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# The Impact of the COVID-19 Pandemic on Infant and Young Child Caregivers' Mental Health and Feeding Practice

## Webinar Transcript

### Jennifer Yourkavitch

Hello and welcome. Thank you for joining us today. I am Jennifer Yourkavitch. I am the director of Monitoring Evaluation and Learning for USA Advancing Nutrition. I am joined by my colleagues Victoria Anders, Aaron Brookhazen and Alyssa Klein, and together we organized these research interest group meetings on the first Friday of the month. We are so lucky today to have two excellent speakers join us, sharing their work related to our theme which is Caregiver's Mental Health and Infant Feeding during the Pandemic, Dr. Carlene Gribble and Dr. Kristen Tully. We are especially grateful to them for agreeing to join us with short notice and to Carlene who is joining late at night in Australia. It is really quite generous, thank you so much. Before I introduce them formally we have one update from Mija Ververs.

### Mija Ververs

Okay, well, it is an update from a different style this time. Okay, so this week we did not send out the scientific updates of the Maternal Child Health Scientific Journal articles nor the breastfeeding and Covid articles. After well over a year now, we have been keeping the scientific repository and we ended this activity this week. Though we know there is sadly still some need - so if you know of anyone who wants to pick up this activity, I am more than happy to support, to help, to transition into that. From my part I feel we have done our share regarding this activity which was predominantly on a volunteer base with 40 Johns Hopkins students and we had over 45 000 views I think over the last year and we reached over 150 countries, I think a thousand people per week consulted it on average.

The good news is that we have a database with over 6200 excerpts, mostly peer-reviewed papers which remains on the website and easily accessible. You can use that for searching answers to all of your questions and the database has the excerpts, has the hyperlinks, you can search by type of publication, by date etc. So I want to thank you all especially the researchers here because without you we would have never been able to populate this repository. So, thank you and let us listen to people who have a really good story now [...]. Thank you.

### Jennifer Yourkavitch

Thank you Mija, any other updates from the steering committee members? See if anyone has something?

## Dan Raiten

I could just add on to what Mija had to say. This is a tremendously valuable resource. It takes a tremendous amount of time and not an insignificant amount of resources but not insurmountable amount of resources. So I want to echo Mija's plea. If there's anybody in this group at your institution who feels like you are in a position to take this on, please let us know because it is a really worthwhile resource and Mija's not going to tout her own program and she is not into self-aggrandizement but she and her team did a tremendously valuable job for the community and it is a really worthwhile thing to pursue. So please if you have any interest whatsoever on taking us on, please let us know. We will do whatever we can to support you. Thank you.

## Jennifer Yourkavitch

Thank you Dan.

## Nigel Rollins

Jennifer, could I just add? It's Nigel here. I was going to write in the chat but I just really wanted to endorse what Dan was saying. It is really an outstanding resource and it should not be overlooked. So it was just to add my sort of work to that, it's a tremendous piece of work and it would be fantastic to see even in whatever focused ways to keep it going. Even if it weren't to go on, it's an outstanding resource but I think seeing something like this doesn't happen very often and a way of building on it would be fantastic.

## Jennifer Yourkavitch

Thanks Nigel, thanks. Maybe I will just ask if there are any questions about that from the group now. Questions or comments? Okay, all right. Then we will move into our presentations and I am thrilled to introduce Dr. Carlene Gribble. She is an Adjunct Associate Professor in the School of Nursing and Midwifery at Western Sydney University. Her interests include infant and young child feeding in emergencies, regulation of the marketing of breast milk substitute, child rights, caregiver, child and child caregiver attachment, adoption reform, treatment of infants within the child protection, immigration, detention and criminal justice systems. She has been involved in policy development and training in the area of infants and emergency since 2006 and has provided advice to UN organizations, health professionals, emergency responders and government bodies internationally and in Australia on the needs of infants and emergencies including the current COVID 19 pandemic. Carlene is also an Australian breastfeeding association community educator and counselor. Welcome Dr. Gribble and I am turning the floor over to you.

## Dr. Karleen Gribble

Lovely, well I am very pleased to be sharing with you tonight. I was asked to present on a paper that I wrote with some colleagues, which is really a review more than anything else. And I feel like many of the people here, in fact, will know it better than what I do. It was written primarily for

practitioners and policy makers to help them weigh up what the risks were in terms of COVID 19 versus maternal separation and reduction in breastfeeding. So I will just share my screen. Sorry, it is being a bit annoying. There we go. Okay.

So, the title of the paper was “Implications of the COVID 19 Pandemic, Response for Breastfeeding, Maternal Caregiving Capacity and Infant Mental Health” and it was published in the Journal of Human Lactation last year. It has actually had quite a lot of downloads; around 13 000, which is quite okay. Quite happy with that for a paper. My co-authors were Kathleen Marinelli, Cecilia Tamori and Marielle Gross. So on the 13th of March last year, the WHO published their clinical management of severe acute respiratory infection when COVID 19 disease is suspected and within that it contained recommendations for maternal and newborn care. Saying that basically there was no change to the normal feeding and contact recommendations apart from the need to take care in terms of hand washing, mask wearing and all of that [...]. But basically if a woman had COVID 19 when her baby was born, the baby should have skin to skin contact with her, initiate breastfeeding within an hour, continue breastfeeding and room-in with their mother. But there were many organizations and hospitals that worked against enabling these practices. Together with some other colleagues, I did some work looking at the COVID 19 guidance from 33 countries early in the pandemic: that was March and April. And what we found was that there really was not great alignment between the WHO recommendations and many country and organizational guidance around the world. Like many of you I guess, and including Mija who was co-author on this paper that I was also author on with Roger Matheson and Anna Kutsudus, we could see that what was happening was potentially as big a deal as what had happened with HIV. Where the risk of transmission of HIV overwhelmed the importance of breastfeeding and resulted in more infants dying than would have been the case if they had continued breastfeeding. So we have been here before.

