

CONTINUUM OF MATERNAL CARE FROM PREGNANCY TO POSTPARTUM PERIOD: A SYSTEMATIC REVIEW

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ABSTRACT

OBJECTIVES

This study aims to review the utilization, determinants, and outcomes of the continuum of maternal care from pregnancy through the post-partum period.

METHODOLOGY

A systematic review was conducted in accordance with PRISMA 2020 guidelines. Electronic databases, including PubMed, Web of Science, and Scopus, were searched for studies published between January 2020 and December 2025. The search strategy was developed based on the PICO framework. Original research studies conducted on women of reproductive age (15-49 years) and reporting at least one component of the maternal continuum of care were included. Study selection was performed independently by two reviewers. A total of 617 records were identified, of which 15 studies met the inclusion criteria. Data were extracted using a standardized format, and risk of bias was assessed using the Joanna Briggs Institute (JBI) checklist. Due to heterogeneity among studies, a narrative synthesis approach was used for analysis.

RESULTS

Antenatal care utilization ranged from 60% to 76%, while skilled birth attendance and institutional delivery showed moderate coverage. Postnatal care remained the least utilized component. Overall, completion of the continuum of care ranged from 30% to 50%. Key determinants included maternal education, socioeconomic status, and residence. Accessibility barriers, health system limitations, and cultural factors contributed to care discontinuity. Completion of the continuum was associated with improved maternal and neonatal outcomes.

CONCLUSION

The continuum of maternal care remains fragmented, particularly at the postnatal stage. Strengthening healthcare systems, improving accessibility, and addressing socioeconomic and cultural barriers are crucial to enhancing continuity of care and improving maternal and neonatal health outcomes.

KEYWORDS: Continuum of Care, Maternal Health, Antenatal Care, Postnatal Care, Systematic Review, Post-partum

INTRODUCTION

Maternal health is a vital community health concern, especially in low- and middle-income nations where the morbidity and mortality of mothers and neonatal health are disproportionately high.¹ Even with the global efforts to optimize maternal healthcare services, there remain critical gaps in the continuity of care during pregnancy, childbirth, and post-partum.² The continuum of maternal care is a concept that focuses on integrating key healthcare services at various levels, including antenatal care (ANC), skilled birth attendance (SBA), institutional delivery, and postnatal care (PNC).³ The continuum of care approach has been universally identified as one of the most effective strategies for minimizing preventable maternal and neonatal deaths.⁴ There is evidence that the care received at each stage has a significant positive

effect on health outcomes compared to the use of services in isolation. Nonetheless, a significant number of women start the antenatal care but do not proceed up to the delivery and postnatal services, hence missing the chance of getting timely interventions.^{5,6} Recent research studies have pointed out that maternal healthcare use decreases steadily up the continuum, with the maximum decrease in the postnatal period.⁷ Barriers to completing care have been identified as socioeconomic disparities, limited access to healthcare facilities, and cultural practices. The discontinuity of care is particularly pronounced among women living in rural regions and those with low educational attainment and low autonomy in decision-making.⁸ Maternal healthcare utilization in Pakistan and other South Asian nations is uneven, with a significant disparity between urban and rural populations. Despite the improvements in the rate of

coverage of antenatal care, postnatal care has been underutilized, thus leading to poor maternal and neonatal outcomes. Therefore, it is important to synthesize current evidence on the continuum of maternal care to understand existing gaps and their associated factors. Therefore, this systematic review aims to evaluate the utilization, determinants, and health outcomes associated with the continuum of maternal care from pregnancy to the post-partum period. The guiding research question was: What is the level of utilization, and what are the key determinants and health outcomes associated with the continuum of maternal care among women of reproductive age in low- and middle-income countries?

