LETTERS IN BIOMATHEMATICS
An International Journal

RESEARCH ARTICLE

OPEN ACCESS

Postpartum Care Practices among Postnatal Mothers: A Qualitative Exploratory Study

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ABSTRACT

Background: Postpartum care practices are influenced by cultural beliefs, family traditions, and health-care advice. Understanding mothers' experiences is essential for providing culturally sensitive postnatal care. Aim: To explore postpartum care practices and experiences among postnatal mothers from rural and urban backgrounds attending a tertiary care hospital. Methods: A qualitative exploratory (descriptive) study was conducted among 21 postnatal mothers selected through purposive sampling. Data were collected using semi-structured in-depth interviews and analysed using Braun and Clarke's thematic analysis. Results: Six themes emerged: Theme 1: Emotional Transition into Motherhood, Theme 2: Challenges of adapting to the Postpartum Period, Theme 3: Postpartum rituals and social restrictions, Theme 4: Health consequences of Postpartum Practices, Theme 5: Traditional Complementary Therapeutic Practices and Perceived benefits, Theme 6: Family-Centered and Social Support facilitating Maternal Recovery. Conclusion: Postpartum practices remain deeply rooted in cultural traditions. While several practices promote maternal recovery, some require modification through culturally appropriate health education.

ARTICLE HISTORY
Received September 29, 2026
Accepted November 02, 2026

KEYWORDS
Postpartum Care, Qualitative Research, Cultural Practices, Postnatal Mothers, Thematic Analysis.

1. Introduction

The postpartum period, also referred to as the puerperium, begins immediately after childbirth and extends for approximately six weeks, during which substantial physiological, psychological, emotional, and social adjustments occur in a woman's life. Although childbirth marks the successful completion of pregnancy, the postpartum period is equally important because it determines the future health and well-being of both the mother and the newborn. During this period, mothers experience recovery from pregnancy and childbirth while simultaneously adapting to new maternal responsibilities, breastfeeding, infant care, and changing family roles. Appropriate postpartum care practices play a crucial role in promoting maternal recovery, preventing complications, and supporting newborn survival[1,6]. In the Indian context, this phase is traditionally regarded as a time of special vulnerability for the mother, and families observe a defined period of rest, dietary regulation and ritual care to protect her health.

The World Health Organization recommends comprehensive postnatal care that addresses maternal physical recovery, mental health, breastfeeding support, nutrition, family planning, newborn care, and early identification of complications. Recent WHO recommendations emphasize respectful, individualized, and woman-centered care throughout the postnatal period to improve maternal and neonatal outcomes[1]. These recommendations highlight that postnatal care should extend into the home and community, where most of the recovery actually takes place.

Worldwide, considerable attention has been directed toward improving maternal health during pregnancy and childbirth. Evidence indicates that many maternal complications, commonly arise during this period. Early identification and appropriate management of these conditions can significantly reduce maternal morbidity and mortality[2]. Postpartum haemorrhage, sepsis, hypertensive disorders, thromboembolism and postpartum depression account for a large share of this burden.

Postpartum care extends beyond medical treatment and encompasses nutritional practices, personal hygiene, rest, emotional support, breastfeeding, newborn care, family involvement, cultural beliefs, and timely utilization of health services. These practices are influenced by individual knowledge, family traditions, socioeconomic conditions, educational status, accessibility of healthcare facilities, and community beliefs. In many societies, particularly in rural settings, traditional postpartum practices are deeply rooted in cultural values and are transmitted from one generation to another. While several traditional practices may provide comfort and psychological support, others may delay appropriate healthcare seeking or interfere with evidence-based maternal and newborn care[3]. The manner in which a woman is cared for after childbirth therefore reflects not only clinical protocols but also the collective wisdom and expectations of her family and community.

India has made substantial progress in reducing maternal mortality through various national health initiatives, improved institutional deliveries, and strengthened maternal healthcare services. Nevertheless, rural women continue to experience disparities in accessing quality postpartum care because of geographical barriers, inadequate healthcare resources, financial constraints, limited awareness, and sociocultural influences. Understanding the lived experiences and postpartum care practices of rural mothers is therefore essential for designing culturally acceptable interventions that enhance maternal and newborn health outcomes[4]. Urban mothers, although closer to health facilities, are not free from these influences, as traditional practices continue to be observed in modified forms within urban households.

