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Women's Perceptions of Breastfeeding Rights During the COVID-19 Pandemic: A Qualitative Study in Quito, Ecuador

Estefanía Rodríguez-Landázuri
Universidad UTE
Iván Dueñas-Espín
Pontificia Universidad Católica del Ecuador
Elizabeth García-Alarcón
Pontificia Universidad Católica del Ecuador
Betzabé Tello
bmtello@puce.edu.ec

Pontificia Universidad Católica del Ecuador

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Abstract

Background

The COVID-19 pandemic affected maternal and newborn care worldwide, including practices that support breastfeeding. This study explored women's experiences and perceptions of breastfeeding rights during the COVID-19 pandemic in Quito, Ecuador, from a bioethical and human rights perspective.

Methods

A qualitative descriptive study was conducted with ten women who gave birth between April 2020 and June 2021 in public or private health facilities in Quito. Semi-structured interviews were conducted between August and October 2021. Data were analyzed using a deductive thematic approach informed by the bioethical principles of autonomy, beneficence, non-maleficence, and justice. Two researchers independently coded the transcripts, and recruitment continued until thematic saturation was reached.

Results

Four themes corresponding to the bioethical principles were identified. Participants described mother-infant separation, delayed skin-to-skin contact and breastfeeding initiation, inconsistent professional guidance, and limited breastfeeding support. Some women reported receiving commercial infant formula during hospitalization or at discharge, including formula samples and feeding products. These experiences were perceived as limiting informed decision-making, interfering with breastfeeding initiation, and increasing uncertainty about breastfeeding. Participants also emphasized the need for trained healthcare professionals, reliable breastfeeding information, stronger public policies, and health-system support to protect breastfeeding during public health emergencies.

Conclusions

Women's experiences during the COVID-19 pandemic identified gaps in breastfeeding support and protection within maternity care. Emergency responses should integrate breastfeeding protection into clinical protocols, professional training, and health policies, ensuring that infection-control measures are evidence-based and consider maternal and infant wellbeing, breastfeeding rights, and ethical principles.

Background

Breastfeeding provides optimal nutrition and immune protection and contributes to maternal and child health [1]. The World Health Organization (WHO) and United Nations Children's Fund (UNICEF) recommend exclusive breastfeeding during the first six months of life and continued breastfeeding alongside complementary feeding up to two years of age or beyond [2]. Breastfeeding is also recognized

within a human rights framework, which includes children's right to health and nutrition and women's right to receive appropriate information and support to breastfeed [3].

Breastfeeding protection is particularly important during emergencies [4, 5]. International guidance on Infant and Young Child Feeding in Emergencies recommends maintaining breastfeeding support during humanitarian crises, natural disasters, and disease outbreaks because breastfeeding provides a safe and reliable source of infant nutrition when access to health services, food, and clean water may be disrupted [4]. This requires health systems to maintain appropriate maternal and newborn care and access to skilled breastfeeding support during emergencies [4].

The COVID-19 pandemic disrupted maternity and newborn care worldwide [6]. During its early stages, uncertainty regarding SARS-CoV-2 transmission led health facilities to implement precautionary measures, including mother-infant separation, restrictions on skin-to-skin contact, and changes in infant feeding practices [7, 8]. As evidence accumulated, WHO recommended maintaining mother-infant contact and breastfeeding with appropriate infection-prevention measures [9]. Nevertheless, separation, delayed breastfeeding initiation, and reduced access to breastfeeding support were reported in different settings [10, 11].

In Ecuador, breastfeeding was already protected through national legislation when the pandemic began. The Law for the Promotion, Support and Protection of Breastfeeding establishes responsibilities for protecting and supporting breastfeeding, [12] while the Code of Childhood and Adolescence explicitly recognizes children's right to breastfeeding and requires public and private health facilities to develop programs that promote breastfeeding [13]. These provisions established a national framework for breastfeeding protection before the COVID-19 emergency.