METHODOLOGY

This systematic review was conducted to evaluate the continuum of maternal care from pregnancy to the post-partum period, focusing on antenatal care, skilled birth attendance, institutional delivery, and postnatal care. The review was carried out in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines, which were followed for study identification, screening, eligibility assessment, and reporting of results.⁹ The study was structured using the PICO framework to define the research components: P (Population): Women of reproductive age (15-49 years), I (Intervention/Exposure): Continuum of maternal care (antenatal care, skilled birth attendance, institutional delivery, and postnatal care), C (Comparison): Partial or no continuum of maternal care, O (Outcomes): (i) Utilization of maternal healthcare services, (ii) Determinants affecting completion of care, (iii) Maternal and neonatal health outcomes. Three electronic databases (PubMed, Web of Science, and Scopus) were systematically searched. The search strategy was developed based on the PICO framework to ensure comprehensive identification of relevant studies. For the population (P), terms such as "women of reproductive age" and "maternal health" were used. For the intervention/exposure (I), keywords included "continuum of maternal care," "maternal healthcare services," "antenatal care," "skilled birth attendance," "institutional delivery," and "postnatal care." For comparison (C), studies reporting partial or no use of maternal care were also included. For the outcomes (O), terms related to "utilization," "determinants," and "maternal and neonatal outcomes" were incorporated. These terms were combined using Boolean operators as follows: ("continuum of maternal care" OR "maternal healthcare services") AND ("antenatal care" OR "ANC") AND ("skilled birth attendance" OR "institutional delivery") AND ("postnatal care" OR "PNC"). The search was limited to studies published between January

2020 and December 2025, conducted on humans, and published in English. Pre-defined inclusion and exclusion criteria guided the selection of the studies. Original research articles were included, including cross-sectional, cohort, and analytical studies published between 2020 and 2025, in which at least one element of the maternal continuum of care is reported and which include women of reproductive age (15-49 years). The exclusion criteria included, but were not limited to, systematic reviews, meta-analyses, narrative or scoping reviews, case reports, editorials or commentaries, and studies that were not part of the maternal healthcare continuum, had insufficient outcome data, or were duplicates. Database searching identified 617 records. All retrieved references were imported into EndNote (version x9) for management, and duplicate records were identified and removed using the software's automatic deduplication function, followed by manual verification. The screening process was conducted independently by two reviewers, who assessed titles and abstracts for eligibility using pre-defined inclusion and exclusion criteria. Full-text articles of potentially eligible studies were then retrieved and evaluated. Any disagreements between reviewers were resolved through discussion and consensus. Blinding was not applied during the screening process due to the nature of the study, identification, and feasibility constraints. The study selection process is illustrated using the PRISMA 2020 flow diagram (Figure 1).⁹ After screening and eligibility assessment, 15 studies met the inclusion criteria and were included in the final qualitative synthesis. Data extraction was carried out using a structured format. Information extracted included author and year of publication, country and study setting, study design, sample size, study population, study duration, and study objectives. In addition, data on antenatal care, skilled birth attendance, institutional delivery, postnatal care, and completion of the continuum of care were recorded. Information on determinants, barriers, and maternal and neonatal outcomes was also collected. The risk of bias of the included studies was assessed using the Joanna Briggs Institute (JBI) Critical Appraisal Checklists, appropriate to the respective study designs. The assessment was conducted independently by two reviewers to evaluate domains including selection bias, measurement bias, confounding, and outcome assessment. Any disagreements were resolved through discussion and consensus. The overall risk of bias for each study was categorized as low, moderate, or high based on the assessment criteria. Because study designs, populations, and outcome measures were heterogeneous, no meta-analysis was conducted. A narrative synthesis approach was taken instead. The results were summarized and presented in tabular form to identify trends in service utilization, determinants of the continuum of care, and maternal and neonatal outcomes.