Qualitative research provides an opportunity to explore women's perceptions, beliefs, experiences, and decision-making processes related to postpartum care in greater depth than quantitative approaches alone. Such insights can guide nurses, midwives, policymakers, and healthcare providers in developing woman-centered and culturally sensitive postpartum care programs[5]. It also gives voice to the mothers themselves, allowing care to be planned around what they actually experience rather than what is assumed on their behalf.

In India, despite significant improvements in institutional deliveries under national maternal health programs, postpartum care remains underutilized, especially in rural communities. Many women receive limited professional follow-up after discharge from healthcare facilities and rely primarily on family members, traditional birth attendants, or community elders for postpartum guidance. Rural mothers often practice dietary restrictions, prolonged confinement, herbal remedies, oil massages, and other culturally prescribed behaviors that vary considerably across regions. Although some of these practices may support maternal recovery, others lack scientific evidence or may increase health risks if practiced inappropriately[6]. Comparing the practices of rural and urban mothers can reveal how urbanisation, education and exposure to health information modify or preserve these traditions.

Studies conducted in different parts of India have demonstrated that postpartum care practices are strongly influenced by education, socioeconomic status, cultural beliefs, availability of healthcare services, and family support. Women residing in rural areas frequently encounter barriers such as transportation difficulties, inadequate healthcare infrastructure, limited awareness regarding danger signs, and restricted autonomy in healthcare decision-making. These challenges may contribute to delayed recognition of postpartum complications and poor utilization of postnatal care services[7]. Such barriers are compounded when the mother's own autonomy is limited and decisions are made chiefly by elders in the household.

Qualitative studies conducted in various countries have highlighted that women's postpartum experiences are shaped not only by healthcare services but also by family expectations, cultural norms, traditional beliefs, and personal perceptions of motherhood. Exploring these experiences among rural mothers allows researchers to understand the meanings women attach to postpartum practices and identify opportunities for integrating beneficial traditional practices with evidence-based maternal healthcare[8]. The present study was therefore undertaken to explore postpartum care practices among postnatal mothers from rural and urban backgrounds attending a tertiary care hospital in Karnataka, India.

2. Need for the Study

The postpartum period remains one of the most vulnerable stages in a woman's reproductive life, yet it often receives less attention than antenatal and intrapartum care. Although institutional delivery rates have increased substantially in India, continuity of care following childbirth remains inadequate in many rural communities. Mothers frequently return home within a short period after delivery, where postpartum care is largely influenced by family traditions and local cultural beliefs rather than professional healthcare advice[1]. The first six weeks after birth are also the period in which mothers establish breastfeeding, adjust emotionally to their new role and are most exposed to traditional practices, making it the ideal window for culturally sensitive guidance.

Healthcare providers often focus primarily on the immediate clinical needs of mothers and newborns, whereas broader aspects such as emotional adjustment, family support, breastfeeding challenges, cultural practices, nutritional behaviors, and healthcare-seeking experiences receive limited attention. Consequently, many postpartum practices remain poorly understood, particularly from the

perspective of rural mothers themselves. Mothers may therefore hesitate to disclose home-based practices to health workers for fear of disapproval, and valuable opportunities for safe counselling are lost.

Most existing studies concerning postpartum care have used quantitative methods that measure knowledge, attitudes, or service utilization. Although these studies provide valuable statistical information, they may not adequately explain why mothers adopt particular postpartum practices, how cultural beliefs influence their decisions, or what challenges they experience while caring for themselves and their newborns. Qualitative research addresses these gaps by providing rich descriptions of lived experiences of women, perceptions, and meanings attached to postpartum care[5]. Understanding these underlying reasons is a prerequisite for designing interventions that mothers and their families will actually accept.

Rural communities are characterized by diverse traditions, social structures, and healthcare access patterns. Identifying beneficial traditional practices alongside potentially harmful customs will enable healthcare professionals to develop culturally appropriate educational strategies rather than simply discouraging traditional behaviors. Understanding mothers' experiences can also assist nurses in providing individualized postpartum counseling that respects cultural values while promoting evidence-based maternal and newborn care. An approach that builds on existing beliefs is far more likely to be accepted than one that dismisses them.

The findings of the present qualitative study will contribute to nursing education, clinical practice, maternal health policy, and community-based interventions by generating context-specific evidence regarding postpartum care practices among postnatal mothers. The study will also provide valuable insights for strengthening postnatal services, improving maternal health education, enhancing family involvement, and ultimately reducing preventable maternal and neonatal morbidity. Comparing rural and urban experiences will additionally help health workers to tailor counselling to the specific context of each mother.

