psychological health challenges. Abdominal and perineal pain accompanied by back pain were reported by 21.58 percent of respondents, while anaemia affected 19.64 percent. Other health concerns included urinary and breast-related problems (16.18 percent) and infections such as fever, foul-smelling discharge, and reproductive tract infections (12.24 percent).

II.CONCLUSION

Reproductive health encompasses a wide range of issues affecting both men and women; however, its most profound implications are experienced by women of reproductive age. Maternal health, particularly antenatal care, constitutes a cornerstone of safe motherhood and child survival. Despite global recognition and progress, substantial socio-economic, cultural, and systemic barriers continue to impede access to quality maternal health services in developing countries. Addressing these barriers is essential for reducing maternal mortality, promoting gender equality, and achieving sustainable reproductive health outcomes. The study demonstrates that while the utilisation of antenatal, intranatal, and postnatal health care services is relatively high, significant disparities and health challenges remain. Early initiation of antenatal care, institutional deliveries, and widespread postnatal

check-ups reflect positive health-seeking behaviour among women. However, the persistence of delivery complications, postnatal morbidities, and economic barriers highlights the need for improved quality of care, enhanced nutritional and mental health interventions, and strengthened public health services to ensure equitable and comprehensive maternal health care for all women.

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