I am just going to summarize what we have in this paper in terms of why are each of these things: skin-to-skin contacts, maternal proximity and breastfeeding, are so important. What is the impact of skin-to-skin contact on the infant? Placed skin-to-skin after birth, healthy newborns perform a series of behaviors culminating in breastfeeding. When infants apply skin-to-skin, they have more effective first breast feeds and because that occurs during a time when infants have high levels of catecholamines in their system that enhances their learning. So the breast feeds that occur during skin-to-skin are more effective, babies learn from them more and so they form a foundation for continued effective feeding. So, infants who are placed skin-to-skin after birth are less likely to be exposed to infant formula in hospital and to breastfeed for longer than infants not placed skin-to-skin.

What's the impact of breastfeeding on infants?

I mean, this is stuff that we all know. Infants are born with an immature immune system and their mother's milk provides them with external immune support. There are many ingredients that actively and passively protect infants against infection and assist in the development of the infant's own immune system, and breastfeeding enables provision of the nutrition and also the interpersonal interactions necessary for normal growth and brain development. And I think one of the things that we brought out in this paper was actually looking beyond the impact of milk and to the impact of these things on the relationship between mother and child. Hang on, I have missed the impact of skin-to-skin on mothers, sorry. I'll just go back to it. When an infant is placed on skin-to-skin on their mother's chest at birth, she has that surge of release of oxytocin and a reduction in the release of cortisol which is important because when mothers are stressed, they find it more difficult to be responsive to their babies. So having a reduced stress responsivity actually makes it easier for

mothers to be responsive to their infants. So, mothers who experience skin-to-skin contact see greater proximity to their infants, they speak to their infants more, they touch them more and are more gentle in their touch in the days after birth, and this continues. So mothers who experience skin-to-skin have more positive interactions with their baby and are more affectionate in their touch for up to a year following birth than mothers who don't experience skin-to-skin.

So what's the impact of breastfeeding on mothers?

The hormones oxytocin and prolactin are released during breastfeeding and act on the maternal central nervous system to promote social responsiveness, maternal behavior, promote maternal proximity and reduce stress responsivity. The close and repeated contact necessary for breastfeeding results in more effective touch and care by breastfeeding mothers. We didn't reference this in the paper because it had not been published at that time but there is recent research showing that when mothers are depressed, if they're breastfeeding, it actually doesn't impact the amount or the quality of the interactions between them and their babies. And so their babies in fact do not show the same sort of brain changes or brain activity that mothers who are depressed and who are bottle feeding experience. So there is not sort of that transmission of abnormality from the mother to the baby. And breastfeeding mothers who experience heightened responses in brain regions associated with maternal sensitivity as compared to mothers who are not breastfeeding. Looking at rooming-in and I have got this definition here because many of the guidance documents around the world have sometimes said that they are recommending rooming-in but in fact they are recommending room sharing with mother and infant kept at a distance. But rooming-in actually means the mother and the infant share the room and the infant bed shares with their mother is an attached sidecar crib or is right beside their mother's bedside in a standalone cot.

So, what is the impact of rooming-in or breastfeeding?

We know that close physical contact is necessary for mothers to identify and respond to their infant's feeding cues and to feed frequently. Frequent breastfeeding is necessary to successfully establish and maintain breastfeeding. The closer infants are to their mothers, the more frequently they breastfeed. Helen Ball in the UK did some research showing that even infants who are in a crib beside their mother's bedside feed less frequently than infants who are in a side car bed. Now obviously, nursery care which was what had been recommended in some of these guidance restricts feeding frequency, but even a mother who is one and a half to two meters from her infant will breastfeed less and that is especially the case if she has had a cesarean section. And women whose infants are behind a screen, which is another thing that's recommended in many guidance documents, will experience greater difficulty identifying the infant's visual hunger cues and so feed less frequently.

The impact of rooming-in on mothers. So mothers whose infants room-in in the days after birth touch, kiss, smile and talk more to their babies during feeding, and have higher maternal attachment scores than mothers whose infants are cared for in a hospital nursery. Some of this research that we cited was really old and the reason why it was so old is because you actually could not do some of this research now because it would be unethical.

So what is the impact of these policies separating infants from their mothers?

This was not cited in our work because it was not published at the time and I think you have had Melissa speak. This is from Melissa Bartik and colleagues but just to summarize, preventing skin-to-skin and separation from mothers has had a devastating impact on breastfeeding and maternal well-being during COVID 19. So you can see, if babies do not experience skin-to-skin, they are much less likely to be exclusively breastfed between one or three months of age. If mothers and infants were

kept in separate rooms, babies four times more likely not to be exclusively breastfed if there wasn't any direct breastfeeding in hospitals, they were six times more likely not to be exclusively breastfed between one and three months of age, and nearly a third of separated mothers who tried to breastfeed when they were reunited with their infants were unable to and many mothers, very distressed by what they had experienced with being separated from their infants, and this is all over the world. I gave a presentation not very long ago for UNICEF Indonesia and as a part of that, there was actually a mother who had had her baby a couple of months earlier and in Indonesia, it is one of those countries where the official recommendations are that if the mother has COVID 19, that mother and infant should be separated, and this poor mum was crying describing the distress that had caused her and how difficult she was finding bonding to her baby, reinitiating breastfeeding after having been separated. So this is something that is happening all over the world.

What is the impact of premature cessation of breastfeeding?

We know that it has adverse health and developmental outcomes so work from the UK, from Quigley, about a third of hospital admissions for infections in the UK are attributable to infants breastfeeding for less than three months compared to breastfeeding for at least six months including six weeks of exclusive breastfeeding. And we know that the more deprived the environment in the UK, and other developed countries, the greater the adverse impact.