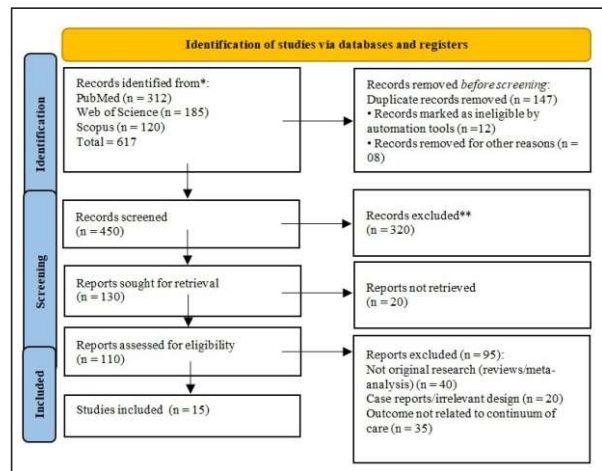


Figure 1: PRISMA 2020 flow diagram illustrating the study selection process for the systematic review on the continuum of maternal care from pregnancy to post-partum period. A total of 617 records were identified through database searches (PubMed, Web of Science, and Scopus). After duplicates were removed and screening, 110 reports were assessed for eligibility. Of these, 15 studies met the inclusion criteria and were included in the qualitative synthesis.

RESULTS

Table 1 presents the general profile of the included studies in this review. A total of fifteen studies published between 2020 and 2025 were analyzed. Most studies were conducted in low- and middle-income countries, with a clear predominance of research from Ethiopia. Other settings included India, Pakistan, Uganda, Zambia, and Cambodia, reflecting a broader range of resource-limited healthcare systems. Most of the included studies utilized a cross-sectional design; one was a prospective study, and another was a multivariate analytical study. The sample sizes varied widely, ranging from small community-based studies with fewer than 700 participants to large national surveys including more than 190,000 women. The majority of the studies focused on women of reproductive age, particularly those with recent childbirth experience. Regarding study objectives, the included studies primarily evaluated the utilization, completion, and predictors of the maternal continuum of care. In addition to these primary objectives, several studies also explored secondary aspects, including regional variations in service coverage, inequalities in healthcare access, and the influence of socioeconomic and demographic factors on care utilization. Overall, Table 1 demonstrates that existing evidence is largely observational and concentrated in developing settings.

Table 1: Characteristics of Included Studies on Continuum of Maternal Care (2020–2025)

Author & Year	Country /Setting	Study Design	Sample Size	Study Population	Study Duration	Aim/Objectives
Atnafu A et al., 2020 [11]	Ethiopia (community based)	Cross-sectional	811	Women with a recent birth	2019	To assess determinants of the maternal continuum of care
Shitie A et al., 2020 [12]	Ethiopia (district-level)	Cross-sectional	621	Mothers (last 1 year of birth)	2019	To evaluate the completion of the maternity continuum of care
Tizazu MA et al., 2021 [13]	Ethiopia (urban)	Cross-sectional	634	Women with a child birth history	2020	To assess completion and associated factors of care
Sertsewold SG et al., 2021 [14]	Ethiopia (community-based)	Cross-sectional	614	Women with a recent birth	2020	To evaluate the utilization of the maternal care continuum
Dadi T L et al., 2021 [15]	Ethiopia (rural)	Cross-sectional	1,431	Rural women	2019-2020	To examine the effect of ANC visits on the continuum
Chham S et al., 2021 [16]	Cambodia (DHS)	Cross-sectional	5,678	Women 15-49 years	DHS 2014 data	To identify determinants of the maternal care continuum
Sserwanja Q et al., 2021 [17]	Zambia (national survey)	Cross-sectional	7,325	Women 15-49 years	DHS data	To assess the national continuum of care coverage
Tenaw SG et al., 2022 [18]	Ethiopia (rural)	Cross-sectional	621	Rural women	2021	To assess completion and influencing factors
Gandhi S et al., 2022 [19]	India (national survey)	Cross-sectional	190,898	Women 15-49 years	NFHS data	To determine predictors of maternal care utilization
Abebe GF et al., 2022 [20]	Ethiopia (DHS)	Cross-sectional	8,885	Women 15-49 years	DHS 2019	To identify predictors of care completion
Sserwanja Q et al., 2022 [21]	Uganda (national)	Cross-sectional	10,152	Women 15-49 years	DHS data	To assess the continuum of maternal care