Ecuador had also established the Mother- and Baby-Friendly Health Facility Standard (Establecimientos de Salud Amigos de la Madre y del Niño, ESAMyN) as part of its national regulatory framework for maternal and newborn care. Introduced in 2016 and updated in 2021, ESAMyN establishes standards for maternity and newborn care, including skin-to-skin contact, timely initiation of breastfeeding, rooming-in, and breastfeeding support in health facilities [14].

Changes in maternity care during the pandemic raise questions about how decisions were made and how the interests and rights of mothers and infants were considered [7]. The principles of autonomy, beneficence, non-maleficence, and justice provide a framework for examining access to information and informed decision-making, practices that promote maternal and infant wellbeing, avoidable harms, and equity in care [15]. This framework also allows consideration of whether breastfeeding-related practices during an emergency were supported by the best available evidence [17–18].

Although the effects of COVID-19 on maternity care and breastfeeding have been documented, fewer studies have examined women's experiences from a bioethical and human rights perspective in Latin America [16]. Understanding these experiences is particularly relevant in settings where breastfeeding protections were already established in national legislation and health-service standards. This study

aimed to explore women's experiences and perceptions of breastfeeding rights during the COVID-19 pandemic in Quito, Ecuador, from a bioethical and human rights perspective.

Methods

Study design

This qualitative descriptive study explored women's experiences and perceptions of breastfeeding rights during the COVID-19 pandemic. The study was informed by principlism, the bioethical framework developed by Beauchamp and Childress, based on the principles of autonomy, beneficence, non-maleficence, and justice. This framework guided data analysis and the organization of findings.

The study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ).

Study setting and participants

The study was conducted in Quito, Ecuador. Participants were women who had given birth between April 2020 and June 2021 in public or private health facilities during the COVID-19 pandemic.

Inclusion criteria were being 18 years of age or older, currently breastfeeding, and having given birth during the specified period. Women with medical contraindications to breastfeeding or who had experienced perinatal loss were excluded.

Participants were recruited through an open invitation distributed on social media platforms (Facebook and Instagram) and through breastfeeding support groups, including La Liga de La Leche Ecuador and affiliated networks of the Universidad Politécnica Salesiana. Purposive sampling was used to recruit women with direct experience of maternity and breastfeeding care during the pandemic. Ten women met the eligibility criteria and agreed to participate.

Data collection

Semi-structured interviews were conducted remotely via Zoom between August and October 2021. Written informed consent was obtained electronically before participation.

The interview guide consisted of seven open-ended questions addressing childbirth, breastfeeding initiation, access to breastfeeding support, information received from healthcare professionals, and perceptions of breastfeeding protection during the pandemic. The guide was pilot tested with two breastfeeding women to assess clarity and relevance; these interviews were not included in the analysis.

Interviews lasted 45–60 minutes and were audio-recorded with participants' permission. All interviews were conducted in Spanish and transcribed verbatim. Interviews were conducted by a trained sociologist with experience in breastfeeding and bioethics who had no prior relationship with the participants.

Data analysis

Data were analyzed using a deductive thematic approach informed by principlism. The four ethical principles of autonomy, beneficence, non-maleficence, and justice served as predefined analytical categories. Transcripts were reviewed repeatedly to achieve familiarity with the data, and relevant segments were coded and organized according to these principles.

Data collection and analysis occurred concurrently. Recruitment continued until thematic saturation was reached, defined as the point at which no substantially new themes emerged from subsequent interviews. Two researchers independently reviewed and coded the transcripts. Coding discrepancies were discussed and resolved through consensus.

Although the four ethical principles provided the analytical framework, coding remained iterative, allowing subthemes and nuances to be identified within each category. No major themes emerged outside the principlism framework that required additional overarching categories.

All interviews were analyzed in Spanish to preserve participants' meanings and contextual nuances. Quotations included in the manuscript were subsequently translated into English by the research team. Participants were not asked to review transcripts or preliminary findings.

Ethics approval and consent to participate

The study was approved by the Committee for Research in Human Subjects (CEISH) of the Pontifical Catholic University of Ecuador (approval code EO-17-2021). All participants provided written informed consent before participation. Identifying information was removed from transcripts, and participant codes were used when reporting findings.