We have got this research here, we have got Nigel in the room, applying and looking at what the impact of this separation could be in low and middle-income countries and looking, weighing up what's the balance between separation and impediment to breastfeeding versus the risk of infection with COVID 19 and it is so clear that separation is a much greater risk than the disease. But if we are looking beyond infectious disease and the impact of separation and reduction of breastfeeding in terms of maternal caregiving capacity, this is also quite significant. So research again from 1980, a very long time ago, this was a randomized controlled trial finding young mothers whose infants were cared for in a hospital nursery had increased rates of substantiated maltreatment, inadequate caregiving and were less likely to have care of their children in the second year of life than those who shared a room with their babies. We found from the roll out of the baby friendly hospital initiative that many countries saw a reduction in infant abandonment including Thailand, Russia and Costa Rica. That was attributable to practices that kept mothers and babies together and supported breastfeeding as opposed to nursery care. Research from Australia, and this was a quite a large study, found that children who weren't breastfed were 3.8 times more likely to have maternal neglect substantiated over their childhood than children breastfed for four or more months. Shorter durations of breastfeeding have been associated with greater rates of disorganized attachment which is a potential indicator of inadequate caregiving. We know that rates of child abuse and neglect increase in times of crisis and that those who are the most vulnerable are young mothers, impoverished mothers, mothers with a history of intergenerational trauma, all those who use drugs. We know that COVID 19 has been very stressful and in fact in the UK, during the time of the first lockdown and shortly after they found that the reporting of abuse of infants had increased by a fifth.

Just to finish off there, what we know is that the infant's early environment is the mother providing physiological and emotional regulation, and equally proximity to the infant powerfully affects and even regulates maternal physiology and psychology, and the cost of depriving mothers and infants of one another is very high. So it is very clear that there should be increased support for mothers and infants to experience skin-to-skin, close proximity and breastfeeding during COVID 19. But policies are continuing to separate mothers and infants. With the same colleagues that I did the work with earlier looking at COVID 19 guidance, we have got more than 100 COVID 19 ... gotten through

more than 100 countries now that we are having a look at that was collected during November and December. And unfortunately there are still very many countries that have policies separating mothers and infants. So it is still continuing, I can finish there.

## **Jennifer Yourkavitch**

Thanks so much Karleen. Thanks so much, really powerful information. We are going to hold questions to the end for discussion. So I will move now to introduce Dr. Kristin Tully. Dr. Tully is a research assistant professor in the Department of Obstetrics and Gynecology at the University of North Carolina at Chapel Hill. Go Hills! She is also a member of the UNC collaborative for Maternal and Infant Health. Her doctorate is in medical anthropology and she completed an NICHD supported post-doc through the Carolina Consortium on Human Development through the Duke University School of Nursing. Kristin seeks to transform perinatal care so that birthing parents and their families are treated in the ways they deserve and are supported in realizing their health goals. Her program of research is currently supported by the Agency for Healthcare Research and Quality, the National Institutes of Health, the Patient-centered Outcome Research Institute and the US Health Resources and Services Administration to address mechanisms underlying the fourth trimester outcomes such as patient safety, breastfeeding, sleep practices and maternal health. The objective is to enable more patient and family centered care which is achieved by partnering with diverse stakeholders to identify unmet health needs and then co-develop sustainable solutions. Welcome Kristin, Thank you. Floor is yours.

## **Kristin Tully**

Thank you so much, it is such an honor. I will share my slides. Can you see the first slide friends?

## **Jennifer Yourkavitch**

Yes, we can.

## **Kristin Tully**

Okay, wonderful. So, thank you so much for this invitation and it is really exciting to share some of what we have been learning on behalf of our team. And so I am speaking today around data from a project that was initiated right before COVID. We had an award in late 2019 and then we have data collection, in-patient shadowing in a hospital here in Chapel Hill. That was in January and February. And then we have been collecting different types of data throughout the course of this pandemic, including interviews with birthing parents, their companions, interviewing healthcare team members. We have been filming in the hospital to see what experiences are within postpartum patient rooms and we are wrapping up longitudinal surveys. We have been conducting for a few months and we will end next month. This has given us a great opportunity not only to understand systems of care, how they have been and with the World Health Organization framework of safe respectful perinatal care and very much following the lead of the Black Mama's Matter Alliance, and women's right to actively participate in their care and to be centered in that journey, and to be accommodated. And

so we talk a lot about addressing preventable deaths and unnecessary suffering but our big goal, of course, is to set people up to thrive and to structure care so that it is serving them.

This project that I am speaking to is funded by AHRQ and UNC is the home, and its multi institutions with Ohio State Systems Engineering and NC State College of Design and then we have a strong diverse team from multiple disciplines across UNC. I just wanted to share with this group that all of my work is compliant with the code of marketing of breast milk, milk substitutes and I think that it is critical that we lead with our values and I just wanted to acknowledge here that my perspectives are not neutral. I was a patient here two times and I increasingly recognize my white privilege and the layers of access that I have and I want that good care, the very high standards, to be more accessible to everyone. And then this project is about being part of the solution to raise what we consider to be the standard of care.

I am going to show some of what we have been hearing from the interviews and I have a few de-identified images to share about what it has been like for families giving birth and transitioning through care, and how the health care team members have been feeling this and living this too. People are incredibly resilient and there is a lot of uncertainty with practice variation in the changing nature of understanding, and even with people who are not first-time parents, going into it so differently. There is a lot of flexibility and so people are strong. People wish it could be different but they understood why protections were in place. We in all of our work substantially oversample black moms and Hispanic moms, and one of the Spanish-speaking participants shared that in her community, it is common to have a lot of family members around for the whole pregnancy and birthing process and due to COVID she felt like her birth experience was cold and she felt alone because she could not have her loved ones around her as much as she wanted.

