CIF-RIG Reaching and Supporting Parents to Breastfeed during COVID

Webinar Transcript

Jennifer Yourkavitch

Okay, let us begin. We have a very full agenda today. Hello everybody, welcome to the COVID Infant Feeding Research Interest Group Meeting for June. My name is Jennifer Yourkavitch. I am the director of Monitoring, Evaluation and Learning for USAID Advancing Nutrition, and together with my colleagues Victoria Anders, Aaron Burkhazen and Alyssa Klein, we host the monthly CIFRIG meetings. Today, we are happy to bring you a great panel of presenters who will be sharing experiences with reaching and supporting parents to breastfeed during the COVID 19 pandemic. So, I will introduce the speakers and will generally hold questions until the end of each presentation with the exception of the first speaker whom I'll introduce in just a moment. But we will take questions for him after his presentation because he will be leaving early today. So now, I will introduce the first speaker, Adam Lewkowitz. Dr. Lewkowitz is an Assistant Professor at Brown University and the Associate Maternal Fetal Medicine Fellowship director. His research expertise lies in developing and implementing technology augmented interventions to improve perinatal health equity, particularly in the postpartum period. Recently he created a novel smartphone application and examined its effect on breastfeeding rates among low-income women. He will be talking about that today. Over to you Dr. Lewkowitz.

Dr. Lewkowitz

Thank you so much. Can you see the screen that I am sharing? I love when zoom works.

Jennifer Yourkavitch

We see that in editing mode, not in presentation. There we go.

Dr. Lewkowitz

Perfect! So thank you for that introduction. I am really excited to speak with you all today about mobile health approaches to breastfeeding. I don't have any financial disclosures but it is important to note that one of the apps that I'll be talking about was one that I created and it's pretty clear, based on my sex, that I am not directly affected by the results of this research, so I am presenting this from the perspective of an outsider. Today, there are four objectives for this brief talk. First, I want to define what mobile health is and then talk about it via a systemic review. They affect efficacy of web-based versus smartphone app-based breastfeeding interventions and lastly step away into discussing the role of virtual breastfeeding support during the current pandemic.

Mobile health is also called mHealth or new media and essentially it is the practice of medicine and public health supported by mobile devices such as mobile phones, tablets, personal digital assistants and the wireless infrastructure. In general, there are three kinds of buckets that these interventions can be in. The first is online or web-based platform that ranges from a static content; like any time we go to a news website and just read the article that was posted, to a more

interactive form even to the extent that a webpage can host a game that has been designed for specific medical education or public health purpose.

Another type of interventions is short message systems or SMS. Those are essentially text messages and those are available on all types of phones. And lastly, if you have a smartphone, you can use an app based platform just like with the online programs there is a wide range of possibilities ranging from automatic chatbots to what are called just-in-time adaptive interventions. And those just-in-time adaptive interventions basically can be set up to send you push notifications and then based on your response to them, focus, provide positive reinforcement on a good behavior or send you to a specific part in the app based on how you are feeling at that moment. In obstetrics, mobile health interventions have been effective in improving outcomes in three main fields. The first is postpartum hypertension. So, there has been a lot of research lately out of Pennsylvania showing that an SMS-based intervention improves health equity in the postpartum setting among women with preeclampsia in terms of their adherence to recommended postpartum blood pressure checks.

