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Original Research Article

Exploring the perspectives and identifying the challenges of postnatal mothers delivered at a not-for-profit tertiary care referral centre in Vellore, South India: a qualitative study

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ABSTRACT

Background: Our study aimed to explore the perspectives of postnatal women and identify the emotional, psychological and physical challenges in the post-natal period.
Methods: Women who delivered in a not-for-profit tertiary referral centre in South India and had postnatal visits in the last quarter of 2022 were contacted for an in-depth interview after verbal informed consent. Snowball sampling was used to contact postnatal women who fulfilled the eligibility criteria till data saturation was reached.
Result: Overall, 27 interviews were recorded based on the inclusion criteria of the study. After the initial coding, five themes evolved namely: Emotional challenges and response to motherhood; physical pain and self-care; cultural practices and support; financial responsibilities and support; and postnatal care beyond maternal nutrition and breastfeeding. Women who accepted their new role as mothers found ways to manage their time between self-care and care of the newborn. Choosing to stay at home for child care was difficult for women who were working earlier. Mothers were apprehensive of the next pregnancy and sexual health was affected in women who decided not to get pregnant again.
Conclusion: Pain interfered with self-care, care of the newborn and daily routine. Nutrition of postnatal women and perineal and newborn care were influenced by local beliefs that interfered with the discharge advice given by health care professionals. Postnatal women decided to go to a closer health centre for minor illnesses of the newborn or postpartum complaints. Birth spacing, Contraception, urinary and bowel symptoms were not addressed regularly at the time of discharge.

Keywords: Postnatal women, Pain interfered, Nutrition of postnatal women

INTRODUCTION

The postnatal period is defined as the period starting immediately after the birth of a newborn and extending to six weeks (42 days) after delivery.[1] It is a crucial phase for the mother, the newborn and the family as they learn to accommodate to the changes at the individual and family level. The birth of a newborn is beyond a familial, cultural and societal event since it adds to the national health statistics. Globally, the World Health Organization (WHO) has termed "positive postnatal experience" as the

target endpoint for all women giving birth and their newborns to be in line with the Sustainable Development Goals (SDGs) on reproductive, maternal and child health.[2]

A "positive postnatal experience" aims to provide mothers, newborns and families with necessary information and support from the healthcare system recognizing the cultural and contextual needs of newborns and mothers.[3] The goal of this guideline is to improve the quality of care for mothers and newborns beyond immunization coverage to improve maternal and newborn wellbeing. The guideline includes maternal assessment for physiological changes in the woman, HIV testing and screening for tuberculosis. It also includes interventions for perineal pain, uterine cramping, pelvic pain, pelvic floor strengthening, and postpartum breast engorgement besides other preventive measures.

Positive motherhood state and transition to new roles were the valued experiences of post-natal mothers, according to a recent meta-synthesis.[4] However, the suboptimal experience of postnatal mothers in different healthcare systems was also reported due to multiple reasons. Mother's lack of knowledge about postpartum health, lack of continuity of care and support from the health care professionals were the major results of a United States (US) based qualitative study.[5]

A systematic review identified lack of perceived need and information about postnatal care as the major impediments to postnatal care.[6] A study in Afghanistan recognized seeking health care for maternal and newborn services as a shame and women could access postnatal care only if accompanied by a male relative.[7] A study on postpartum and newborn care in Kerala and Uttarakhand found multiple harmful practices in the community.[8,9]

India, with its geographical and regional diversity, has culturally rooted beliefs and practices towards postnatal care.[10] The sex of the newborn child has a great influence on the quality of life of postnatal women.[11] The choice of birthing centres which continue to provide postnatal care is influenced by multiple factors other than the maternity benefit funds.[12] The health of postnatal women is greatly influenced by the familial, cultural and healthcare systems in Indian settings. The health needs of postnatal women and the reasons for seeking health care remain unexplored in India.