3. Materials and Methods

Study setting: The study was undertaken in the postpartum clinic of [name of hospital], a tertiary care hospital in [city], Karnataka, India, from [month] to [month] 2026. Study design: A qualitative exploratory (descriptive) design was adopted and the data were analysed using reflexive thematic analysis. This approach was chosen because it allows the lived experiences of mothers to be described in their own words, without imposing predetermined categories.

Study participants and sample size and sampling: The sample consisted of twenty-one postnatal mothers (12 rural, 9 urban) who had delivered within the previous 12 months, recruited by purposive sampling. Inclusion criteria were: age ≥ 19 years, within one year postpartum, ability to communicate in Kannada or English, and willingness to give written informed consent. Mothers who were critically ill or unwilling to be audio-recorded were excluded. Recruitment continued until data saturation was reached, when no new codes or themes emerged from successive interviews.

Data collection and procedure: Data were collected using a semi-structured in-depth interview guide, which was pilot-tested before use. Each interview lasted 40–60 minutes. Audio recordings and field notes were taken, and data collection continued until saturation was reached. Data were analysed using Braun and Clarke's six-step thematic analysis: familiarisation, coding, searching for themes, reviewing themes, defining and naming themes, and writing the report. The study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ). Interviews were conducted in a private room of the clinic in the participant's preferred language, audio-recorded, transcribed verbatim and translated into English where required. Each transcript was read several times before coding, and codes were grouped into categories and themes with constant comparison across rural and urban participants.

Ethical approval: Approval was obtained from the Institutional Ethics Committee of Kodagu Institute of Medical Sciences, Madikeri (IEC No. KoIMS/IEC/32/22-23, dated 12/01/2023). Written informed consent was taken from all participants. Confidentiality and anonymity were maintained throughout the study. Participation was voluntary and participants could withdraw at any time without any consequence. Data were stored securely with password protection to prevent misuse. Participants were identified by codes rather than names in all transcripts and reports.

Trustworthiness was maintained to ensure rigour using the criteria of Lincoln and Guba. Credibility was ensured by prolonged engagement with participants, triangulation of semi-structured interviews with field observation, member checking of transcripts and interpretations with participants, and peer debriefing with experts who reviewed the interpretations and findings. Field notes recorded non-verbal cues and contextual details that enriched interpretation of the transcripts.

Transferability was ensured by providing rich, detailed descriptions of the participants, setting and findings, supported by purposive sampling. Dependability was ensured by transparency in participant selection and interviewing, a detailed audit trail of every step, a code–recode strategy and an inquiry audit. Confirmability was ensured by bracketing and by maintaining a reflexive journal documenting the researchers' thoughts, assumptions and biases throughout the study. Direct participant quotations have been presented to allow readers to judge the fit between the data and the interpretations.

4. Results

TABLE 1: PARTICIPANT CHARACTERISTICS (N = 21)

SL NO	CHARACTERISTIC	FREQUENCY
01	**AGE**	
a.	Age (20–25 years)	7
b.	Age (26–30 years)	8
c.	Age (>30 years)	6
02	**PARITY**	
a.	Primipara	11
b.	Multipara	10
03	**AREA**	
a.	Rural	12
b.	Urban	9

TABLE 2: THEMES, CATEGORIES AND PARTICIPANT NARRATIVES EMERGING FROM THE DATA

Theme	Category	Initial Codes	Participant Quotes
Emotional Transition into Motherhood	Emotional fulfillment despite pain Mother infant bonding	Postpartum pain, emotional relief, joy of motherhood	24 years old mother said "I was in pain while recovery but felt relaxed and happy on seeing my little baby"
	Emotional adaptation	Pain forgotten, maternal happiness, bonding	"I forgot all aches looking at my baby" said by 33 years old mother
Challenges of adapting to the postpartum period	Lifestyle adjustments after childbirth	Sleep deprivation, infant care, frequent visitors, fatigue	"I used to have less sleep every time as my baby would be awake till mid night and more relatives would come home to see me and baby during day time" said by 29 years old mother
	Increased caregiving responsibilities Maternal role transition	Loss of personal space, increased responsibility, role adjustment	26 years old mother said "I felt I lost my comfort zone as I have to focus more on my baby and family too"
	Breastfeeding challenges	Breastfeeding pain, nipple trauma, discomfort	"I suffered a lot with my cracked nipples every time when I feed my baby"
Postpartum rituals and social restrictions	Traditional dietary restrictions	Food restriction, cultural dietary belief	"I was not given any fruits especially water melon to eat saying it increases my belly size"
		Water restriction, family belief, dehydration	"My mother would not give much water to me saying my belly size will increase if I drink more water"