Results

Participant characteristics

Ten women participated in the study. Participants ranged in age from 24 to 37 years. Four participants were primiparous and six were multiparous. Deliveries occurred in both public and private health facilities in Quito, Ecuador, during the COVID-19 pandemic. Most participants had completed tertiary or postgraduate education and were employed or engaged in professional services (refer Table 1).

Table 1 Characteristics of participants (n = 10)

Participant	Age (years)	Parity	Health sector	Education level	Employment status
P1	32	Multiparous	Private	Tertiary	Employed
P2	28	Primiparous	Private	Postgraduate	Professional services
P3	30	Primiparous	Private	Tertiary	Professional services
P4	35	Multiparous	Public	Tertiary	Employed
P5	37	Multiparous	Public	Tertiary	Employed
P6	36	Multiparous	Private	Tertiary	Professional services
P7	30	Primiparous	Public	Postgraduate	Professional services
P8	24	Primiparous	Public	Tertiary	Professional services
P9	37	Multiparous	Private	Postgraduate	Employed
P10	28	Multiparous	Public	Tertiary	Employed

Note**:** Participants gave birth in public or private health facilities in Quito, Ecuador, between april 2020 and june 2021 during the COVID-19 pandemic.

Analysis of the interviews generated four themes corresponding to the bioethical principles of beneficence, autonomy, non-maleficence, and justice.

Beneficence: changes in maternity care practices and breastfeeding support

Participants described modifications in maternity care practices that affected the initiation and establishment of breastfeeding. Several women reported delayed skin-to-skin contact, postponed breastfeeding initiation, and temporary separation from their newborns following delivery. These experiences were frequently attributed to COVID-19 prevention protocols implemented by health facilities.

One participant recalled:

“After my cesarean section, I had to wait several hours before seeing my baby. There was no skin-to-skin contact, and breastfeeding started much later.” (Participant 4)

Women also reported restrictions on close physical contact with their newborns during hospitalization. Some participants described limitations on rooming-in practices and difficulties keeping their infants close following childbirth.

“We were not allowed to have the babies close to us in bed, which made it difficult, especially for mothers recovering from surgery.” (Participant 4)

Participants perceived that these restrictions interfered with breastfeeding initiation and affected their early interactions with their newborns.

Autonomy: access to information and breastfeeding decision-making

A recurring theme across interviews was the lack of consistent information regarding breastfeeding during the pandemic. Participants reported receiving contradictory advice from healthcare professionals regarding breastfeeding initiation, supplementation, and infant feeding practices.

One participant explained:

“There was no clear information about breastfeeding. Some doctors encouraged it, but nurses insisted on formula feeding to avoid the baby crying.” (Participant 5)

Another participant described uncertainty resulting from conflicting recommendations:

“I was very confused because some said I should put the baby to the breast immediately, while others told me to give formula so the baby would stay calm. It was difficult to know what to do. No one explained the benefits of breastfeeding or provided support to initiate it properly.” (Participant 5)

Several women reported that they did not receive sufficient information regarding breastfeeding recommendations during COVID-19 or opportunities to discuss feeding decisions with healthcare professionals.

Non-Maleficence: exposure to commercial infant formula and perceived harm

Women described the routine provision of commercial infant formula during hospitalization and at discharge, often in the absence of adequate breastfeeding counseling or support. Several participants reported that healthcare providers introduced formula shortly after birth because they considered breast milk production insufficient, despite limited assessment of breastfeeding practices or maternal concerns.

One participant recalled:

“No one informed me about breastfeeding. They gave my baby a bottle and, before discharge, they also gave him formula because they said he was not getting enough milk. They told me I was not producing enough milk. My baby did not really take it, but I suffered because I thought he was not eating well.” (Participant 5)

In addition to supplementation, some women reported receiving commercial infant formula products, bottles, and promotional materials from health facilities at discharge.

