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Original Article

Obstetrics and Gynaecology Section

Perceptions of COVID-19 Positive Postnatal Women Who Delivered in an Isolation Facility: A Qualitative Study

SUMAN PAUL[1], SWAPNA MOHAN[2], SAJIDA ABDULLA[3], KARUNAKARAN VIDHUKUMAR[4], KR RADHA[5]

ABSTRACT

Introduction: During the pandemic, pregnant women were tested as part of admission protocols and, regardless of their symptoms, underwent the unique ordeal of giving birth in isolation. Isolating women from their families at the vulnerable perinatal period is likely to create mental health issues that may affect the mother-child dyad.

Aim: To explore the lived experiences of mothers who delivered in isolation during the Coronavirus Disease 2019 (COVID-19) pandemic.

Materials and Methods: This qualitative study was conducted in the Department of Obstetrics and Gynaecology at a designated COVID-19 Government Medical College, Ernakulam in the Indian state of Kerala from August 2021 to September 2021. A phenomenological approach was used to explore the perceptions and experiences of mothers who gave birth in isolation during the early days of the COVID-19 pandemic. The women were recruited through purposive sampling and contacted by phone due to pandemic restrictions. After obtaining consent, data were collected through telephonic, in-depth interviews using a semi-structured guide. Each interview lasted 40-60 minutes. Data saturation occurred after 12 participants. The audio recordings were transcribed, and the data were analysed using Colaizzi's method of data analysis.

Results: The participants were aged between 25 to 38 years; five were primigravidae. Most had no symptoms or only mild symptoms of COVID-19. From the analysis, two main themes and ten subthemes emerged. The main themes were negative feelings and positive feelings associated with giving birth in isolation. The negative subthemes included fear, sadness, worry, guilt, stigma, feelings of helplessness, and inconvenience. The positive subthemes included better medical care, supportive interpersonal interactions, and postpartum rest.

Conclusion: The study concluded that the panic surrounding COVID-19, along with restrictive protocols, contributed to the negative experience. Peer support within the hospital environment emerged as an important positive factor, along with supportive care from hospital staff and encouragement from family. The findings can inform public health policies in future outbreaks to address the needs of women giving birth in isolation.

Keywords: Child birth experiences, Coronavirus Disease 2019, Maternal mental health, Postnatal isolation, Social distancing

INTRODUCTION

Postnatal care provides comprehensive care to a woman after delivery, aiming to optimise physical and mental health, support breastfeeding, and provide counselling and mental preparation for adapting to the new life of motherhood and the changes in her own mental and physical status. Research on the psychological impact of pandemics on postnatal mothers reveals fears of contamination, social isolation, and lack of support [1]. Disruptions in the delivery of maternal healthcare have been attributed to mobility restrictions imposed by the government, redeployment of health workers, and reallocation of equipment and facilities to cater to the pandemic [2]. Studies conducted in UK mothers with infants aged between birth and twelve weeks during the COVID-19 pandemic found that women felt far less socially supported [3]. Pregnant women face uncertainty about the future, high infection rates, and high mortality during pandemics. These pandemic stressors adversely affect the mother and foetus compared with those who were pregnant in the pre-COVID-19 period [4]. Quarantine, physical distancing, and home isolation are known to be associated with stress, anger, and confusion in the postnatal period [5].

The initial postnatal days are crucial for helping the woman gain confidence in caring for the newborn and in establishing bonding. In the setting of COVID-19 infection, there is also concern about the mother's health and the neonate acquiring the infection. In the current study, the institutional policy allowed the neonate to be cared for by a COVID-19-negative bystander in a separate room, allowing contact with the mother only for breastfeeding. The mother and family often chose this isolation policy due to the uncertainty about the effects of COVID-19 infection in the neonate. As part of providing quality care during the most unique and vulnerable phase in a woman's life, this study was designed to explore the expectations and experiences of postnatal women forced into isolation lasting more than a week, usually owing to a COVID-19 positive status.

There is a dearth of research on the emotional state of women delivering in isolation facilities in Kerala. The primary aim of this study was to report the perceptions, expectations, and postnatal experiences of COVID-19 positive women delivering in an isolation facility. The secondary objective was to study the effect of isolation on the maternal mental state in the postnatal period.

MATERIALS AND METHODS

This qualitative study was conducted in the Department of Obstetrics and Gynaecology at a designated COVID-19 Government Medical College, Ernakulam in the Indian state of Kerala from August 2021 to September 2021 on the females who had delivered at the institution during June 2020 to August 2020. It was initiated after obtaining approval from the Institutional Research Committee and the Institutional Ethics Committee (IEC Number 44/2020). A phenomenological approach was used for qualitative data analysis, as the aim was to report the perceptions, expectations, and postnatal experiences of COVID-19 positive women delivering in an isolation facility.