	Beliefs regarding body heat and recovery	Alcohol consumption, traditional remedy, perceived protection	"I was given small quantity of alcohol to drink at night saying it increases body heat and I and my baby will not get cold"
	Cultural practices	Postpartum isolation, ritual purity, family customs	"I was not allowed to enter kitchen for 16 days , separate plate , spoon and glass was kept for me, performed pooja after 16 days and then allowed to enter" said by 23 year old mother
Health consequences of traditional postpartum practices	Consequences of food restrictions	Hot diet, dehydration, constipation, painful defecation	"For all dishes they would add pepper and would give only hot foods, were not giving water so I suffered pain, bleeding while passing motion"
	Coping with restrictive practices	Water restriction, hidden behaviour, unmet physical need	"I was given only 3 small glasses of water each morning, afternoon and night after food so I would hide and drink water without being noticed by my mother" said by 22 year old mother
Traditional Complementary therapeutic practices in postpartum care and perceived benefits	Indigenous healing practices	Herbal medicine, ritual preparation, traditional remedy	28 year old mother said "every morning for 16 days I was given herbal medicines prepared by my mother in law and hot iron spatula(made hot by keeping the iron spatula in fire) would be dipped in before giving me to drink in big glass"
	Traditional Nutritional supplements	Traditional foods, nutritional beliefs	"I was given betal leaves to chew every day saying it is for health. Weekly once I was given mutton soup too"
	Traditional body care practices	Oil massage, heat therapy, relaxation, improved sleep	"My mother would massage me every day with 3 different types of oil mixed (coconut oil, sesame oil and mustard oil) would make me sit in front of fire for 45 min and would pour very hot water on me before actual bath. I would feel exhausted during the process but later got very much relaxed and would get good sleep"
Family-Centered and Social Support Facilitating Maternal Recovery	Protective Family support	Maternal advice on encouragement of bed rest, restriction of household work, emphasis on physical recovery, prevention of future health problems, family-guided postpartum care	"My mother always advices me to sleep flat always and limits me from working as I need to recover early and be fit in later days"
	Social support and expectations from relatives	Family support, social interaction, visitor burden	"All my relatives would come to my home to see me and my baby. They would bring lots of eatables along with ghee and meat. Would feel happy to see them but sometimes difficult to manage.

5. Major Themes with Categories

Theme 1: Emotional Transition into Motherhood

Categories

- Emotional fulfilment despite pain
- Mother–infant bonding
- Emotional adaptation to motherhood

Theme 2: Challenges of Adapting to the Postpartum Period

Categories

- Lifestyle adjustments after childbirth
- Increased caregiving responsibilities
- Maternal role transition
- Breastfeeding challenges

Theme 3: Postpartum rituals and social restrictions

Categories

- Traditional Dietary restrictions
- Traditional medicinal remedies
- Beliefs regarding body heat and recovery
- Cultural practices

Theme 4: Health Consequences of Postpartum Practices

Categories

- Consequences of dietary restrictions (dehydration, constipation and painful bowel movements)
- Physical discomfort
- Coping with restrictive practices

Theme 5: Traditional Complementary Therapeutic Practices and Perceived benefits

Categories

- Indigenous healing practices (herbal medicine, oil massage, heat therapy)
- Traditional nutritional supplements