For genetics, artificial intelligence interventions have been leveraged to improve the diagnostic accuracy of uncommon genetic conditions and women with gestational and non-gestational diabetes who use an app-based glycemic control program have been shown to have improved glycemic control throughout their pregnancies. But what about mobile health and breastfeeding? So, I am going to spend the rest of the time talking about our systematic review that my mentor Dr. Cahill and I recently published in Clinical Obstetrics and Gynecology. I am happy to share this pdf with you all if you're interested when this is over. In this review, we focused on the two most published breastfeeding interventions. As you see, most published is a little bit subjective. One was web-based and the other was app-based. Of the eight studies that were published to date using web-based breastfeeding interventions, they still fit within this umbrella of web based but you will see that the actual mHealth intervention was strikingly different. So, two studies used discussion boards based on the web. One was asynchronous which means that you basically write a comment and then at some point you hope that someone answers you, synchronous means that it's more of a live chat function; so people are told that from one to three there'll be someone available and it's more interactive. The next two studies, one provided online access to support: kind of like a synchronous discussion board but the difference was that pending people's responses and questions, they were referred to in-person support. Another used a website to provide an educational semi-interactive breastfeeding game. Two different projects tried to leverage certified lactation consultants using mobile health, so one used an on-demand CLC available via discussion board, another actually used a CLC available live via webcam. One group of investigators developed a game-based learning platform which is intentionally almost like a virtual reality setup, it's pretty neat. And the last which we will see is the only RCT in this collection, essentially translated the historical pen on paper writing what side of the breasts, started feed, how long the feed was and number of dirty diapers, translated that from the paper to a web page. It cannot be more clear that the heterogeneity of these web-based interventions means that we can't really synthesize the results in terms of their effectiveness, and the other thing that makes it difficult to describe their impact is that the outcomes range in these studies range from just breastfeeding initiation at all, all the way to exclusive breastfeeding at six months.

This is the table that we made, that is in the manuscript and I wanted to point out that the majority of the studies are published outside the United States and particularly in Europe and Australia. There is one study in Taiwan and only one randomized trial. In general, the studies were fairly large like one to two hundred people, largest was eight hundred. These are all the different interventions and you can see how different the outcomes were and the fact that most of these outcomes are reported by participant report of infant nutrition which in and of itself can be a little bit controversial.

When we look at the six studies outside the United States, every single one reported an effective increase in breastfeeding rates to women who received the intervention. A study published in Ireland did note however that in their cohort of women, which included women in cities and women in rural settings, the web-based intervention was much more effective among urban women than among rural women. Among the two studies published in the United States, one study did not show any effect and the study that did show effect was the randomized trial and as I mentioned, that intervention is somewhat limited because it doesn't really take advantage of any of the web-based potential that an mHealth intervention can be. It was essentially an online diary but it did work.

To switch gears a little bit, from online to phones, there are even fewer studies on app-based breastfeeding interventions. Four in total have been published to date and of those, only three have clinical outcomes; two of those studies use a commercially available app and when I say commercially available, that means that it was designed by someone that was not the investigators and was downloaded by participants through iTunes or Google play. The Australian study used an app that was made by a CLC in the United States which I have used myself, it's phenomenal, and I promise I am not biased. The US study was also identified as an app but the purpose of this app was to help women identify an in-person breastfeeding champion that was in their community or family. Once the app worked, the participant through this process of identifying this person, the app was no longer used for support. Two studies developed their own apps, one in Thailand and then the one that I did in the United States. Again, the heterogeneity really limits the ability of talking collectively of how app-based interventions may affect infant nutrition outcomes. It is also important to note that the outcomes again for these studies were really different. This is the table and you will see that I did the randomized trial. The rest were longitudinal mixed methods or prospective cohort studies. The commercially available app that was used in Australia is "Breastfeeding Solutions". It is fairly common and it is coincidentally one of the ones that we recommend our patients in Rhode Island to download if they are interested. The app I made was called "Breastfeeding friend". It is not commercially available, it was only used for research purposes. Both commercially made apps were shown to improve breastfeeding outcomes. These were in pre and post-intervention studies, so they lacked kind of the robustness of a randomized trial but they were effective which is exciting. The Thai app had a very small number of patients included and also predominantly focused on patient satisfaction with the app as well as kind of breastfeeding support. So we can't really include that in outcomes. And then, the study that I did was shown to be completely ineffective in terms of impacting breastfeeding rates from initiation until six months postpartum, but was highly regarded as a breastfeeding support resource, particularly after hospital discharge. Which suggests that women may view this type of support as particularly helpful if it is further optimized.