These events and the medical care they are part of a special life transition and people miss sharing that with those closest. So there is some sadness especially when you know you can have one person with you and you can't switch out, and so those have been some hard conversations for people about who that is going to be and how that goes. The changing nature of what is permitted is also hard and so one of the moms talked about the anxiety that she felt not being able to have her doula with her, because that is what she had been expecting going into that and then I think she was holding out hope that that might work out. But it didn't for her, and so that was just hard because you have to be mentally prepared to give birth.

Another mom spoke about not being able to have newborn pictures because of course care was more clustered to minimize people in and out of rooms and so it was hard too because then people weren't able to walk around the hallway, to have that movement or go to the pantry to get juice and crackers, and that was challenging for them because they did not want to in their words "bother the nurses" for that care and I really want to elevate how critical in all circumstances, and then especially in such high stress with the dual pandemics of COVID and racial injustice in the US and elsewhere, how important it is to have a trusted person with you and that can be manifested in many forms. But people talk about companionship being the world to them. You need someone who knows you and who can support you. Somebody in your corner. And so people were grateful when their partners or whoever they chose could be there and it was stressful on setting that up. And so people talk about safety explicitly including their companion; their involvement is a key part of things going well.

So I frame these things here as protections, but a quote that we have is that 'the restrictions have been very strict' and so these things that we have in place to minimize risk and to keep people as safe as we can, then of course there are implications of that with the experience and so it can be



isolating, as some people describe, being trapped in these small postnatal unit rooms. And a surprising thing from my perspective is that there has been a lot of concerns that we have heard about people being hungry, and sometimes ordering food especially for our Spanish-speaking families. That process is not clear, sometimes it takes a long time for that to come, then sometimes it's the wrong order and we have had stories shared repeatedly about that and the stress that that causes, including last week a mom saying she was hungry and she felt she could not make milk because she was not nourished and we address that immediate need. And this is the sort of lack of clarity that we want to fix so that people have all the things they need. There are hierarchies of need and clearly food is a foundational part.

So mass and other protections that can make communication hard, I think there's a lot of ways that we can strengthen patient provider communication and shared decision making and when you can't read someone's cues as well, and this is for all patients but then when it's a whole other story when someone is COVID positive, and there are those different protocols and layers of sound. So it's hard to know how serious something is and of course we cannot see the smiles as much either. So we know that affirmation and reassurance is really important, and this can feel overwhelming and in the best of times transitioning through care and adjusting to a new person and your recovery. So that is something to think about: the ways that we can proactively make people feel more comfortable and facilitate information exchange.

I know that you know this working group is focused on infant feeding and this session is with maternal mood. I just wanted to share how these things fit in the context of how birthing parents have been defining safety in our project because again now, COVID is intersecting with this. We have some common themes and these are from interviews with 40 birthing parents where you know safety is about outcomes. It is also the mom not feeling alone and feeling safe, and also their perception of clinician awareness of their needs and clinicians following protocols; it includes receiving physical support like getting with maneuvering around the room, getting out of bed, it is about resources, privacy, bedside manner, responsiveness, communication and then information access for patients and their companions and then of course care coordination.

So, you all were talking a little bit about rooming-in. I wanted to elaborate how the protocols can be differentially experienced and this here is from outpatient healthcare team members speaking about the disproportionate number of Spanish-speaking families that have been separated from their understanding, and so this person elaborates that it is hard to know where the break in the system is. We might consider that the conversations maybe do not go quite the same way as they would with an English-speaking family, and maybe things are not framed in a way that it doesn't feel like a recommendation, and I have slides that I can maybe pull up in the discussion if we want about people who have to protect themselves from a system that can do them harm and so their self-preservation and the questions that people ask and the fears that they have, and I am specifically talking about Spanish-speaking families. And so really being intentional about how we walk through these things together can help.

I will start to wrap up because I am mindful of the time. But I wanted to also share with the inpatient interactions then. Some moms are saying that they feel the need to be watching the healthcare team members, they're worried about the equipment and whether that is safe and has been sterilized or cleaned, and so they are seeking peace of mind that when people are in different rooms and they don't know the circumstances of others on the unit, they are worried about that and about transmission and so doing things in front of people and offering that sort of reassurance is helpful. I have just a little bit about what we have seen within the hospital about breastfeeding outcomes and



I separated that by English speaking and Spanish speaking in our current sample. And as you might expect, people are deviating from their plans. I did want to elevate the critical importance of donor human milk.

You can see in this slide that among our English-speaking families, that 19% use that and these are among healthy. Our study is on the healthy diets not with any cue but a lot of people just within their inpatient stay are not meeting their goals. This example, we can perhaps talk about it in more depth if you like. Just, when we counsel, this is an example of a late pre-term delivery and lactation and nursing and interpreter here with the Spanish-speaking family and, all of these things going on, and they are talking about baby losing interest with breastfeeding, but there was no acknowledgement or discussion around the baby's developmental status and abilities and how that might play a role in the baby's behavior and the strategies that you can do to realize your breastfeeding goals. So again, this specific example is not unique to COVID but it's even more important when we have constraints with outpatient support. So we need to set people up. This is from our surveys; I just wanted to flag that people have a lot of concerns about COVID specifically as part of their fourth trimester and some of it, the second bullet on here, is about missing out on the experiences that they wanted such as having what we call their village; with their friends and other members. So there is a lot of worry about logistics, about getting sick and about care for other family members, including other children.

As I alluded to with outpatient, things are not always as easy as they might be with getting supplies and counseling and so, that's helpful to think about these journeys through care, and the barriers that are differentially experienced. I will end here just saying the words of one of the healthcare team members about how systems of care are still fragmented and therefore not serving as comprehensively or as equitably as we like and so we have a lot of hope and enthusiasm to be part of this revolution together to acknowledge and then accommodate our overlapping needs throughout the perinatal journey. Thank you.