Hussen AM et al., 2023 [22]	Ethiopia (DHS)	Cross-sectional	4,693	Women 15-49 years	DHS 2019	To evaluate completion in emerging regions
Kitila SB et al., 2023 [23]	Ethiopia (prospective cohort)	Prospective study	720	Pregnant women	2021-2022	To assess barriers and facilitators of care
Rahaman M et al., 2024 [24]	Pakistan (national)	Cross-sectional	National data	Women 15-49 years	DHS data	To contextualize the WHO continuum of care model
Debie A et al., 2025 [25]	Ethiopia (national analysis)	Multi variable analysis	National data	Women 15-49 years	DHS trend data	To assess trends and contributors to care

The use of antenatal care was moderate to high in the literature, with most at 60-75 %. The patterns were the same, with skilled birth attendance and institutional delivery, the use of postnatal care was relatively low. The final continuum of care was not completed optimally, with an average of 30% to 50% of the continuum completed, indicating discontinuity, especially post-delivery.

Table 2: Components of Continuum of Maternal Care Across Included Studies

Author & Year	Antenatal Care (ANC ≥4 visits%)	Skilled Birth Attendance (%)	Institutional Delivery (%)	Postnatal Care (%)	Completion of Continuum (%)
Atnafu A et al., 2020 [11]	62.0%	58.4%	55.1%	38.6%	33.5%
Shitie A et al., 2020 [12]	65.2%	60.3%	57.8%	42.1%	37.2%
Tizazu MA et al., 2021 [13]	68.5%	63.7%	61.2%	44.9%	39.8%
Sertsewold SG et al., 2021 [14]	60.0%	56.0%	52.4%	36.2%	31.8%
Dadi TL et al., 2021 [15]	64.7%	59.1%	54.8%	40.5%	35.6%
Chham S et al., 2021 [16]	70.3%	66.8%	64.2%	48.7%	42.5%
Sserwanja Q et al., 2021 [17]	67.8%	62.9%	60.5%	45.6%	40.2%
Tenaw SG et al., 2022 [18]	63.5%	58.2%	55.7%	41.3%	36.4%
Gandhi S et al., 2022 [19]	72.4%	69.1%	66.8%	52.0%	46.5%
Abebe GF et al., 2022 [20]	66.0%	61.5%	58.9%	43.8%	38.7%

Sserwanja Q et al., 2022 [21]	68.9%	64.2%	61.7%	47.3%	41.9%
Hussen AM et al., 2023 [22]	65.8%	60.7%	58.1%	44.2%	39.5%
Kitila SB et al., 2023 [23]	71.2%	66.5%	63.9%	49.6%	43.8%
Rahaman M et al., 2024 [24]	74.0%	70.3%	68.5%	53.7%	48.9%
Debie A et al., 2025 [25]	76.5%	72.8%	70.4%	55.1%	50.6%

Table 3 summarizes the determinants and barriers affecting the continuum of maternal care across the included studies. Socio-demographic factors such as low maternal education, low income, and rural residence were commonly reported. Accessibility-related barriers included long distances to healthcare facilities, transportation difficulties, and financial constraints. Health system factors, including limited-service availability, inadequate infrastructure, and a shortage of trained staff, were also frequently identified. In addition, cultural and behavioral factors such as low awareness, traditional beliefs, and limited decision-making autonomy were reported to influence maternal healthcare utilization.