What do we do in terms of next steps? So, first it will depend on what type of intervention you make. Web pages are easier to develop and they are much easier to edit with feedback as the process happens, if you are kind of doing it live. If you choose to go the app route, a commercially available app is much more efficient, but it has the limitation of not being targeted specifically to your patient population. So that is why I would argue that even though it is time consuming and very expensive, it is important for breastfeeding mobile health intervention to incorporate patient preferences so that way, we optimize the intervention to the target end users and make sure that women feel like the app is not only accessible to them but desirable to be used at 2:00 in the morning when they are struggling to latch.

In terms of research, I don't want to knock all of us who are trying our best to get it out there, but there really has not been the most publications on this. And the data is not of the highest standard. So there is a need for further data and in those studies, I argue that we should include a control group, make sure that if an app is used, unlike a web page which tracks automatically the

number of users, for an app that needs to be built in so that way you can confirm that your participants are actually using your study invention. And perhaps most importantly, all the benefits that have been shown for mobile health and breastfeeding to date are predominantly in women who are not marginalized. So, it is important that we demonstrate that these mobile health interventions are as effective in geographically, economically, racially marginalized women as they are in women without these issues. I wanted to take a brief moment because we have all been living this ongoing COVID nightmare to commend us as a community for how we have been able to pivot over the last year and a half. So I don't think anyone in 2019 could have envisioned that the widespread uptake of tele-lactation support and resources, how we were able to switch in-person groups and education, prenatal and postpartum to the virtual format and I want to commend us and also encourage us to take the next step to develop and devise and examine the efficacy of our interventions of this transition to virtual to see if they are actually improving outcomes or at least not taking a step backwards. If you remember one thing from my talk, I want us to view mobile health interventions particularly with breastfeeding through a precision medicine approach. One intervention will not fit all populations. It is not appropriate for me to take an intervention that was geared for low income woman in St Louis and apply it to a woman in Rhode Island. Every intervention should be tailored to the population that you are in and that in and of itself is one of the potential powers and strengths of these mobile health interventions. These are all my citations and like I said, I am happy to share this systematic review. This is my family a few months ago as we, on a COVID day, stuck at home and I am happy to take any questions now or later on via email. There is an underscore here so it is Adam underscore Lewkowitz, I am sorry you can't see that. So, thanks again for the opportunity.

Jennifer Yourkavitch

Thanks so much Adam. Let us see, are there any questions? Feel free to raise your hand. I think I see one in the chat. Adam if you wouldn't mind not sharing your screen so we can see the full view, great. Feel free to put your email address in the chat if you would like people to get that okay. I see a hand, Kristin Tully, go ahead.

Kristin Tully

Hi, thank you so much. You spoke about the importance of incorporating patient perspectives. I wondered if you could speak to that a little bit more, your recommendations for approaches for doing that especially among minoritized populations.

Dr. Lewkowitz

Yeah, that is a great question. In general, when you make a mobile health intervention, it is a multi-phase process and people tend to focus unfortunately on the actual technology aspect and not who is using it. So kind of the best practice way to design these interventions is with a multi-phase approach. The first phase is, you create what is called a wireframe which is a PowerPoint or whatever it is that you think is the best intervention that could be and then you present that to focus groups of the target end users. In my experience, they all provide incredible feedback that essentially makes you redo the entire wireframe to make it better up from their perspective. And then once the feedback is consistently positive, what I like to do is do individual user interviews. I do mostly apps, so I give the app to a group of 10 or 15 women individually, let them use it for a month and then come back and say how can I make it more accessible, how can I make it something that you turn to in a time when you want help? The key is to use, if you are trying to do

a breastfeeding intervention, to get pregnant woman and postpartum women and obviously in your target and population in terms of demographics. Great question. I really admire your work also.

Jennifer Yourkavitch

Thank you, Adam. I see a question in the chat. Could you tell us a bit more about how these apps are used?

Dr. Lewkowitz

Yes, so, the app that was the commercially available app, and I am forgetting the name right now, essentially combines all of the videos and pdfs that the CLC has created on her website into an app based form so that you could use it in bed. Like if you are struggling with a latch at 2:00 in the morning, you just fire up the app and look at it then instead of going to your computer. So, the app that I made, actually one of the issues with it is that it was not widely used at all by the women. So over a four month period on average, only 11 users per median. The potential in why we thought apps would work is particularly, it not only allows you to centralize resources but allows it to be an essentially on-demand intervention. But it didn't work and we are trying to figure out why people were not using it. That was not a great answer but the idea is that just like anyone uses an app, it can happen at any point of the day and if you design your app to have all the content embedded within the phone, then you don't actually need Wi-Fi service because for low-income women the problem is not owning a smartphone, the problem is consistently paying for service. So, that is a key point.