Our study aims to explore the perspectives of postnatal women and identify the emotional, psychological and physical challenges in the post-natal period. Thus, the objectives of the study were as to explore the perspectives and challenges of postnatal mothers, who presented to a healthcare facility for an unscheduled visit during the postnatal period, who did not come for their scheduled postnatal visit, either a special visit or routine care in the postnatal period, who presented to a healthcare facility for the scheduled visit during the postnatal period.

METHODS

This prospective qualitative study was done in a "not-for-profit tertiary care referral centre in Vellore, South India" after Institutional Review Board Clearance. Ref: IRB Min. No. 15906 [OTHER] dated 22.11.2023. It was done on a cohort of women who delivered in 2022 as part of a large cohort study to track postnatal events up to 18 months.

This study was sponsored by the Indian Council of Medical Research. The interviews were conducted in the department of obstetrics and gynaecology Christian Medical College, Vellore telephonically between August to December 2024.

Inclusion criteria

Women who delivered in 2022 in the not-for-profit tertiary referral centre in Vellore, South India and had postnatal visits in the last quarter of 2022 were contacted for an in-depth interview after verbal informed consent. A written informed consent for follow up as part of the larger cohort study has been obtained earlier. The scheduled visits could be for a routine postnatal visit or a special visit warranted by the presence of obstetric, medical, surgical, intrapartum or postpartum complications. Women who did not present for their scheduled visits and those who were seen during unscheduled visits were also contacted.

Exclusion criteria

Women who were pregnant with the next child, who expired and had psychiatric conditions were excluded.

Sample size

Postnatal women who presented for unscheduled visits, special visits, scheduled routine visits and women who did not come for scheduled visits were interviewed. Snowball sampling was used to contact postnatal women who fulfilled the eligibility criteria till data saturation was reached.[13]

Data collection and analysis

After informed consent, in-depth telephonic interviews were conducted in the regional language by the co-investigators. The interviews were recorded and transcribed in English. The transcribed interviews were read and approved. Initial descriptive coding of the transcript was done by the four co-investigators (RK, SR, JM, GM).

Based on the initial coding, five themes were generated: Emotional challenges and responsiveness to motherhood; physical pain and self-care; cultural practices and supports; financial responsibilities and supports; and postnatal care beyond maternal nutrition and breastfeeding.

RESULTS

Overall, 27 interviews were recorded based on the inclusion criteria of the study. Among the participants, 12 postnatal mothers had a caesarean section, five had forceps-assisted vaginal delivery, and ten had a normal vaginal delivery. Of the postnatal mothers, 18 were primigravida, seven were multiparous women and two of them were 2nd gravida with previous abortions and no living child.

Irrespective of the mode of delivery, primi-postnatal mothers presented for unscheduled visits to the health care system where they delivered or went to a nearby health care centre. About five postnatal mothers came for scheduled visits and ten women were seen for a special visit. The summary of each of the 5 identified themes are mentioned below, an importantly sample phrases that reflect the thoughts of the mother have been included verbatim but translated into English from the vernacular language. The table has a summary of the demographic details of the participants.

Emotional challenges and responsiveness to motherhood

Postnatal mothers were appreciative of the joy of having a child along with the unpredictable emotional changes of a new mother. Women felt challenged to manage between self-care and the responsibilities of motherhood. Women who accepted their new role as mothers found ways to manage their time between self-care and care of the newborn.

Choosing to stay at home for child care was difficult for women who were working earlier. Mothers were apprehensive of the next pregnancy and either prepared for an early 2nd pregnancy or delayed it. Sexual health was affected in women who decided not to get pregnant again.

"I had two abortions… infertile for three years... so I am overwhelmed with joy!". "I had mood swings... as it is forceps.I had pain in the stitches site. Pain radiating to my left leg. I used to hear songs whenever I feel low."

"I didn't have proper food, proper sleep. Though baby sleeps, I won't be able to sleep properly if I need to cook healthy food and eat. I would get angry and cry, get stressed in spite of that."