## Jennifer Yourkavitch

Thank you Kristin, really powerful to hear the words of people experiencing this and to home in on specific situations. Thanks so much for sharing that. Everyone, you can put your questions in the chat, you can unmute. We are free to discuss now. We have had two great presentations. The first being the overview of the situation globally, what has been happening with policies, the effects of those policies, the consequences being experienced in population levels and then a great deep dive homing-in on specific experiences in the words of people experiencing them. So thanks to both presenters.

Okay, I have not been looking at the chat. Let us see what is there. Okay Mija, we are going to start with your question here. Thanks. Do you want to read it Mija or would you like me to?

## Mija Ververs

No, I feel it's a bit unfair and maybe I put Karleen here on the spot and I do not expect really you will have fully the answer but, with all you have seen - and you have seen hundreds from 100 different countries; guidance materials. If something like this happens again; a novel disease outbreak and starts to be regional or even global, are there any lessons learned so far? How could we have done differently and is there anything you think we should prepare us for? Thank you.

## Jennifer Yourkavitch

I think that one of the biggest problems that we have had is the conflicting guidance. So, specifically, the guidance from the USCDC has caused and is still causing enormous difficulty. From early on, our first data collection; the USCDC guidance, was out early. So it was the first, I guess, big guidance that was published. The first one that came out was the China Consensus Guidance which was in English and published in a journal, then there was the USCDC. Shortly after the USCDC, there was the Royal College of Obstetricians and Gynecologists and then the WHO guidance was last but not long after. So it was all over a period of just over a month that those four guidance documents were published. For the guidance that was published in March and April, the USCDC guidance was the most cited guidance document. It was very well utilized but unfortunately it wasn't reliable and so it was taken up. And we know from emergency communication, it's like, be first to be right, be credible. The CDC was out early but it wasn't accurate.

Unfortunately because it was out so early, countries and organizations took it up. And we know from our second lot of collection that many countries have not changed. They have not revised their guidance from back in March or April last year, so it has stuck. But even countries that have, they are still referring to it explicitly. So saying things like the WHO and the Royal College of Obstetricians and Gynecologists say that to keep mothers and infants together and to support breastfeeding, the USCDC do not have a direct recommendation. They talk about risks, actually this is what a lot of them are doing now. They are just saying we will just leave it up to mothers to decide. We would not provide a clear recommendation. Which is abandonment. It is really not good enough. So I guess that would be one of the things to get right the first time and to give sufficient weight to breastfeeding because I think we would have a very different story if we had had WHO and RCOG and the USCDC saying the same thing. I think in countries like Indonesia and Thailand and Belarus and lots of other places, we would be seeing quite different practice. I mean, it is just difficult to think about the ramifications of that guidance. That would be my one thing. We have to learn from what happened with HIV, we have to learn from what happened with this pandemic, and place sufficient weight, and not make recommendations to separate mothers and infants and to reduce or prevent breastfeeding, unless we have got evidence to show that it is necessary. The weight should be on the other, do not change anything unless you have got evidence to show that it is safer to do that. But unfortunately, how do you change really entrenched views about what is important and what is not important? I don't know. Yeah, sorry, sorry. I just ranted there.

## Kristin Tully

I just like to add that my colleague Professor Allison Stewbe wrote about and then what happens after discharge, they are going home together and so thinking about what is being served by the separation and then what is going to happen the next day. I can put a link in the chat. But I think that my systems perspective here too is like thinking about expanding models of care that increase patient comprehension throughout their journey. So, more group prenatal care, more midwifery care especially in the US, so that people can be more equipped and comfortable to ask and to understand, and to not have new information in the hospital. We need to be educating, especially in the third trimester, and equipping people to make decisions and to be having realistic expectations, and then have care plans to meet those needs.

## Jennifer Yourkavitch

Thanks Kristin. So educating along the continuum of care, along the people surrounding the mother-baby dyad, and also the agencies who are responsible for issuing guidance to get it right and out early because that makes a big difference for people. That is continually what is going to be cited and stop defaulting to separating mothers and babies. That should not be the default that is what I'm hearing. Okay Kimberly, I see your hand is raised.

## Kimberly Mansen

Great! Well, I just wanted to thank both Dr. Gribble and Dr. Tully for these great presentations and your thoughtful and insightful awareness of the maternal experience in these times. Part of our goal is to also be advocating for the gaps in research and what needs to be done. From your experience and perspective, I have heard we have done the analysis on what policies exist and maybe we can definitely dive deeper in all these areas but what I heard today was the analysis on the policies; what is happening or at least what is mandated to happen, and then we have some research on maternal experience in different pockets in the hospital or what they experienced because of that. Where would you say that this group should be helping to advocate especially keeping the maternal mental health, trying to mitigate the consequences of these practices? I know this is a flood of gas that we could be talking for hours on where we need to go. But from your perspective for what you have worked on, where would you say the priorities are especially in light of understanding if this situation were to happen again in a similar way? Just a repeater couch for the question, from a maternal health perspective what are the areas that we need to prioritize for next steps in research in order to know what will be best for the next time in a similar situation in the future?

## Jennifer Yourkavitch

Thanks Kimberly. Karleen or Kristin, do you have a response?

## Karleen Gribble

Yeah, my thoughts on this, one of the parts of the recommendations from WHO was that psychological support be provided to separated mothers and infants. Looking at the guidance from around the world, it was pretty rare for that to be as a part of COVID 19 maternal and newborn care guidance, for support for mothers who were separated from their infants. So it has not really been on the radar and none of the guidance documents that actually recommended separation had any content about psychological support. I think it is actually because, for my work, I really apply a child rights framework to it and what has been really disturbing to me is how little understanding there has been of the needs of infants in these circumstances. Infants have been separated from their mothers, they are being cared for in neonatal nurseries where there has not been visitors allowed and not a single guidance document mentioned anything about having increased staffing levels in nurseries to provide emotional care to infants.