Table 3: Determinants and Barriers Affecting Continuum of Maternal Care

Author & Year	Socio-demographic Factors	Accessibility Factors	Health System	Cultural / Behavioral Factors	Key Findings	Socio-demographic Factors
Atnafu A et al., 2020 [11]	Low education, low income	Long distance to the facility	Limited service availability	Low awareness	Education and income strongly influenced care completion	Low education, low income
Shitie A et al., 2020 [12]	Young maternal age, low literacy	Transport issues	Poor facility readiness	Lack of knowledge	ANC attendance significantly predicted completion	Young maternal age, low literacy
Tizazu MA et al., 2021 [13]	Uneducated mothers	Rural residence	Inadequate staff	Cultural preference for home delivery	Institutional delivery improved continuum completion	Uneducated mothers
Sertsewold SG et al., 2021 [14]	Low socioeconomic status	Distance barriers	Poor quality of care	Limited decision autonomy	Wealth index and education were major predictors	Low socioeconomic status

Dadi TL et al., 2021 [15]	Rural residence, low education	Travel difficulty	Limited ANC follow-up	Poor health-seeking behavior	The frequency of ANC visits is strongly associated with completion	Rural residence, low education
Chham S et al., 2021 [16]	Low maternal education	Financial constraints	Health facility access issues	Traditional beliefs	Economic status influenced service utilization	Low maternal education
Sserwanja Q et al., 2021 [17]	Low household wealth	Rural accessibility issues	Inadequate health coverage	Cultural barriers	Urban residence increased the likelihood of care completion	Low household wealth
Tenaw SG et al., 2022 [18]	Low education level	Distance to health centers	Lack of trained staff	Limited awareness	ANC utilization predicted a full continuum	Low education level
Gandhi S et al., 2022 [19]	Low education, poverty	Cost barriers	Regional disparities in services	Gender inequality	Socioeconomic inequality influenced maternal care use	Low education, poverty
Abebe GF et al., 2022 [20]	Low literacy	Rural location	Limited infrastructure	Cultural practices	Multi-level factors affected completion	Low literacy
Sserwanja Q et al., 2022 [21]	Low-income households	Poor transport	Limited service availability	Low decision-making power	Wealth and urban residence were key determinants	Low-income households
Hussen AM et al., 2023 [22]	Low maternal education	Distance barriers	Health system gaps	Poor awareness	Education and ANC visits were strong predictors	Low maternal education
Kitila SB et al., 2023 [23]	Low education, unemployment	Geographic inaccessibility	Staff shortages	Cultural resistance	Barriers identified at the individual and system levels	Low education, unemployment
Rahaman M et al., 2024 [24]	Socioeconomic inequality	Regional disparities	Health system variation	Gender norms	Contextual factors influenced continuum completion	Socioeconomic inequality

Debie A et al., 2025[25]	Wealth index, education	Rural-urban gap	Service availability	Behavioral factors	Improvements linked to better access and education	Wealth index, education
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A region-wise analysis of determinants revealed variations across settings. In the South Asian region (India and Pakistan), socio-demographic factors such as low maternal education, poverty, and gender inequality were reported in 2-3 studies as key determinants. Accessibility barriers, including financial constraints and disparities in healthcare services, were also commonly identified. In contrast, studies from Sub-Saharan Africa (Ethiopia, Uganda, and Zambia) more frequently reported socio-demographic determinants such as rural residence, low literacy, and low household wealth across the majority of included studies. Accessibility-related challenges, including long distances to health facilities, transportation difficulties, and inadequate infrastructure, were consistently highlighted in more than half of the studies. Health system limitations and cultural factors were also more prominently reported in these settings. Table 4 summarizes the maternal and neonatal outcomes associated with the continuum of maternal care across the included studies. Most studies reported that completion of the continuum of care was associated with improved maternal outcomes, including reduced complications, morbidity, and mortality. Similarly, neonatal outcomes, including improved survival, reduced morbidity, and a lower risk of low birth weight, were consistently observed across studies.