"I had sleeplessness, somehow, I managed, with an attitude that I only have to take care of my babies, that is more important than my sleep. I will sleep whenever they sleep in the daytime. When they wake up for feeding, I will also wake up."

"Time management. I used to make my baby play and stay awake during the day." "I am depressed because I stopped working... I work in a computer centre, but with looking after child. I am fine." "I am not using any contraception. I feared I would become pregnant, so there is some anxiety to have sexual intercourse, there is some unhappiness about that."

"They asked me to avoid the next pregnancy for a few years, that also I know, but only planned this pregnancy soon as I am elderly."

Physical pain and self-care

Physiological changes of pregnancy and delivery, either normal or operative were the commonly narrated experiences of postnatal women. Perineal pain or post-laparotomy pain were the primary concerns of most participants.

Pain interfered with self-care, care of the newborn and daily routine. Women who had gaping wounds needed additional visits to the health care system. Breast pain, either due to engorgement or cracked nipples, was expressed as a cause of significant discomfort by the participants.

"because of cesarean, I had some difficulties, difficult to get up and do work. I had severe pain while sitting and standing up."

"I had difficulty with swelling of my hand, back pain in the early days. I had nausea after delivery, perhaps due to the antibiotic for infection." "I have back pain for the first three months and felt pain in the sutures area."

"Due to cesarean, I had difficulty in getting up in the bed and in walking. I had pain at wound site, disturbance in the night leads to lack of sleep causing weakness in the body." "I gained a lot of weight after surgery. I was thin before marriage. But now I have gained 20 kgs, because of this, my wound took time to heal well. I also got an umbilical hernia which I did not notice much during pregnancy."

"I had severe leg pain and felt very tired, drowsy, and giddy. I was unable to do normal household work and had difficulty taking care of my twin babies. I was taking the thyroid tablets properly, in the house, everyone became busy taking care of their babies, and I totally forgot to take the tablets."

"My wound stitches gaped...I was unable to care for my baby...Re-suturing was done from outside the hospital, that too gave way…I would have pain all the time that prevented me from caring for the baby"

"I had difficulties in breastfeeding, my nipples are cracked and they are smaller in size and therefore, not adequate for breastfeeding".

Cultural practices and supports

Culturally, most primigravida women were staying with their parents at the time of delivery. Parents and siblings

were the major source of emotional and psychological support during the initial postnatal period. Postnatal women who had lost one or both parents felt devoid of the assistance needed during that time. Spouses were available and able to help the postnatal mothers and in newborn care in some families.

Nutrition of postnatal women, perineal and newborn care was influenced by local beliefs that interfered with the discharge advice given by health care professionals. *"I had infertility, my mother died, and then my father died, my sister helped me with problems after delivery as normal delivery."*

"My husband was supportive., he started taking care of the baby after one and half months, so I managed. I used to take tablets for pain given at the time of discharge."

"I went back to my mother for better care and also to come out of mental trauma by spending time with my sister and brother."

"Taking care of two babies simultaneously was a difficult task. I have my mother and husband along with me to take care of the household work along with babies."

"When I went to my mother-in-law's house, I had some difficulties as no one was there to support me, at my house, a lot of people were there around to help with my babies and me."

"I had some whitish vaginal discharge which was foul-smelling... I'm unable to bear it as I will be bathing once in two days only during this wound infection It's rainy season, and my relatives insisted I take a bath once in two days."

"My family told me not to eat mango; hospital told me to eat everything; elderly parents want me to avoid some food. I ate groundnuts, as advised by family members.

Financial responsibilities and supports

Costs associated with travel to the hospital and direct costs of medical care for delivery were the major determinants of the choice between private or public health systems among postnatal women. Postnatal women decided to go to a closer health centre for minor illnesses of the newborn or postpartum complaints if the hospital where they delivered was far away. *"because of the distance. I went to a government hospital." "Financially I was having problems, but I continued in the private hospital, because I had one previous abortion."*

"Financially, we are low, middle class, baby had fits, fortunately though spinal fluid was taken, it was normal fits, referral to private hospital…as we have to pay, prefer to go to government hospital."