I know from research that some of my colleagues have done here in Australia, when you have an infant in a neonatal nursery without a parent there to provide them with emotional care, those infants are very often left to cry and we have seen some really awful footage from Indonesia showing rows and rows of babies in cribs with those neonatal face masks on just crying and crying because

nobody is there with them. I think that these psychological issues just aren't on the radar when people are thinking about infectious disease but I think we do not value those things in any case. We think it is a small thing to separate a mother and an infant for a few days or a couple of weeks when really those days and weeks after birth are such an important time for both the infant and the mother. And the consequences can reverberate through the lives of both because of the trajectory that it takes the relationship on. I do not know whether I have actually answered your question. And Mija has just put a comment in there about the psychosocial support aspect that has been worked on with the Ebola outbreak. It is so important and some of those resources are just really helpful and good to see. But the conclusion that I have come to after looking, because I am doing some more work looking actually specifically at neonatal nursery and NICU guidance around maternal infant contact. Unfortunately, it seems like babies are not really seen to be people at all and their psychological needs are not being considered. So how do you change that? How do you fix that? I don't know.

## **Jennifer Yourkavitch**

Thanks Karleen. Important points. Kristin, did you have a response to that?

## **Kristin Tully**

Sure, if I could elevate the importance that Karleen just outlined of having adequate staffing levels, we need to have nursing staff levels that reflect national recommendations. And we need to have interpreters staffing levels to permit the sort of communication that we all want. We also need to have systems of payment so that interpreter services are not costs, they are not reimbursed now and so use of them is not incentivized. And I really like your point about how the structure that we have in place demonstrates our values: who we value and who we don't. My last part of the response is that I think everyone, families and healthcare team members alike might benefit from more positive coping strategies and I'll put a link in the chat for Postpartum Support International. It has a lot of online groups for families including dedicated ones for women of color and in Spanish too. So that is one of many wonderful resources.

## **Jennifer Yourkavitch**

Thank you Kristin. Dan, I see your hand.

Okay Dan, we can't hear you.

## **Dan Raiten**

How's that?

## **Jennifer Yourkavitch**

Great!

## Dan Raiten

I want to thank both presenters, that was two great presentations and it is a very compelling set of issues. I just want to note that these conditions, these infections, are the same in the sense that they all engender the need for a response, but they are also different. HIV is not COVID and we had to learn a lot at the boundaries. And if it wasn't for the advent of antiretrovirals, we would not have been able to really build, effectively move forward with the infant feeding agenda. In my experience over the years, I think that the response to COVID has been terrific. It is not perfect but I think it exemplifies the kind of things that we need to be doing. And we really responded quickly with regard to the biology. We have Sheiley McGuire on the call here today. Her team and the work she is on, Lars Boat and his team and the teams in Australia, all of those folks really got on the case quickly. But I do not want to lose sight of the importance of the biology and the complexity of the biology in this context. There is a difference between the biology and the behavior and we need to not lose sight of that in our advocacy for the importance of infant feeding. That is my only comment.

I think as we move forward to try and develop, and we will have conversations about how we move forward with the framework for response, that balance is going to have to be acknowledged and attended to carefully. And I will ask, parochially, who still does not have any idea about nutrition, and nutrition is critical, and is not being attended to either from a biological point of view or as we are hearing now from a care point of view. I will throw that out to the group for consideration. Thank you.

## Jennifer Yourkavitch

Thanks Dan. I don't see other hands so we are going to continue moving through the chat. Oh Sheiley, I see your hand.

## Shelley McGuire

Just a quick response. I was thinking the same thing Dan. Like how do you get it right the first time when we didn't know what right was? Half of my brain is saying that, the other half of my brain is saying there is a standard sort of response to something like this where we assume the benefits of breastfeeding are going to outweigh the risks. And I don't know. It is a great question Nigel. I am going to turn it over to you.

## Nigel Rollins

Yeah, I think Karleen alluded that WHO was not the first out but there is the responsibility of authorities as Karleen said to get it right, get it out quick. But some of that, certainly from a WHO side, we have due process where we bring in people from all over the world. It all happened very quickly, it happened remotely and we tried to look at whatever evidence we could at that time. That inevitably took some time to say what were the likely risks etc., and that probably resulted in a one or two-week delay whenever other guidance came out. However, the WHO approach would be to look at both the risk of the external risk of the virus and then the risk of what you lose if you stop breastfeeding. And I suppose the question is that, I put a note in the chat that, in the context of an external threat most of us react in a risk-averse way, we do not think about what happens with the counter-factual. So, we do not measure what is going to be lost if you disrupt the normal. We simply

try to quantify it. And there were publications coming out saying “SARS-Cov-2 RNA fragments”. Now these were being put out. This is no disrespect to laboratory scientist Sheiley but there were publications coming out saying we have found SARS-Cov-2 RNA fragments and we recommend that breastfeeding should stop.

Now, I just do not see how that person can fully weigh up the full public health consequences of that, but yet that gains traction in the public discourse. So I would say that the reaction in civil society is not surprising at all, to take that risk-averse position. That is what we all do for our children. But it really does heighten and it demonstrates the importance of authorities really taking the right approach to balance things up. We can comment on the WHO timeline for that, knowing what happened in heist, it moved very quickly but not quickly enough. So that is clear as well.

The other point I just put into the chat box is that the inclination to Jettison breastfeeding so easily in the context whenever nobody knew about the true transmission risk nor the consequence of infection, the readiness for leading national authorities to Jettison breastfeeding just at the possibility of harm, I think is a real reflection on how we value breastfeeding in general. And then you have got to say, how is it that we have got to this place where in society, breastfeeding is almost the atypical that whether on a bus, on a public bench, in a shop, a mother who wants to breastfeed is seen as atypical whereas giving a bottle. That is sort of a societal level but it does reflect the value which we as society put on breastfeeding and our lack of a full appreciation of the remarkable biological and I picked up in your word there, the biology of human milk is just extraordinary. And yet we have become so complacent with our protection of breastfeeding and breast milk, and that to me is an underlying question because preparation for any future pandemic is not just the decision making that happens at that moment. It is got to be also partly how we understand infant feeding as a key contributor to lifelong health and not just the immediate here and now.