“They gave us formula samples and baby kits with bottles and formula cans when we were discharged.” (Participant 6)

Another participant stated:

“I do not remember the exact brand, but they gave me a diaper bag, a can of powdered formula, and ready-to-feed formula samples.” (Participant 6)

These experiences were perceived as discouraging breastfeeding and increasing maternal uncertainty regarding milk production and infant feeding. Several women associated formula supplementation with difficulties establishing breastfeeding and reduced confidence in their ability to breastfeed successfully. Emotional distress was further compounded by mother-infant separation, inconsistent feeding recommendations, and limited breastfeeding support during the postpartum period.

Justice: equity, professional training, and state responsibility

Women emphasized the responsibility of governments and health systems to protect breastfeeding during public health emergencies through public policies, professional training, and access to accurate information. Concerns were raised regarding inconsistencies in healthcare professionals’ knowledge and practices, which participants believed contributed to misinformation and unequal breastfeeding support.

One participant highlighted the need for public education initiatives:

“There should be government campaigns explaining the importance of breastfeeding. It is essential for both the mother’s and baby’s health.” (Participant 2)

The importance of professional training emerged as a recurring theme. Participants considered that healthcare workers should receive continuous education on breastfeeding management and counseling in order to provide evidence-based guidance.

“My suggestion to the government is that they should train their professionals so that they can teach and support others, even mothers themselves, through groups and meetings or anything that can help ensure those successful first six months that the baby needs.” (Participant 3)

Another participant emphasized that protecting breastfeeding requires qualified professionals capable of addressing misinformation and supporting mothers during periods of uncertainty:

“If we truly want to protect breastfeeding, then we need professionals who are trained in breastfeeding. There is a lot of misinformation and many myths. This creates frustration for mothers.” (Participant 3)

Participants also linked breastfeeding support to broader maternal and child rights and viewed breastfeeding protection as a collective social responsibility.

“I believe it is crucial that public policy prioritizes women’s health and, within that, the protection of babies. There should be a policy that truly supports motherhood in all its dimensions, from breastfeeding to care, because sustaining life is linked to the rights of women, children, and adolescents.” (Participant 4)

Differences in access to breastfeeding support were also reported. Women with greater economic resources were able to seek assistance from private lactation consultants, whereas others relied exclusively on services available within the public health system. Participants perceived these differences as important because they influenced access to information, counseling, and practical breastfeeding support during a period of heightened uncertainty.

Overall, participants identified the need for stronger public policies, systematic professional training, reliable breastfeeding information, and equitable access to support services to protect mothers and infants during future public health emergencies.

Discussion

This study examined women’s experiences of breastfeeding care during the COVID-19 pandemic in Quito, Ecuador through a bioethical and human rights perspective. The findings identified challenges across the four principles of autonomy, beneficence, non-maleficence, and justice [18]. Participants described inconsistent breastfeeding information, delayed mother-infant contact and breastfeeding initiation, use and promotion of commercial infant formula, and limitations in breastfeeding support. These experiences occurred despite international recommendations supporting breastfeeding during the pandemic and an existing national regulatory framework for breastfeeding protection [8,14]. The findings suggest that emergency responses may create gaps between breastfeeding policies and maternity care practices when evidence-based breastfeeding protection is not adequately integrated into emergency decision-making [5,17].

Breaches of autonomy: inconsistent information and disempowered decision-making

Women in this study described receiving inconsistent and sometimes contradictory information regarding breastfeeding during the COVID-19 pandemic. While some healthcare professionals encouraged breastfeeding and maternal-newborn contact, others recommended commercial infant formula supplementation or imposed restrictions that were not always accompanied by clear explanations. These experiences generated uncertainty and limited women's ability to make informed decisions about infant feeding.

Similar findings have been reported in other settings during the pandemic. Studies conducted in different countries documented rapid changes in clinical protocols, conflicting recommendations, and uncertainty among healthcare professionals regarding breastfeeding management in the context of SARS-CoV-2 infection further demonstrated substantial variation in national guidance regarding breastfeeding and

maternal-newborn separation, often resulting in practices that were inconsistent with emerging evidence and international recommendations [7,19,20].