"I got a mild infection at the stitch site. I went to a local hospital in my native place they examined me and told me it was nothing to bother... They insisted I keep the wound dry, for which I struggled for 1-1/2 months."

"I am unaware of the financial status as my husband was taking care of everything."

"It's very far from my home, so I went to the local government hospital."

"My husband is a painter, though not much income...we receive help from both my mother's and in-law's house, they help us without restrictions."

Postnatal care beyond maternal nutrition and breastfeeding

Health education at the time of discharge was primarily focused on breastfeeding and maternal nutrition. Technique and frequency of breastfeeding were stressed in most of the discharge advice. Though the majority of the participants were primigravidae, birth spacing and contraception were not discussed regularly. Mothers with medical problems were recommended to review for follow-up after delivery. Urinary and bowel symptoms were not addressed regularly at the time of discharge.

"As I delivered twins there were some difficulties breastfeed both the babies, two hourly, everything should be kept separate for both babies and should not be identical, my breastmilk was not adequate for both the babies, so they ask to start on formula milk, they taught us how to clean the bottle in hot water and dry. I should take personal hygiene."

"They told me not to lift heavy weights, not to strain much, to prevent back pain they taught me some exercises. I could take all kinds of food."

"They taught me the positions of breastfeeding; baby had to pass urine and stools periodically to ensure adequate feeding...to breastfeed exclusively."

"I had blood pressure and sugar problems, they gave me tablets and explained how to take them.as I conceived immediately with my second baby they taught me how I should manage both the babies."

"I even had painful defecation…after nine days I visited the hospital where I delivered, they prescribed a syrup, after which defecation problem was relieved."

"I used to have urinary incontinence...whenever I strain or whenever I sneeze, urine leaks out, mam, automatically. I went for a checkup. The doctor reassured me that I'll be fine."

"To give the baby a bath daily, to use pillow while feeding to do sitz bath twice a day."

Table 1: Demographic characteristics.

Case. no	Group	Obstetric score	Mode of delivery	Age	Religion	Occupation	Education	Socioeconomic status
1	1,4	Primi	LSCS	20	Hindu	House Wife	12	Lower middle
2	3,5	G2P1L1	NVD	37	Hindu	House Wife	UG	Upper lower
3	2	Primi	LSCS	31	Hindu	House Wife	UG	Upper middle
4	1,4	Primi	Low-Forceps	24	Hindu	House Wife	UG	Upper middle
5	4	Primi	Outlet Forceps	25	Hindu	House Wife	PG	Lower middle
6	3,5	G2P1L1	NVD	29	Hindu	House Wife	PG	Upper Lower
7	1	Primi	Low-Forceps	29	Hindu	House Wife	UG	Lower middle
8	1	Primi	NVD	30	Hindu	House Wife	19	Upper middle
9	3	G2P1L1	LSCS	30	Hindu	House Wife	UG	Upper middle
10	5	Primi	NVD	30	Hindu	House Wife	PG	Upper middle
11	5	Primi	Low Forceps	22	Hindu	House Wife	10	Lower
12	4	Primi	NVD	21	Muslim	House Wife	UG	Upper lower
13	2	Primi	NVD	31	Christian	House Wife	10	Lower middle
14	5	G2P1L1	LSCS	24	Hindu	House Wife	UG	Upper Lower
15	3	G2P1L1	LSCS	25	Muslim	House Wife	UG	Upper middle
16	5	G2P1L1	NVD	30	Hindu	House Wife	PG	Upper middle
17	4	Primi	NVD	19	Hindu	Student	UG	Upper middle
18	3,5	Primi	Low Forceps	24	Hindu	House Wife	12	Upper lower
19	5	Primi	LSCS	29	Hindu	House Wife	15	Upper lower
20	5	Primi	LSCS	26	Hindu	House Wife	12	Upper middle
21	5	Primi	NVD	20	Hindu	House Wife	12	Lower middle
22	2	Primi	LSCS	37	Christian	House Wife	10	Upper lower
23	4	Primi	LSCS	32	Hindu	Working	PG	Upper lower
24	2	Primi	LSCS	31	Christian	Working	12	Upper lower
25	2	Primi	LSCS	41	Hindu	House Wife	UG	Lower middle
26	4	Primi	LSCS	27	Hindu	House Wife	UG	Lower middle
27	2	Primi	NVD	20	Muslim	House Wife	10	Upper lower