Theme 6: Family-Centered and Social Support Facilitating Maternal Recovery

Categories

- Protective family support
- Social support and expectations from relatives

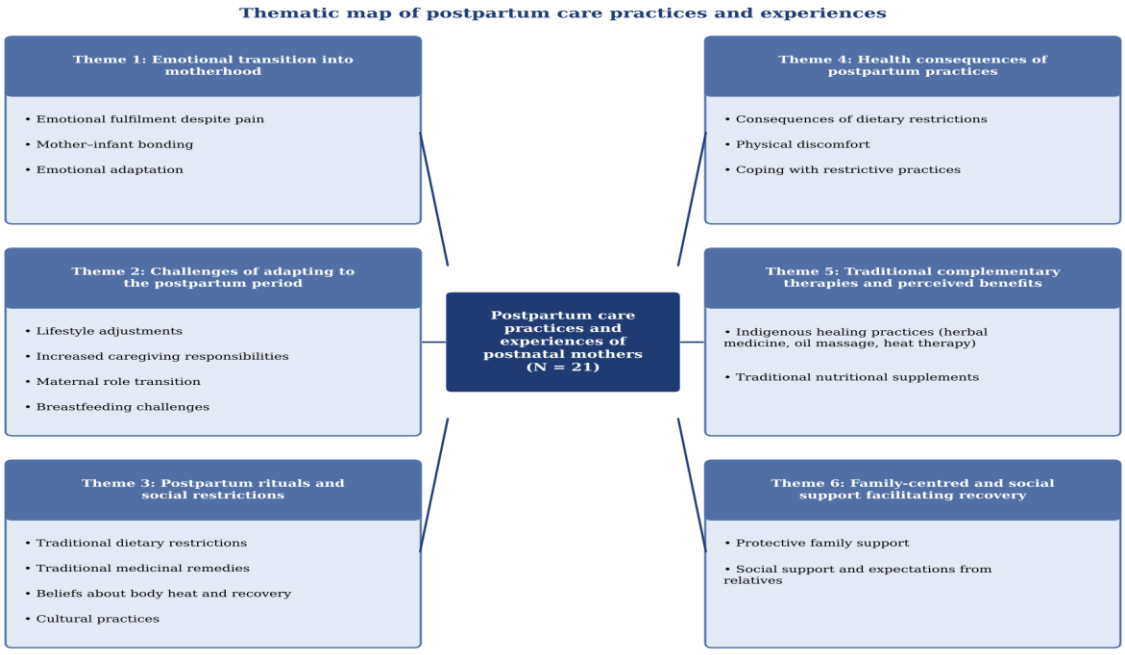


Fig 1: Thematic map of themes and categories emerging from the data

TABLE 3: Force Field Analysis of Postnatal Mothers' Experiences Based on Qualitative Findings

Category	Negative Force (Restraining Factors)	Positive Force (Driving Factors)	Suggested Solution/Implication
Emotional adaptation to motherhood	Postpartum pain, physical discomfort during recovery	Happiness after seeing the newborn, strong mother–infant bonding, emotional satisfaction	Reinforce early skin-to-skin contact, emotional counselling, and family support to enhance positive maternal adaptation while addressing pain adequately.
Transition to maternal role	Loss of personal comfort, increased household and babycare responsibilities	Sense of responsibility, maternal identity, family involvement	Promote equitable sharing of household responsibilities and encourage partner and family participation in newborn care.
Sleep and lifestyle adjustment	Sleep deprivation due to infant care, frequent visitors, fatigue	Increased confidence in caring for the baby, gradual adaptation to maternal responsibilities	Educate families regarding scheduled visiting hours and encourage shared caregiving to improve maternal rest.
Breastfeeding experience	Cracked nipples, painful breastfeeding, discomfort	Successful breastfeeding despite challenges, motivation to nourish the infant	Provide early lactation counselling, assessment of breastfeeding techniques, and prompt management of cracked nipples
Traditional dietary practices	Restriction of fruits and fluids, dehydration, constipation, painful bowel movements	Family intention to promote recovery through culturally accepted dietary practices	Respect beneficial cultural practices while providing evidence-based nutrition education emphasizing adequate hydration, fruits, fibre, and balanced meals.
Postpartum rituals and practices	Social isolation, restricted mobility, use of separate utensils, limited autonomy	Cultural identity, emotional security, family acceptance, continuation of traditions	Respect cultural rituals that are harmless while discouraging practices that compromise maternal dignity, nutrition, hydration, or mobility.
Hydration practices	Deliberate restriction of water intake, risk of dehydration	Family belief that restriction improves recovery	Educate mothers and caregivers on the importance of adequate fluid intake for healing, breastfeeding, and prevention of constipation.
Traditional medicinal remedies	Consumption of alcohol, herbal preparations without scientific validation, potential health risks	Perceived improvement in body warmth and recovery, strong family support for traditional care	Assess safety of traditional remedies during postnatal visits and educate families regarding safe and harmful practices without disregarding cultural beliefs.
Complementary postpartum therapies	Exhaustion from prolonged massage, heat exposure and hot water bathing	Relaxation, improved sleep, perceived pain relief and comfort	Encourage safe massage practices performed by trained personnel while avoiding excessive exhaustion and adequate hydration.
Traditional nutritional supplementation	Excessive reliance on certain foods based solely on cultural beliefs	Consumption of ghee, meat, mutton soup, betel leaves believed to improve strength and recovery	Integrate culturally acceptable foods with evidence-based nutritional recommendations tailored to maternal health needs.
Family and social support	Frequent visitors causing fatigue and difficulty managing daily activities	Emotional encouragement, practical support, provision of nutritious foods and gifts	Encourage balanced social support by limiting visitor burden while promoting meaningful assistance with household and infant care.