From a bioethical perspective, these findings raise concerns regarding respect for autonomy. Autonomy requires that individuals receive accurate, understandable, and evidence-based information that enables voluntary and informed decision-making [21]. When information is inconsistent or incomplete, women's capacity to actively participate in decisions affecting their own health and that of their infants may be constrained [22]. In the context of breastfeeding, informed decision-making is particularly important because feeding choices have immediate and long-term implications for maternal and child health [23].

These findings may also be interpreted within a human rights framework [3]. The Convention on the Rights of the Child recognizes the responsibility of States to ensure that parents and caregivers receive information and support regarding child health and nutrition, including the advantages of breastfeeding [5,24]. Access to reliable information therefore constitutes not only a prerequisite for informed decision-making but also an important component of the protection of maternal and child rights during public health emergencies [25].

Taken together, the experiences reported by participants suggest that emergency responses should include clear, evidence-based communication strategies that support informed breastfeeding decisions while reducing uncertainty among both healthcare providers and families.

Breaches of Beneficence: Disruption of Practices that Promote Maternal and Infant Wellbeing

Participants described maternity care practices that limited early mother-infant contact, including delayed skin-to-skin contact, postponed breastfeeding initiation, and temporary separation following birth. Women perceived that these measures interfered with the establishment of breastfeeding and reduced opportunities for early bonding with their newborns.

The principle of beneficence requires healthcare professionals and institutions to act in ways that promote the wellbeing of patients and maximize potential benefits [15]. In maternal and newborn care, this principle is reflected in evidence-based practices such as immediate skin-to-skin contact, rooming-in, early initiation of breastfeeding, and the provision of skilled breastfeeding support [18]. These interventions have consistently been associated with improved breastfeeding outcomes, enhanced maternal-infant bonding, and better short- and long-term health outcomes for both mother and child [11].

The experiences reported by participants are consistent with findings from other countries during the COVID-19 pandemic. Studies documented substantial changes in maternity care practices, including restrictions on companionship during childbirth, limitations on maternal-newborn contact, and disruptions to breastfeeding support services [22,26]. Although many of these measures were introduced to reduce the risk of viral transmission, they often resulted in reduced opportunities to implement practices known to support maternal and infant wellbeing [11].

Evidence accumulated throughout the pandemic increasingly supported the maintenance of breastfeeding and close maternal-newborn contact, even among women with suspected or confirmed SARS-CoV-2 infection [27]. The WHO consistently recommended skin-to-skin contact, rooming-in, and direct breastfeeding with appropriate infection-prevention measures, emphasizing that the benefits outweighed the potential risks of transmission [23]. Similarly, studies conducted during the pandemic found that maintaining breastfeeding support was associated with better maternal experiences and improved breastfeeding outcomes [28].

WHO guidelines consistently emphasize that direct breastfeeding with appropriate hygiene measures poses minimal risk of COVID-19 transmission, while offering substantial immunological protection to the newborn [11]. Research has shown that human milk from COVID-19-positive mothers contains SARS-CoV-2 specific IgA and IgG antibodies, suggesting a protective effect against infection.[29] Interrupting breastfeeding under the guise of infection prevention therefore deprived newborns of critical health benefits during a period of heightened vulnerability [30].

In Ecuador, this issue is particularly relevant because ESAMyN already included skin-to-skin contact, timely breastfeeding initiation, rooming-in, and breastfeeding support within maternity care [14]. The experiences reported by participants therefore suggest a gap between established maternal and newborn care standards and some practices implemented during the emergency. Emergency protocols should preserve these practices whenever clinically feasible and modify them only when supported by evidence and an individualized assessment of risks and benefits.

From a bioethical perspective, the experiences described by participants suggest that some infection-control measures prioritized potential risks while giving insufficient consideration to the established benefits of practices that promote maternal and infant health. Beneficence requires not only preventing disease but also actively supporting interventions known to improve health and wellbeing [16]. The disruption of breastfeeding-supportive practices therefore raises important ethical questions regarding whether maternal and newborn interests were adequately considered during emergency decision-making.