Table 4: Maternal and Neonatal Outcomes Associated with Continuum of Care

Author & Year	Maternal Outcomes	Neonatal Outcomes	Key Findings
Atnafu A et al., 2020 [11]	Reduced maternal complications	Improved neonatal survival	Continuum completion reduced adverse outcomes
Shitie A et al., 2020 [12]	Lower maternal morbidity	Reduced neonatal illness	Complete care improved maternal and child health
Tizazu MA et al., 2021 [13]	Fewer delivery complications	Reduced low birth weight	Institutional delivery improved outcomes
Sertsewold SG et al., 2021 [14]	Reduced maternal risk	Lower neonatal mortality	Continuum care improved survival rates
Dadi TL et al., 2021[15]	Reduced pregnancy complications	Better neonatal outcomes	Frequent ANC improved maternal health

Chham S et al., 2021 [16]	Improved maternal health status	Lower neonatal mortality	Access to services improved outcomes
Sserwanja Q et al., 2021 [17]	Reduced maternal mortality risk	Improved neonatal survival	Continuum completion linked to better outcomes
Tenaw SG et al., 2022 [18]	Lower complication rates	Reduced neonatal morbidity	ANC and PNC improved outcomes
Gandhi S et al., 2022 [19]	Reduced maternal complications	Reduced neonatal mortality	Service utilization improved outcomes
Abebe GF et al., 2022 [20]	Better maternal health	Lower neonatal risk	Completion is associated improved outcomes
Sserwanja Q et al., 2022 [21]	Reduced maternal morbidity	Improved neonatal survival	Continuum care positively impacted outcomes
Hussen AM et al., 2023 [22]	Reduced maternal complications	Reduced neonatal mortality	Completion improved both maternal and neonatal health
Kitila SB et al., 2023 [23]	Improved maternal outcomes	Better neonatal health	Addressing barriers improved outcomes
Rahaman M et al., 2024 [24]	Reduced maternal risk	Improved neonatal outcomes	WHO-based continuum improved outcomes
Debie A et al., 2025 [25]	Decline in maternal complications	Reduced neonatal mortality	Trends show improved outcomes with better coverage

The risk of bias of the included studies was assessed using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist appropriate for the respective study designs. Two reviewers independently evaluated each study across domains, including selection bias, measurement bias, confounding, and outcome assessment. Any discrepancies were resolved through discussion and consensus. Overall, the majority of studies demonstrated low risk of bias in outcome measurement, as standardized survey tools were commonly used. Community-based studies generally showed low selection bias, whereas national survey-based studies exhibited moderate risk due to sampling variability. Confounding factors were not fully addressed in several cross-sectional studies, contributing to moderate risk in some cases. In general, most studies were categorized as having low to moderate risk of bias, indicating acceptable methodological quality.

Table 5: Risk of Bias Assessment of Included Studies

Author & Year	Selection Bias	Measurement Bias	Confounding Control	Outcome Assessment	Overall Risk of Bias
Atnafu A et al., 2020 [9]	Low	Low	Moderate	Low	Low
Shitie A et al., 2020 [10]	Low	Low	Moderate	Low	Low
Tizazu MA et al., 2021 [11]	Low	Moderate	Moderate	Low	Moderate
Sertsewold SG et al., 2021 [12]	Low	Low	Moderate	Low	Low
Dadi TL et al., 2021 [13]	Low	Low	Low	Low	Low
Chham S et al., 2021 [14]	Moderate	Low	Moderate	Low	Moderate
Sserwanja Q et al., 2021 [15]	Moderate	Low	Moderate	Low	Moderate
Tenaw SG et al., 2022 [16]	Low	Low	Moderate	Low	Low
Gandhi S et al., 2022 [17]	Low	Low	Low	Low	Low
Abebe GF et al., 2022 [18]	Moderate	Low	Moderate	Low	Moderate
Sserwanja Q et al., 2022 [19]	Moderate	Low	Moderate	Low	Moderate
Hussen AM et al., 2023 [20]	Moderate	Low	Moderate	Low	Moderate
Kitila SB et al., 2023 [21]	Low	Low	Low	Low	Low
Rahaman M et al., 2024 [22]	Moderate	Low	Moderate	Low	Moderate
Debie A et al., 2025 [23]	Moderate	Low	Moderate	Low	Moderate