Inclusion criteria: COVID-19 positive mothers who delivered near term while in isolation and had been discharged from the designated isolation facility of the Department of a Government Medical College in Kerala.

Exclusion criteria: It included women in preterm labour; those with severe maternal medical co-morbidities (e.g., severe preeclampsia, postpartum haemorrhage, postoperative, wound infections); women who required Intensive Care Unit (ICU); those who did not consent for the study; those who could not be contacted; or those who could not speak the local language were excluded.

Study Procedure

The socio-demographic profile and the interview guide containing questions or issues to be explored were prepared by an expert panel [Appendix 1]. Because direct in-person interviews were not possible due to the COVID-19 situation, telephonic in-depth interviews were conducted with recorded verbal consent. Sensitive questions that could cause distress or anxiety were avoided. Data saturation occurred after interviewing 12 participants [Table/Fig-1]. The study included postnatal women who had delivered and been discharged from the COVID-19 isolation obstetric ward. If during the study any participant needed extra care, she would be given appropriate advice for psychiatric, obstetric, or neonatal referral. The interviews were conducted at times convenient for the mothers. The data collection tools were reviewed and supplemented by subject experts in psychiatry and obstetrics, who have extensive experience in qualitative research. The broad topics for the interview schedule were first identified in concurrence with the subject experts (the first, fourth and fifth authors). For example, the topic of handling delivery in isolation was formulated into the main question: "How did you react to the COVID-19 result?" with a follow-up question: "What support did you get?" Further probing questions were sometimes asked, such as: "What were the most negative and positive feelings you had during the experience?" Another topic focused on support from the health system, formulated as: "What was the health system's response, and were your expectations met?" probed with: "How did these affect you positively or negatively?" Yet another topic concerned interpersonal interactions with relatives and acquaintances, asked as: "What were the supportive and non supportive behaviors you encountered?" followed by: "How did these interactions make you feel?"

Proxy name	Age (in years)	Parity	Education	Symptoms of COVID-19	Mode of delivery	No. of days in hospital
P1	31	P1L1	Postgraduate	Anosmia	LSCS	14
P2	28	P1L1	Graduate	Mild sore throat	LSCS	11
P3	27	P3L3	Graduate	Mild sore throat	Normal delivery	11
P4	38	P2L2	SSLC	Asymptomatic	LSCS	11
P5	25	P1L1	Graduate	Cough	Normal delivery	11
P6	33	P2L2	Graduate	Asymptomatic	Normal delivery	14
P7	25	P1L1	Graduate	Asymptomatic	LSCS	11
P8	25	P2L2	Graduate	Asymptomatic	Normal delivery	11
P9	25	P1L1	Graduate	Asymptomatic	LSCS	19
P10	30	P2L2	12th pass	Asymptomatic	LSCS	11
P11	36	P2L2	Postgraduate	Asymptomatic	LSCS	11
P12	35	P2L2	SSLC	Asymptomatic	LSCS	11

[Table/Fig-1]: Socio-demographic characteristics.
LSCS: Lower segment caesarean section; SSLC: Secondary school leaving certificate

The interviews were conducted in Malayalam by the first author, who has 14 years of experience in obstetrics. Some interviews required breaks of a few minutes to several hours when mothers needed to tend to their babies. The average duration of the interviews was 40-60 minutes. The recordings were anonymised and transcribed. Data obtained were translated from Malayalam by the first and second authors. The authors read the data multiple times to derive codes, which led to the emergence of subthemes and themes.

All interviews were read multiple times by two authors (the first and the third authors) separately to capture the respondent's experience. Next, significant statements were extracted and compared. Each quote was analysed, and the meaning conveyed identified by three authors (the first, second and third authors). These phrases were read again and regrouped into codes and then grouped under subthemes. A fundamental structure was identified, combining the themes to develop a narrative of the core experience of the participants. Thus, positive and negative experiences were identified as broader themes, with subthemes described under these themes. For example, a quote such as "Protocols on COVID-19 testing kept changing and it would make an already down patient even more down" was placed under sadness and helplessness, along with similar quotes highlighted under the same experience (grief). Statements reflecting sadness and helplessness—such as being repeatedly positive, discharge delays due to changing protocols (as quoted above), sadness due to isolation during delivery, and sadness due to inability to breastfeed—were grouped under the subtheme of sadness [Table/Fig-2].