Breaches of Non-Maleficence: avoidable harm associated with mother-intanf separation and commercial infant formula use

The principle of non-maleficence requires healthcare professionals and institutions to avoid causing harm [17]. While many maternity care measures implemented during the COVID-19 pandemic were intended to reduce the risk of viral transmission, participants described experiences that were perceived as harmful to both breastfeeding and maternal wellbeing.

One of the most frequently reported concerns was the separation of mothers and newborns following birth [10]. Participants described delayed contact with their infants, restrictions on proximity, and interruptions in breastfeeding initiation [11]. Although these measures were often introduced as precautionary strategies, growing evidence during the pandemic indicated that routine separation was

not supported by available data and could have unintended negative consequences [11]. WHO recommendations consistently supported maintaining maternal-newborn contact and direct breastfeeding, even among women with suspected or confirmed SARS-CoV-2 infection, provided appropriate infection prevention measures were followed [29].

The potential harms associated with separation extended beyond the immediate postpartum period. Tomori et al. (2020) argued that separation policies may undermine breastfeeding, reduce maternal-infant bonding, and increase vulnerability to other health risks [11]. Similarly, Gribble et al. (2023) documented that breastfeeding was frequently undermined by COVID-19 guidance worldwide despite the lack of evidence supporting routine separation [7]. The women interviewed in this study described emotional distress, uncertainty, and difficulties establishing breastfeeding following these practices.

Concerns related to non-maleficence also emerged from participants' accounts of commercial infant formula use. Women reported the routine provision of formula during hospitalization and at discharge, sometimes without adequate breastfeeding assessment or counseling [31]. Some described receiving formula supplementation shortly after birth because healthcare professionals considered their milk supply insufficient, while others reported receiving formula samples, bottles, and promotional materials upon discharge [32]. These practices generated doubts about their ability to breastfeed and, in some cases, contributed to early breastfeeding difficulties [1]. The distribution of formula samples and feeding products additionally raises concerns regarding the International Code of Marketing of Breast-milk Substitutes, which seeks to protect families from inappropriate marketing practices [25,33]. Evidence from the COVID-19 pandemic indicates that marketing of breast-milk substitutes expanded in several contexts, sometimes using pandemic-related concerns to influence infant-feeding decisions [34–36]. Protecting breastfeeding during emergencies therefore requires both appropriate clinical support and effective implementation of regulations governing the promotion and distribution of breast-milk substitutes [37].

In healthy mother–infant dyads in whom breastfeeding is possible, routine formula supplementation without a clinical indication is not a neutral intervention. Formula feeding differs from human milk feeding in its effects on the developing gut microbiota and has been associated with a higher occurrence of some gastrointestinal and respiratory infections. Human milk also provides nutritional, immunological, and developmental benefits that cannot be fully replicated by breast-milk substitutes [1]. These potential consequences should therefore be weighed against the expected clinical benefit before supplementation is introduced.

From a bioethical perspective, these concerns become particularly relevant when commercial infant formula is introduced routinely in circumstances in which breastfeeding assessment and support could represent a feasible alternative. During the pandemic, evidence increasingly indicated that breastfeeding could be safely maintained while following appropriate infection-prevention measures [29]. Consequently, supplementation without a clear clinical indication, particularly when provided without

adequate breastfeeding assessment and support, may have exposed mothers and infants to avoidable risks while limiting opportunities to establish breastfeeding successfully [30].

From the perspective of non-maleficence, the ethical concern is therefore not the use of commercial infant formula itself, but its unnecessary or routine use when the expected benefits do not clearly outweigh its potential biological and breastfeeding-related consequences.