G- Gravida, P- Parity, L- Living, LSCS- Lower Segment Cesarean Section, NVD- Normal Vaginal deliveryGroups: 1. Those mothers who had an unscheduled visit. 2. Those mothers who didn't come for a scheduled visit. 3. Those mothers who came for a scheduled visit.4. Those mothers who didn't have a special visit. 5. Those mothers who came for a special visit.

DISCUSSION

Our study identified the gap between the standard guidelines on postnatal care and the expectations of postnatal women influenced by socio-cultural beliefs and practices. Traditionally, postnatal care is considered to be less important than antenatal or intrapartum care and is handled in the contexts of family and community. Scientific guidelines consider the physiological changes in postnatal women as a bio-medical event and aim for a better quality of care focusing on maternal nutrition and support.

On the other hand, better utilization of maternity health services by postnatal women was found when culturally competent communication was provided by health care professionals to postnatal women.[6] These schemes to be evident from this study also. Many of our participants were not aware of the emotional or psychological changes and demands of motherhood. Familial structure prioritized the responsibilities of motherhood and newborn care to women with less involvement of fathers and in-laws. A recent qualitative evidence synthesis on postnatal care found the younger generation of men to be willing to be involved in postnatal care.[14] Health professionals should aim for a discussion on the responsibilities of parenthood, support for self-care and mental health of postnatal women and ensure the availability of fathers and family members during the postnatal period.

Our study identified the distance and costs of visiting a private health care system as reasons for missing scheduled postnatal visits. A recent qualitative synthesis of the perspectives of women on the uptake of postnatal services identified access, availability and societal norms as factors that influenced the utilization of postnatal services.[15] Majority of the studies included in the qualitative synthesis were done in high income countries.

Only one study was done in India that reported a lack of skill set in delivering postnatal counselling and a lack of privacy.[16] Health care systems should give the options of a telephone consultation or a home visit to improve the interpersonal aspects of postnatal follow-up care. Postnatal discharge counselling primarily focused on the details of breastfeeding alone. Common symptoms of urinary and bowel problems, weight loss or gain and sleeplessness were not adequately informed to our participants. Home remedies and symptomatic management of common symptoms should be included in postnatal counselling.

The utilization of Accredited Social Health Activists (ASHA) through the government's National Health Mission should be encouraged. A study found that 96% of

postnatal women were seen by ASHA workers during a home visit.[17] Mandatory follow-up of women with medical and obstetric complications should be communicated to postnatal women and their family members and proactively followed with a telephonic reminder.

This is a qualitative study done in a single tertiary care referral centre. Our study results support the existing qualitative evidence synthesized on the utilization of postnatal care services in India and globally. Postnatal women delivered in 2022 were interviewed toward the latter part of 2024 and at the beginning of 2025.

The recalled memory of postnatal women is to be considered in interpreting the findings of our study. The generalizability of our study results to other primary and secondary care settings will need to be explored. This study was done when women were recruited for a large cohort study. The influence of the advice of research staff during that period could not be assessed clearly.