Themes	Minor themes	Phrases/quotes
Negative feelings	Fear/Panic	Fear from being shifted alone in an ambulance or car with a stranger driver. Fear due to media hype regarding COVID-19. Fear regarding risk of infection to neonate due to non availability of routine immunisation/ fear of dying without a funeral.
	Sadness	Due to isolation. Child denied exclusive breastfeeding. Compromised Parent- child bonding. Prolonged hospital stay due to persistent positive RT-PCR.
	Worry	Safety of children left at home. Lack of support during and after delivery. Baby getting infected.
	Guilt	About having infected others.
	Stigma	Spreading rumours and Distancing attitude from neighbours and relatives.
	Feeling helpless	Delayed discharge due to COVID-19 protocol and Lack of support from community.
	Inconvenience experienced	Lack of continuity in obstetric care, Primary contacts forced to go into quarantine and denying mothers support from closest family members.
Positive feelings	Medical care related	Better COVID-19 care. Better medical care in pregnancy and Faster post op healing due to early ambulation.
	Supportive interpersonal interactions	Inpatients helping each other/supportive medical staff and psychologist/family and neighbours/ health department staff.
	Postnatal rest	Home quarantine helped family bonding.

[Table/Fig-2]: Themes and subthemes.
RT-PCR; Reverse transcription polymerase chain reaction

STATISTICAL ANALYSIS

After obtaining consent, the telephone-recorded interviews were transcribed verbatim by the principal investigator. Colaizzi's data analysis framework was used, with deductive coding after familiarisation with the data; patterns were identified and themes arrived at [6]. Two researchers independently reviewed the data and identified relevant phrases, which were coded into a coding book and further categorised. Similar categories were grouped to develop subthemes and themes.

RESULTS

The postnatal women were aged 25 to 38 years, and the majority had received higher education. Most were asymptomatic and tested positive as part of the protocol for admission for delivery. All women availed the routine counselling session offered by the hospital and did not feel the need for further counselling since they remained in constant touch with their immediate family for emotional support. The following themes and subthemes emerged from their experience.

THEMES

A. Negative feelings:

- **Subtheme: Fear/Panic:** The fear around COVID-19 was amplified by the media and instilled panic in COVID-19 positive women after testing as part of the predelivery admission protocol. As lockdown was declared and panic escalated worldwide, participants expressed fear of death creeping in. Isolation was perceived as a threat to security, and the sudden calls from health authorities caused panic. Since routine immunisation was halted, participants feared that their neonates would be susceptible to vaccine-preventable diseases.

  P3: "When we say COVID, what we see on TV is all the doctors wearing white coats, fully covered up, so that is the picture coming to our mind. So what came to my mind is, if I die, even my body won't be shown to anyone."

  P3: "They (healthcare providers) would all call and ask the same questions: Where did you get it from? Where did you go? Did anyone have fever at home?"

  P7: "My husband is stressed about the baby getting other infections, as the baby's vaccination was delayed."

- **Subtheme: Sadness:** The postnatal mothers expressed sadness about unexpectedly leaving their families behind and delivering in an isolation facility. Factors contributing to their grief included prolonged hospital stay, the baby being denied exclusive breastfeeding, and delayed parent-child bonding, as babies were in isolation with a bystander.

  P1: "I was sad when I repeatedly tested positive."

  P7: "They couldn't bring the baby frequently from a different ward, so in between they advised formula feeds that my mother would give. I felt bad that my child wouldn't be getting the benefits of exclusive breastfeeding."

  P8: "When labour pain started, I felt sad thinking no one was with me. For my first delivery, everyone was there."

  P9: "Protocols for COVID-19 testing prior to discharge kept changing, and that would make an already down patient feel even more down."

- **Subtheme: Worry:** Mothers were worried about leaving their children behind at home or at quarantine centres and whether they would turn COVID-19 positive. Worry was also related to their own care during delivery and thereafter, without any close family members and the neonate getting infected.

  P2: "I was so tensed—very tense thinking about the kids—can't describe it."

  P6: "The main worry was being separated and isolated, and there would be no bystander for me since close family members were positive."

- **Subtheme: Guilt:** "Early on in the pandemic, there was fear of contracting the disease as well as spreading the disease. Mothers felt guilty if they would have spread the disease when they were asymptomatic."

  P12: "Prior to getting my result, I had gone near the babies of other patients. I felt terrible if those babies could be infected now that I am COVID-19 positive."

- **Subtheme: Stigma:** Compared to most other states in India, Kerala as a society is extremely guarded about communicable diseases since the state had successfully handled a Nipah outbreak (2018) and the public was already aware of Personal Protective Equipment (PPE) kits and quarantine. There was close scrutiny of persons who turned COVID-19 positive and their primary contacts, and this led to a panic situation among the public at times. Some of the respondents painfully recalled the baseless rumours spread about them.