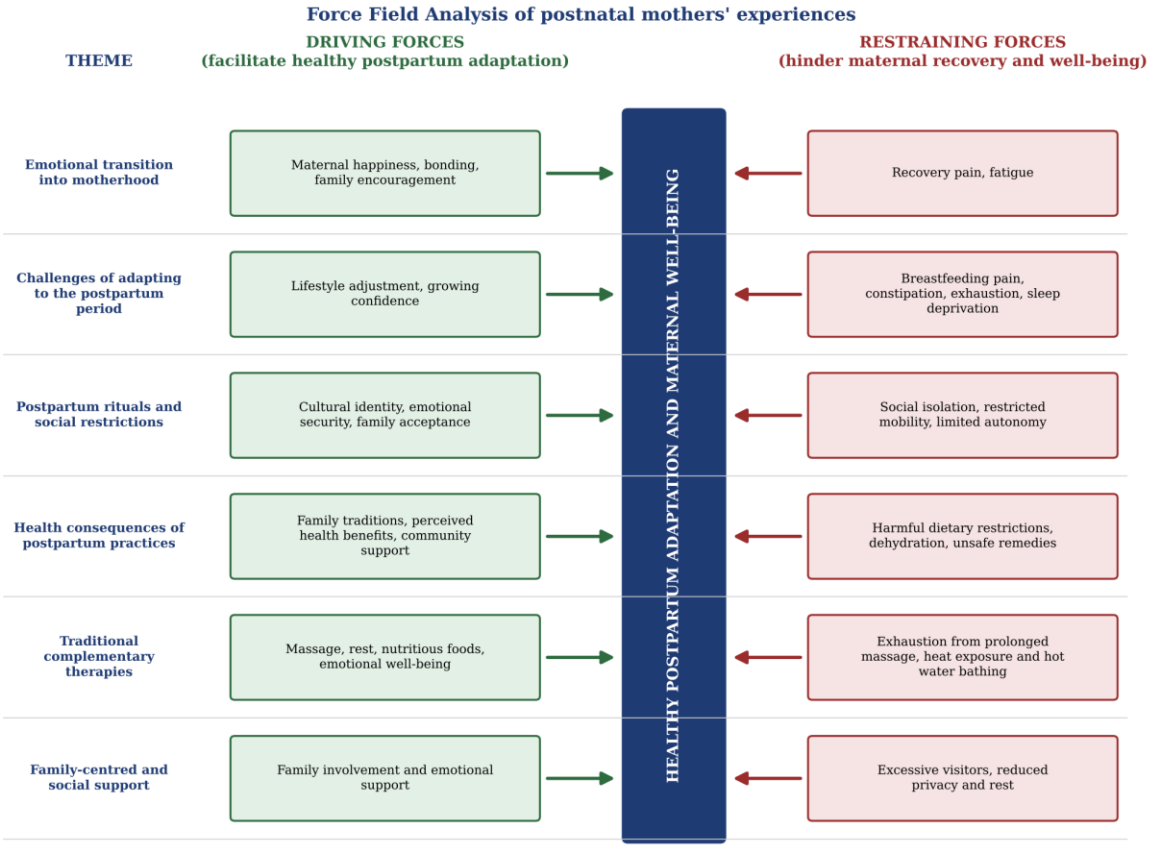


Fig 2: Force Field Analysis of postnatal mothers' postpartum experiences

TABLE 4: Overall Interpretation and Discussion

Theme	Restraining Forces	Driving Forces	Practice Implication
Emotional transition into motherhood	Recovery pain, fatigue	Maternal happiness, bonding, family encouragement	Strengthen emotional and psychological support during the early postnatal period.
Challenges of adapting to the Postpartum period	Breastfeeding pain, constipation, exhaustion, sleep deprivation	Life style adjustment	Modifying the life style and adapt to the circumstances facilitating wellbeing.
Postpartum rituals and social restrictions	Social isolation, restricted mobility, use of separate utensils, limited autonomy	Cultural identity, emotional security, family acceptance, continuation of traditions	Respect cultural rituals that are harmless while discouraging practices that compromise maternal dignity, nutrition, hydration, or mobility.
Health consequences of postpartum practices	Harmful dietary restrictions, dehydration, unsafe remedies	Family traditions, perceived health benefits, community support	Deliver culturally sensitive health education that preserves beneficial traditions while modifying unsafe practices.
Traditional complementary therapeutic practices and perceived benefits	Exhaustion from prolonged massage, heat exposure and hot water bathing	Massage, rest, nutritious foods, emotional wellbeing	Strengthens the mother and focus on overall wellbeing of the postnatal mother.
Family centred and social support facilitating maternal recovery	Excessive visitors, reduced privacy and rest	Family involvement and emotional support	Promote family-centred postpartum care with guidance on appropriate support and maternal rest.

6. Discussion

From the participants' narratives, six themes were generated (Fig 1). Force Field Analysis (Fig 2, Table 3) identified driving forces that facilitate healthy postpartum adaptation and restraining forces that hinder maternal recovery and well-being. The analysis focused on solutions that translate qualitative findings into practical recommendations for nurses, midwives, and maternal health policymakers, strengthening the study's implications for practice. Force Field Analysis was chosen as an interpretive framework because it helps to identify which forces should be strengthened and which should be reduced to facilitate healthy postpartum adaptation.

The study findings were consistent with those of similar studies. Fuad et al. conducted a study among 725 postpartum mothers in Malaysia, where mothers preferred complementary therapies during the postpartum period because of cultural beliefs regarding faster recovery. The study revealed that 85.5% used complementary and alternative medicine (CAM) during the postpartum period. The most commonly used modalities were manipulative body therapies (84.1%), including massage, reflexology, hot stone compression, and body wrapping, followed by biological-based therapies (33.1%)[9]. The present participants similarly described oil massage, heat therapy and hot water bathing as sources of relaxation, pain relief and improved sleep, with family members being the main motivators of these practices.