DISCUSSION

This review demonstrates that although antenatal care utilization is relatively higher, continuity of maternal healthcare from pregnancy to the post-partum period remains suboptimal, with marked dropouts at delivery and postnatal stages. This pattern is consistent with recent global evidence showing that maternal healthcare utilization declines progressively across the continuum, particularly during the post-partum period.²⁶ The overall continuum of care completion in the current review ranged from 30% to 50%. Similar results have also been indicated in recent research, but with large variance. A 2024 community-based study reported a completion rate of 37%, and another study (with a completion rate as low as 32% in post-partum women) reported a completion rate.^{27,8} In contrast, some studies in LMICs have reported very low completion rates as low as 6.19%, with large differences across settings.²⁸ Similarly, evidence indicates that completion rates across LMICs may range broadly from 5% to 75%, reflecting heterogeneity in healthcare access and utilization.²⁹ The socio-demographic factors, i.e., maternal education, household

wealth, and place of residence, were consistently associated with better utilization of maternal healthcare services.^{19,20,23,30} This is in line with recent studies showing that women with higher educational levels and economic power are more likely to complete the continuum of care.^{23,30} Additionally, women's autonomy has also been cited as a determinant that affects maternal healthcare uptake, especially in South Asian contexts.^{30,31,32} Factors that affect accessibility, such as distance to health facilities, transportation difficulties, and financial constraints, remain among the greatest challenges. There is an indication that access to health facilities and to transport are very important factors that enhance the likelihood of completing the continuum of care.³³ Similar findings have been observed in several recent studies that highlight geographic and financial barriers, which disproportionately impact rural populations.^{23,28} Health system factors are also critical to maternal Healthcare utilization. Lack of trained medical practitioners, insufficient infrastructure, and poor-quality services are among the factors that cause discontinuity of care. Recent research emphasizes that healthcare systems need to be strengthened and that continuity of services across all levels should be ensured to guarantee better maternal and neonatal outcomes.²³ In addition, insufficient health education, counseling, and follow-up systems have been linked to increased dropout rates of maternal healthcare services.³⁴ Cultural and behavioral factors, such as traditional beliefs, limited awareness, and limited decision-making autonomy, also influence healthcare-seeking behavior. It has been demonstrated that women who receive health education and counseling are much more likely to complete the continuum of care.^{26,30,31} Moreover, community support and partner involvement have been identified as significant mediators of maternal healthcare use.²⁶ Notably, the continuity of maternal care has been closely linked to better maternal and neonatal outcomes. It is shown that the combined risk of maternal and neonatal mortality can decrease by as much as 15% through prenatal, delivery, and postnatal care, which has been established to be integrated.^{5,34} In other research, it was shown that an enhanced continuum of care is associated with a decrease in maternal complications, neonatal morbidity, and long-term adverse consequences.³⁴ In Pakistan, the same issues persist, including urban-rural access inequity and service quality disparities.^{31,32} Socioeconomic and regional disparities remain as some of the key factors that hinder the use of maternal healthcare services, especially postnatal care.^{24,31,32} These results are in line with general regional data on South Asia, where maternal healthcare utilization patterns are most affected by the structural and social determinants.³¹ Overall, the findings of this review, in comparison with recent external evidence, highlight that the continuum of maternal care remains fragmented

across many settings. To overcome these gaps, a combination of interventions aimed at enhancing access to healthcare, strengthening healthcare systems, improving maternal education, and promoting awareness needs to be implemented to ensure continuity of care throughout all stages.

CONCLUSION

The continuum of maternal care remains suboptimal, with significant dropouts across antenatal, delivery, and postnatal stages, particularly during the postnatal period. Socioeconomic disparities, accessibility barriers, health system limitations, and cultural factors contribute to incomplete care. Strengthening integrated maternal healthcare services and improving access and awareness are essential to ensure continuity of care and improve maternal and neonatal health outcomes.

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