The harms identified by participants were not limited to infant-feeding outcomes. Women described anxiety, frustration, guilt, and loss of confidence in their ability to care for and nourish their infants [17]. Similar findings have been reported in studies examining maternal experiences during the pandemic, in which disruptions in breastfeeding support, altered birth practices, and social isolation were associated with increased psychological distress and poorer postpartum experiences [17,38]. These findings indicate that practices affecting breastfeeding may have consequences not only for infant nutrition but also for maternal wellbeing and confidence during a particularly vulnerable period.

Taken together, these findings suggest that some infection-control and infant-feeding practices implemented during the pandemic may have unintentionally generated harms that were insufficiently considered during the emergency response. The principle of non-maleficence requires that efforts to prevent one form of harm should not create additional avoidable harms [7]. In maternal and newborn care, this requires balancing infection prevention against the potential consequences of mother–infant separation, unnecessary supplementation, disruption of breastfeeding, and maternal psychological distress. Protecting mothers and newborns during emergencies therefore involves not only preventing infection, but also preserving breastfeeding support, maternal wellbeing, and early mother–infant relationships.

Breaches of justice: inequities in access to breastfeeding support and the role of the State

The principle of justice requires the fair distribution of healthcare resources, opportunities, and protections [15]. In this study, participants emphasized the responsibility of governments and health systems to protect breastfeeding during public health emergencies through public policies, professional training, and access to reliable information. Women described inconsistencies in breastfeeding support and expressed concern about the limited preparation of some healthcare professionals to provide evidence-based guidance during the pandemic.

Studies conducted during the COVID-19 pandemic reported disruptions in breastfeeding support services, reduced access to in-person counseling, and diminished availability of community support networks [20,39]. These barriers frequently affected women already facing social and economic disadvantages, contributing to existing inequities in maternal and child health outcomes [17].

From a human rights perspective, these findings are particularly relevant. The Convention on the Rights of the Child recognizes the obligation of States to ensure that parents and caregivers receive information, education, and support regarding child health and nutrition, including the advantages of

breastfeeding. Subsequent interpretations by the Committee on the Rights of the Child have emphasized the responsibility of governments to protect, promote, and support breastfeeding through health systems, legislation, and public policies [24,40]. The experiences reported by participants suggest that these protections were not always fully realized during the pandemic.

The findings are also relevant within the Ecuadorian legal framework. In addition to international human rights instruments, the Ecuadorian Code of Childhood and Adolescence recognizes breastfeeding as a right of children. Article 24 establishes the right to breastfeeding as a means of ensuring the affective bond between mother and child, adequate nutrition, growth, and development [13]. The same article also places an obligation on public and private health institutions to develop programs that promote and support breastfeeding. Viewed in this context, participants' accounts of limited breastfeeding support, inconsistent information, delayed initiation of breastfeeding, and routine supplementation with commercial infant formula suggest important gaps between existing legal protections and the experiences of women during the pandemic.

These findings underscore that the protection of breastfeeding during public health emergencies is not only a clinical or ethical matter but also relates to the implementation of existing national and international commitments regarding maternal and child health.

An important finding was the emphasis participants placed on the role of governments in protecting breastfeeding. Women repeatedly highlighted the need for public information campaigns, qualified healthcare professionals, and accessible support networks. Participants viewed breastfeeding support not solely as an individual responsibility but as a collective social commitment requiring institutional support and public investment [30].

The need for professional training emerged as a recurring theme. Participants perceived that inconsistencies in clinical practices and breastfeeding recommendations reflected gaps in professional preparation. Similar concerns have been identified in studies conducted in different countries, where healthcare providers reported challenges in maintaining evidence-based breastfeeding practices during rapidly changing pandemic conditions [19]. Strengthening professional competencies in breastfeeding counseling and ethical decision-making may therefore represent an important strategy for improving the quality and consistency of maternal and newborn care during future emergencies [41].

The findings also highlight the importance of integrating breastfeeding protection into emergency preparedness planning. International initiatives such as the Infant and Young Child Feeding in Emergencies Operational Guidance emphasize the need for coordinated actions that protect breastfeeding, support maternal-infant dyads, and ensure that vulnerable populations receive appropriate assistance during crises. Participants' experiences suggest that these considerations should occupy a more central place within public health emergency responses [4].