Likewise, Udgiri reported that dietary restrictions remained common among Indian mothers in a cross-sectional study among 200 postnatal mothers in North Karnataka, India, which explored traditional postpartum beliefs and practices. The study found that while several beneficial practices, such as consuming fresh and nutritious food, drinking hot water, using warm clothing, and maintaining a separate room for the mother and newborn, were commonly followed, many potentially harmful practices also persisted. These included food taboos (76%), discarding colostrum (15%), prelacteal feeding (18%), avoiding tooth brushing (14%), and holy smoke administration (34%). Safe cultural practices, such as oil massage and abdominal support, were also widely practiced. The study further identified significant associations between cultural practices and factors such as maternal literacy, socioeconomic status, religion, family type, rural residence, and maternal age. The author concluded that while culturally beneficial practices should be encouraged, harmful traditions require targeted health education and counselling to improve maternal and newborn health outcomes[10]. Consistent with these findings, mothers in the present study reported restriction of fruits, fluids and certain foods leading to constipation and dehydration, as well as emotional comfort derived from family-centred rituals. The strength of the present study lies in its use of in-depth interviews and multiple strategies for trustworthiness; its limitations include a single-hospital setting and a relatively small sample, so transferability to other regions should be made with caution.

7. Implications for Nursing Practice

- Develop culturally sensitive postpartum education. Education should acknowledge beneficial traditions while correcting harmful ones.
- Involve family members in counselling. Mothers-in-law and husbands, who strongly influence postpartum decisions, should be included.
- Train midwives to identify beneficial and potentially harmful traditional practices. This assessment should form part of every routine postnatal visit.
- Integrate evidence-based recommendations into routine postnatal care. These should include guidance on hydration, balanced diet, safe massage and early mobilisation.

8. Conclusion

Postpartum care practices are shaped by culture, family, and personal beliefs. Many traditional practices provide emotional comfort and perceived physical benefits, whereas others may not align with current evidence. Healthcare professionals should acknowledge women's cultural beliefs while promoting safe, evidence-based postpartum care. Nurses and midwives, as the professionals in closest contact with mothers after childbirth, are ideally placed to bridge the gap between tradition and evidence through respectful, family-centred counselling.

Financial Support

Nil

Conflicts of Interest

The authors declare that there are no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author on reasonable request.

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