## Jennifer Yourkavitch

Yeah, thanks Nigel. Karleen, your hand has been up, you have been waiting.

## Dr. Karleen Gribble

I just wanted to make comment about the need in all of this to actually factor in the psychological impact. I think there is the perception in wealthy countries with reasonable health services that the risks to infants when they are not breastfed is small. And that is simply not the case when you are considering issues like child abuse and neglect. The cost of separating mothers and infants in those early days, the cost of removal of breastfeeding for the most vulnerable, for those mothers who are going to find things difficult in any case, is actually quite massive. So we are looking at enormous loss of human potential, enormous societal costs that can flow on from there. I think it is just not something that we think about or that we quantify, but I think we are going to be seeing the impact of what has happened during this pandemic cascade through the lives of the women and children who have been separated because of the pandemic. I just wanted to raise that as something that should be more considered. It is not just about the milk, it is about the relationship, it is about the diet, it is about the connection between the mother and the infant. I think that in this pandemic, there was a lot of focus on the milk and not as much, from where I was coming from, not as much on the relationship. Thanks.



## Jennifer Yourkavitch

Yeah and the psychological health of both yeah. Thanks Karleen.

Okay, I am going to go into the chat. Kimberly asks who is putting out guidance on what psychosocial support looks like for neonate and mothers. Does anyone know?

## Mija Ververs

I have put to her but I can do it here again, a case study from the Ebola response. But again that is Ebola and this was in DRC where the separation was instrumental and we still do not know whether it was right or wrong because we still do not know how the virus appears, if at all, in breast milk and when. But, that said, there were a lot of lessons learned in previous outbreaks and as you know they are repetitive these outbreaks, and they learned that the separation needs to be really well guided by psychosocial support. There are a little bit more details in what I put there in the chat as a link. But that was a major lesson learned: how a mother has a diagnosis of a serious illness and then does not see her child, suddenly it is taken away. The implications physiologically for her stopping breastfeeding suddenly, but also how is my child going and they introduced this crèche, this nursery on the side of the Ebola treatment to the next door that sort of kept at least the woman in the ETU, in the Ebola Treatment Unit, because she was not going to look for her child, at least she knew that her child was next door and the child would regularly be shown to her. That was a major issue for a mother and if you want an infectious person to stay in an Ebola treatment unit, this is what you need to do; to look after that child, to ensure that the mother is okay with what is happening. But that is typical to Ebola. I do not want to drag at all to that so back to you.

## Jennifer Yourkavitch

Thanks Mija, that is really interesting and helpful to know what steps can be taken to support the mental health of the dyad there. Other thoughts or comments on that? This is about guidance for psychosocial support during this time.

## Kristin Tully

Just to say I do not think it was optimized before this time either and so it is a great opportunity to know how we might care for people once they are discharged in all the ways.

## Jennifer Yourkavitch

Yeah, more learning from this time, yeah.

## Dr. Karleen Gribble

I was just going to say that I am not aware that there is really very much out there when it comes to infants and in some of the guidance, there is some discussion about use of face time and that sort of thing so that mothers can see their babies. And I know that has happened in many places and that is something that is, I guess, similar to what Mija was saying. But when it comes to infants, that

psychosocial support is actually around having somebody, a substitute who is actually able to be responsive to them. And we know that in nurseries, nurses are too busy; they can't do that. So unless you are putting in extra staff that is what it comes down to. And then support when mother and infant are reunited because I have spoken to some mothers who are separated from their babies and just how difficult it has been for them. Sometimes they have felt rejected by their babies and if that feeling of rejection, if that's actually not dealt with, it becomes reinforced and that relationship does not repair. Whereas if the mother is helped to actually understand her baby and her baby's responses to her, then she is able to rebuild the relationship. But it is not something that I have really seen discussed anywhere in the context of COVID or any sort of any other situation but there is stuff in the literature, there is stuff on building attachment in premature infants and I have used some of that in relation to foster careers. So, I will put that in the chat in case people are interested.

## **Jennifer Yourkavitch**

Thanks Karleen. Some important points, another gap in care sort of highlighted and underscored by this time. Along those lines, Linda has a comment in the chat “reflection on the importance of preparedness and appropriate pre-pandemic policies and practices that support proper infant feeding like BFHI”. I am just going through the chat here. If you have a question please feel free to unmute or raise your hand.

## **Kristin Tully**

I put some links in the chat for websites that we developed in English and Spanish that are family facing which includes a section on COVID and is sort of a resource hub for the international guidance, and also addresses emotions and has tips and things to consider for daily life and for breastfeeding.

## **Jennifer Yourkavitch**

Great! Thanks Kristin. I have a question for you Kristin. You mentioned patients not meeting their breastfeeding goals and gave us a few statistics on that. I am wondering if you know how that compares to pre-pandemic times. People leaving the post-natal care meeting their goals where you are.

## **Kristin Tully**

We are looking at charts of all births for like five years and so we can get into specifics but I know and consistent with the literature too that people were not meeting their goals before either. I have not looked about a comparison and if that is substantially different. I would expect everything to be a little bit harder now and to see that and all these different metrics.