Taken together, the findings indicate that justice in maternal and newborn care extends beyond access to healthcare services alone. It also includes equitable access to breastfeeding support, reliable

information, trained professionals, and public policies that protect the rights and wellbeing of mothers and children, particularly during periods of social disruption and public health emergencies [22].

Implications for Practice and Policy

The findings have implications for maternal and newborn care during public health emergencies. Breastfeeding protection should be integrated into emergency preparedness plans, ensuring that protocols remain aligned with evidence and international recommendations supporting skin-to-skin contact, rooming-in, and breastfeeding whenever clinically feasible [42].

Healthcare professionals require ongoing training in breastfeeding support, ethical decision-making, and risk communication [19]. Participants reported inconsistent information and clinical practices, highlighting the need for education that combines breastfeeding management with counseling skills that promote informed decision-making and respect for maternal autonomy [43].

Stronger measures are also needed to prevent inappropriate promotion of commercial infant formula during emergencies [30]. Participants reported receiving formula products and promotional materials despite intending to breastfeed, underscoring the importance of enforcing the International Code of Marketing of Breast-milk Substitutes and related World Health Assembly resolutions [1].

Finally, policies should ensure equitable access to breastfeeding support, including qualified counseling and community-based services. Such measures may be particularly important during health crises, when access to support may be limited [3].

Limitation

This study provides qualitative evidence from Ecuador, a setting that remains underrepresented in research on breastfeeding, bioethics, and public health emergencies. By examining women's experiences during the COVID-19 pandemic through a principlism framework, it offers insights into the ethical dimensions of maternity care and breastfeeding support during health crises.

Several limitations should be acknowledged. Participants were recruited through social media and breastfeeding support networks, which may have favored the inclusion of women with a particular interest in breastfeeding. In addition, the sample may not have fully captured the diversity of experiences and healthcare contexts present in Quito during the pandemic. Nevertheless, thematic saturation was achieved, and participants' accounts were consistent across interviews, supporting the credibility of the findings.

Conclusions

This study highlights how changes in maternity and newborn care during the COVID-19 pandemic affected women's experiences of breastfeeding in Quito, Ecuador. Mother–infant separation, delayed breastfeeding initiation, inconsistent information, insufficient breastfeeding support, and unnecessary

formula supplementation created tensions with the principles of autonomy, beneficence, non-maleficence, and justice. These findings emphasize that protecting breastfeeding during public health emergencies requires evidence-based and proportionate measures that preserve mother–infant contact, informed decision-making, and skilled breastfeeding support. Existing breastfeeding legislation and standards such as ESAMyN provide an important framework, but their protection should be maintained and effectively implemented during emergencies.

Abbreviations

COVID-19
Coronavirus disease 2019
ESAMyN
Establecimientos de Salud Amigos de la Madre y del Niño (Mother- and Baby-Friendly Health Facility Standard)
SARS-CoV-2
Severe acute respiratory syndrome coronavirus 2
UNICEF
United Nations Children's Fund
WHO
World Health Organization

Declarations

Ethics approval and consent to participate

This study was conducted in accordance with the Declaration of Helsinki. The study was approved by the Committee for Research in Human Subjects (CEISH) of the Pontifical Catholic University of Ecuador (approval code EO-17-2021). Written informed consent was obtained from all participants before data collection.

Consent for publication

Informed consent was obtained from all subjects involved in the study

Competing interests

The authors declare that they have no competing interests.

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Author Contribution

ERL contributed to the conceptualization and methodology of the study, conducted the investigation and data collection and participated in data analysis. BT contributed to the conceptualization and methodology of the study, supervised the research, participated in data analysis and interpretation, and drafted the original manuscript. IDE and EG contributed to the analysis and interpretation of the findings and critically reviewed and edited the manuscript. All authors read and approved the final manuscript.

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Data availability

The data used and/or analysed during the current study are available from the corresponding author on reasonable request

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