  P3: "I feel everyone should get this disease. They should realise how the actions and attitude of other people affect a person who got the disease."

  P3: "The neighbours spread the news that I was in ICU, and even that I was dead. The disease didn't cause any problem; all the rumours and attitude of the people was the problem."

- **Subtheme: Feeling helpless:** In spite of the government machinery working to ensure adequate care was delivered, at times the mothers felt helpless. These were related to prolonged hospital stay stipulated by strict discharge protocols and, at times, lack of support from the community.

  P9: "Whenever I asked about discharge rules—they would say it is not in their control. The list comes from COVID-19 cell."

  P9: "During the entire COVID-19 situation the people who suffered the most were the women who delivered in the COVID-19 ward."

- **Subtheme: Inconvenience Experienced:** Participants expressed inconvenience related to their experience, in terms of lack of continuity in obstetric care since they were referred without any choice on their part due to the COVID-19 protocol. Since primary contacts who were close family members were forced to go into quarantine, mothers felt a lack of family support. Also, a break in continuity in postnatal and neonatal services was expressed as mothers could not follow up at the place of their delivery.

  P1: "It was 1½ hours away from my home, whereas I had intended to deliver at a place near my home."

  P7: "You feel like going back to the hospital where you delivered for further consultation and for clearing doubts, but I cannot go back here because this hospital is only for COVID now."

B. Positive feelings:

- **Subtheme: Medical Care Related:** Women felt safer, even though isolated. It was perceived that they got better treatment for COVID-19 as well as the pregnancy was cared for better in hospital. It was also noted that lack of a bystander led to early ambulation with faster postoperative healing.

  P1: "I felt in the hospital the blood sugars could be checked frequently and insulin adjusted—that wouldn't have been possible at home."

  P8: "I realised many people had severe problems; it was good I was admitted even though I had no symptoms."

- **Subtheme: Supportive Interpersonal Interactions:** The immediate and foremost support the pregnant women received were from their mothers and husbands. They couldn't be there in person for them, but supported them amply through video calls and phone calls. Participants remembered with gratitude and appreciated the care given by doctors and staff nurses. They felt sympathy for staff working in PPE kits. The in-patients were supportive and a feeling of kinship evolved. Other factors—counselling psychologists and frequent enquiry from Public Health staff—were well-appreciated. Unexpected help from neighbours, relatives, and friends was comforting.

  P1: "Staff used to take care of me better than a mother would take care of her daughter."

  P3: "Now we know the people around us very well—who will help us, who will stab us from the back."

  P9: "Phones were kept silent since there were others like me and we didn't want the babies to be disturbed. Everyone helped others a lot."

- **Subtheme: Postpartum Rest:** Mothers felt rested and cared for by family after the isolation experience, even as ritual baths and visits after delivery were curtailed due to home quarantine.

P3: Anyway, after delivery we are usually not very active and mostly resting, so it did not feel like a quarantine.

DISCUSSION

The main objective of this study was to understand the experiences of COVID-19 positive pregnant women who had to undergo delivery in an isolation facility. Although there is published data on the Western population, so far no study has been reported from India, and authors found the similarities due to the pandemic situation. The difference in cultural factors emerged as a new dimension in our setup. The experiences were categorised into negative and positive. Mothers could provide a lot of information about their experiences as they had gone through an unforeseen delivery experience and could give vivid details, especially fear while being transported alone, admitted in isolation, delay in discharge due to protocol, etc.

The initial reports of COVID-19 in pregnant women speculated that pregnancy per se would not be a risk factor [7]. As the pandemic progressed, increased maternal morbidity and preterm labour were reported [8]. The data on the safety of neonates was also established much later, and many mothers chose to isolate the neonate to prevent cross-infection. In current study, authors found specific references to death in isolation, dying without a funeral, and anxiety related to the PPE kit, which was perceived as a reminder of death. This was particularly so because the region had undergone a threat of Nipah virus infection in 2018 with a case fatality rate of 91%, and the PPE kit was associated with a disease of almost certain mortality. This study population in the south Indian state had undergone an experience of fear and severe isolation two years prior to COVID-19 [8]. Apart from the fear of mortality, it was reported that some participants were fearful that the transient cessation of immunisation services would put the neonate at risk of other preventable diseases.