CONCLUSION

In conclusion, the postnatal period involves a vital phase of transition to motherhood. Health care systems should be inclusive to look beyond medical and biological changes in postnatal women. Postnatal care should address the challenges of a new mother and the newborn. Postnatal counselling should involve fathers and family members to increase the awareness of care needed for postnatal women towards holistic care with the involvement of familial, cultural and societal competence. Healthcare systems should collaborate with ASHA workers to complement care at discharge, thus ensuring healthy postnatal practices along with traditional beliefs and practices.

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REFERENCES

1. WHO recommendations on maternal and newborn care for a positive postnatal experience. Available at: https://iris.who.int/bitstream. Accessed on 14 February 2025.
2. The United Nations Sustainable Development Goals. Available at: https://sdgs.un.org/goals. Accessed on 21 March 2025.
3. Wojcieszek AM, Bonet M. WHO recommendations on maternal and newborn care for a positive postnatal experience: strengthening the maternal and newborn care continuum: BMJ Global Health. 2023;8:10992.
4. Finlayson K, Crossland N, Bonet M, Downe S. What matters to women in the postnatal period: A meta-synthesis of qualitative studies. PLoS One. 2020;15(4):231415.
5. Martin A, Horowitz C, Balbierz A, Howell EA. Views of women and clinicians on postpartum preparation and recovery. Matern Child Health J. 2014;18(3):707-13.
6. Al Hadi A, Paliwoda M, Dawson J, Walker K, New K. Women's Utilisation, Experiences and Satisfaction with Postnatal Follow-up Care: Systematic literature review. Sultan Qaboos Univ Med J. 2022;22(4):455-71.
7. Newbrander W, Natiq K, Shahim S, Hamid N, Skena NB. Barriers to appropriate care for mothers and infants during the perinatal period in rural Afghanistan: a qualitative assessment. Glob Public Health. 2014;9(1):93-109.
8. Meera G. Postpartum and newborn care. A qualitative study." Indian J Comm Heal. 2018;3:163-5.
9. Saxena V, Jelly P, Sharma R. An exploratory study on traditional practices of families during the perinatal period among traditional birth attendants in Uttarakhand. J Family Med Prim Care. 2020;9(1):156-61.
10. Withers M, Kharazmi N, Lim E. Traditional beliefs and practices in pregnancy, childbirth and postpartum: A review of the evidence from Asian countries. Midwifery. 2018;56:158-70.
11. Pallika S, Rasania S. Gender of the baby and its impact on the health-related quality of life of postpartum women. Indian J Comm Fam Med. 2021;8(1):14-7.
12. Jayanthi TP, Suresh S, Padmanaban P. Primary health centres: preferred option for birthing care in Tamilnadu, India, from users' perspectives. J Health Popul Nutr. 2015;33(1):177-86.
13. Naderifar M, Goli H, Ghaljaie F. Snowball sampling: A purposeful method of sampling in qualitative research. Strides Dev Med Edu. 2017;14(3):78.
14. Finlayson K, Sacks E, Brizuela V, Crossland N, Cordey S, Ziegler D, et al. Factors that influence the uptake of postnatal care from the perspective of fathers, partners and other family members: a qualitative evidence synthesis. BMJ Glob Health. 2023;8(2):11086.
15. Sacks E, Finlayson K, Brizuela V, Crossland N, Ziegler D, Sauvé C et al. Factors that influence the uptake of routine postnatal care: Findings on women's perspectives from a qualitative evidence synthesis. PLoS One. 2022;17(8):270264.
16. Bhattacharyya S, Issac A, Rajbangshi P, Srivastava A, Avan BI. "Neither we are satisfied nor they"-users and provider's perspective: a qualitative study of maternity care in secondary level public health facilities, Uttar Pradesh, India. BMC Health Serv Res. 2015;15:421.
17. Chaurasiya SK, Singh NP, Shukla SK, Bajpai PK, Mathew DJ. Assessment of the services of ASHA workers on antenatal and postnatal care in a district of western Uttar Pradesh, India. J Family Med Prim Care. 2020;9(7):3502-7.

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