## **Jennifer Yourkavitch**

Okay, thanks. Another question from our group is about communication strategies and materials for the next pandemic. “Is there something ... I am thinking about the higher level things we have talked

about; policies and agencies who are responsible for putting out statements, doing that faster, more accurately, not defaulting to separation. But what about, Kristin maybe in your context again, in a hospital setting, communication strategies and materials that might be prepared now in preparation for a situation coming where we have all of these precautions again, we have PPE, we are limiting the number of people coming and going and that sort of thing. You mentioned some practices like doing things in front of mothers so they can see you sterilizing the stethoscope, things like that. Are there other changes to communication or practice that could be implemented maybe now, going forward, or at least prepared for the next time?

## **Kristin Tully**

I think the biggest innovation is to partner with birthing parents when creating these sort of guidance documents and materials, and in all tools, to do that alongside them so that it is addressing their priorities and framed in ways that are clear and actionable for them. We try to do that in all the projects and I think that is a good strategy to have; to seek to truly collaborate, and that is not easy to do that in an authentic way. You can only move at the speed of trust.

## **Jennifer Yourkavitch**

Thanks Kristin. Thank you. A note from Alexandra in the chat. She is conducting a study now that will have some information about some questions raised here today and we will share back with the group. We look forward to that, thanks Alexandra. Anything else I want to say about that?

## **Dan Raiten**

Jennifer

## **Jennifer Yourkavitch**

Hold on one second Dan, Alexandra, is there anything else that you want to say? I see you speaking but we can't hear you.

## **Aleksandra Wesolowska**

I would like to add that I am from Poland and in Poland the guidelines have been changed three times during the pandemic. So I think we come from the Chinese protocol to WHO protocol. I think it may be interesting to evaluate how its influence of this time changing on these mothers and baby well-being. I will be happy to share my results very soon I hope. Thank you.

## **Jennifer Yourkavitch**

Great, thank you so much. All right, Dan you wanted to say something.

## **Dan Raiten**

I would never argue with my friend Nigel, I agree with everything that he said but here is the fundamental question as Mija has noted, Ebola is different than COVID, HIV is different than Ebola. The question is, what do we do when we learn that there is an infectious organism in the environment that has a potential for doing harm? What do we do? Are we suggesting that our first response is continue doing everything that we do with regard to infant feeding practices until we find out that we need to do something else or do we take a different approach? How many babies are we willing to put at risk to advance the infant feeding agenda as important as it is? I think as we move forward, what we need to do is come up with an algorithm that's sort of a series of if/then questions and recognize that it's going to take some time. It is going to take some time to figure out what exactly we are dealing with. We responded really quickly. I am not going to have any recriminations about how we dealt with COVID because we did it really quickly. We did it as quickly as we could but with all the respect to WHO, they did a terrific job in trying to respond to this given the nature of the information that we added here. So, I think as we move forward, we need to be cognizant of a balance between understanding the biology and the risk versus advancing the infant feeding agenda as important as it is. It is not versus it to end but we need to set up a process that really will allow us, as extensively as possible, to get us the answers that we need so that we do not put anybody at risk or harm.

## **Nigel Rollins**

So Dan, I do not think we are saying things differently here. I don't know what the processes were within the US and the CDC and I don't know what the processes were within China. The principle of balancing risk, I think, is the essential part of. It is not just the risk of potential acquisition but the risk of what happens if you don't breastfeed. And I didn't hear that well framed in those guidelines. And I suppose that in that sense we are saying exactly the same thing and the question is whether there was that level of examination even with imperfect data. So even by March, there had been two to three months of experience from China and I can't recall any report. We certainly heard of the reports in adults and if you looked at all the visuals there was never any children or babies on those stretchers. There weren't any reports of children or babies dying any time. And even that very circumstantial evidence pointed to what has become a much more robust evidence space in terms of both transmission transmissibility and also the consequences of infection. So, I can't comment on the processes in the US and China. I think, to me in retrospect the question is whether there were hastened; the decisions were taken in haste on the first thing of we must prevent this infection, without due consideration of the consequences of that. And it was a very difficult ... these things have always been difficult but it is that framework of balance that has got and I agree entirely, Ebola is inordinately different from Zika, and Zika is different from HIV, and HIV is different from SARS-Cov-2. But there needs to be that balancing of risk and also by context.

## **Dan Raiten**

Absolutely, we are in violent agreement as usual.

## **Jennifer Yourkavitch**

In the chat from Kristin and Sheiley, thank you. Other comments, questions?

We are down to the end of our time. Thanks so much for this rich discussion, for the excellent presentations highlighting this critical issue. I wanted to note coming up next month in June, our topic is “Supporting Actors Beyond or Around the Mother Child Dyad and Their Role” the actor’s role in infant feeding during the pandemic. So, if you have an interest in presenting on that topic, please do contact Victoria. She is the one who sends the meeting invitations. So, you will have her email address there and I think we can put it in the chat. And then in July, looking forward to July, Vaccine Hesitancy among Pregnant and Lactating People and Implications for Infant Feeding. So if you are interested in that topic too, please contact us.

## Dan Raiten

In August, we are also going to be talking about this framework issue and where we are going to try and be as aggressive as possible with moving forward with some sort of a framework to respond to future situations. And in August, we are going to be having a webinar on lessons learned and we will cover HIV, Ebola and SARS-Cov-2. So pay attention, we will be back to you on this.

## Jennifer Yourkavitch

Excellent! That sounds great. All right everyone, with that I will close our session.

Thank you so much for joining us. Thank you to the presenters. Take care.

## Shelley McGuire

Take care, thanks everybody it was great. Happy Mother's Day.

## Jennifer Yourkavitch

Oh yeah, Happy Mother's Day. Thank you for saying that, bye.



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Implemented by:  
JSI Research & Training Institute, Inc.  
2733 Crystal Drive  
4<sup>th</sup> Floor  
Arlington, VA 22202

Phone: 703-528-7474  
Email: [info@advancingnutrition.org](mailto:info@advancingnutrition.org)  
Web: [advancingnutrition.org](http://advancingnutrition.org)

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