Studies have shown that when mothers were forced to go into isolation, the loss of family time, reduced interaction with partners, and reduced parent-child bonding increased the risk to mental health, and the need for continuous monitoring and early diagnosis of mental health disorders has been emphasised [9]. The present study has confirmed these concerns. Another area that has received attention during COVID-19 isolation is related to breastfeeding owing to unclear guidelines. The protocol of minimum contact with the mother affects breastfeeding, and the long-term effects of partner separation on parent-child bonding, with further implications for the child's development, have been raised [10], and our study population confirmed the same. Some studies have reported the need for support for both parents as well as supportive peer parental groups [11]. This was not expressed by our participants, since postnatal women in India are supported by their mothers and other near relatives as part of the culture. However, it has to be kept in mind that with changing family structure this may be a concern in the future. In addition, traditional attendants who give care to the mother and baby chose to stay away due to stigma, thus making the mothers miss the ritual bath and care.

The pandemic experience has exposed lacunae in maternal and neonatal health care programs [12]. This was compounded by the unavailability of family support due to COVID-19 restrictions. Patients also felt a lack of continuity in obstetric care. In most cases, pregnant women were the first to contract the disease, and immediate family members were sent to quarantine facilities or isolated at home. This led to more anxiety as mothers worried about children left behind at home or shifted to facilities. The prolonged hospital stays due to strict discharge protocols were strongly distressing. This has also been validated as a stressor among vulnerable postnatal women, and a need for changes in public health policy has been suggested [13].

The mothers who were infected in the initial days of lockdown expressed distressing feelings of guilt at being the index case and the reason for quarantining other family members or infecting them, as well as a segregated feeling of being persecuted or isolated by society. This is similar to the stigma reported in tuberculosis patients [14].

Positive feelings expressed in studies include a sense of safety and a better delivery experience [15]. Apart from this, our respondents pointed out an advantage of faster postoperative wound healing owing to ambulation being a necessity in the absence of a bystander.

Supportive care from health workers was hugely appreciated, especially in the initial days when there were few patients; later on, even when the wards were full, patients sympathised with the staff working in PPE kits and applauded the care they provided. Another experience they delightfully shared was that inpatients supported each other.

Studies have actually reported the postnatal period in the lockdown era as a time of relaxation, quoting the cultural experience of postnatal women in the Indian context [16]. Though some rituals were missed, our mothers also reported a sense of relief and calm experienced during the postnatal period.

Limitation(s)

Mothers who delivered early in the first wave of COVID-19 were interviewed, which is both a strength and a limitation. While the experiences of women who delivered in the most uncertain and frightening stages were recorded, as the pandemic progressed, newer perceptions may have emerged and some may have disappeared. Another limitation is recall bias, since the women were interviewed within two months after delivery, and due to postnatal needs some of them were interviewed in two sessions.

CONCLUSION(S)

The negative experiences women had were partly due to the panic created by the pandemic and partly due to the restrictive protocols. This highlights the need to consider pregnant women as a vulnerable group requiring customised protocols. Public health policies in future pandemics should ensure a continuum of care for this population. Lactation consultants and peer groups may help in assessing these needs. Since there is an overwhelming emotional upheaval during this experience, periodic surveillance may be suggested to detect mental health problems. In future isolation scenarios, patients supporting each other can be viewed as an important stress reliever and utilised to meet the needs of the quarantined population. From this experience, it can also be concluded that if there is no option for a bystander, providing care in general wards to an isolated population may be more feasible and less distressing than isolating them individually.

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PARTICULARS OF CONTRIBUTORS:
1. Assistant Professor, Department of Obstetrics and Gynaecology, Government Medical College, Ernakulam, Kochi, Kerala, India.
2. Assistant Professor, Department of Obstetrics and Gynaecology, Government Medical College, Ernakulam, Kochi, Kerala, India.
3. Assistant Professor, Department of Paediatrics, Government Medical College, Ernakulam, Kochi, Kerala, India.
4. Professor, Department of Psychiatry, Government TD Medical College, Alappuzha, Kerala, India.
5. Professor, Department of Obstetrics and Gynaecology, Sree Narayana Institute of Medical Sciences, Kochi, Kerala, India.

NAME, ADDRESS, E-MAIL ID OF THE CORRESPONDING AUTHOR:
Dr. Suman Paul,
Assistant Professor, Department of Obstetrics and Gynaecology, Government Medical College, Ernakulam, Kochi-683503, Kerala, India.
E-mail: sumananukoch@gmail.com

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[APPENDIX 1]

Relevant socio-demographic details collected included:

1. Age
2. Occupation/Education
3. Parity
4. Mode of birth vaginal/instrumental delivery/caesarean
5. No of days of hospital stay
6. No. of counselling sessions availed