Jennifer Yourkavitch

Thank you, and there is a request in the chat to locate the name of this app. I know that you may be leaving us before you can do that. If not, I think we will be able to make your slides available to participants and then they will have those references.

Dr. Lewkowitz

I found it. I sent it.

Jennifer Yourkavitch

Thank you.

Dr. Lewkowitz

Thank you guys very much. Sorry to leave early. Have a great day.

Jennifer Yourkavitch

Breastfeeding solutions, okay thanks so much Adam. We are going to move into the next presentation. So, we will have four more presentations and I would like to save questions for the end of the whole block. But please do feel free to put them in the chat. We will be monitoring the

chat and then we can bring them up later or you can raise your hand at that time. Moving into our second presentation, this is coming from Alexandria Schmall, Mackson Maphosa and Pamela Murakwani, and they will be talking about male change agent engagement to improve IYCF (Infant and Young Child Feeding) in Zimbabwe. And this is formative research on the topic related to covid-19. So, an introduction of those presenters Mackson Maphosa is a Zimbabwean communications specialist coordinating Amalima Loko social behavior change communication initiatives in Zimbabwe's Huanga and Binga districts, providing leadership, technical support and training in the development of social and behavior change communication strategies. Mackson has experience in capacity building, social behavior change and communications, and reproductive health, health and nutrition, agriculture and resilience building, including social marketing and social franchising. Alexandria Schmall is a public health nutritionist and behavioral scientist with a decade of program policy and mixed methods, research experience in nutrition, food systems, food environments, social behavior change and inclusive development across more than 30 countries globally. Throughout her career, she has held various positions with United Nations agencies, USAID and international nonprofits including cultivating new frontiers in agriculture, where approaches to improve diets, nutrition and equity among vulnerable populations are implemented. Pamela Murakwani is the health and nutrition lead for the BHA funded Amalima local program in Zimbabwe and in her role, she spearheads and provides technical leadership for the health and nutrition interventions at country level. She is interested in interventions that value the voice of women, minority and marginalized groups for health and nutrition development. Over to that team.

Alexandria Schmall

Thank you very much. This is Alexandria and I will be sharing the slides on behalf of the team. First, we will hear from Mackson. Over to you Mackson.

Mackson Maphosa

Thank you, hello everybody. Please allow me to get rid of video bandwidth concerns. So, I am going to be taking you through Amalima Male Champions Campaign and I am reporting from the position of an insider as I was part of the implementers.

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So, we did not initially have male involvement as a part of the original programs design. We realized the need for a focus on male involvement after our formative research when we realized that women did not necessarily have control to do some of the things that we were asking them to do. At the same time, there was a lot of social pressure in terms of adopting a number of recommended infant and young child nutrition behaviors and practices. What quickly comes to mind is the recommended duration of exclusive breastfeeding, where women were afraid to be constantly seen taking time to breastfeed by older and powerful women in the household, and also their husbands. So, this denied infants the satiative benefits and the high rich and nutrition dense hind milk. The LQAS also showed us that some of the behaviors and practices that were being recommended were being adopted but not in the ideal sense, although information about what is recommended was almost universal. So, at this point, we were now convinced of the need for male involvement but didn't know how to promote this and what exactly to do. So we did an operation research …

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and in this operations research, we spoke to married couples, separated the men and the women and we asked women to tell us what support they would want to get from their spouses regarding all the different facets of infant and young child feeding, from exclusive breastfeeding, complementary feeding, wash concerns, diet diversity issues and so forth. And we came with a big list of the kind of supportive and facilitating behaviors that women wanted men to do for it to be easier for them to adopt these behaviors. We then took that list to the men and asked the men what they were not willing to do and we generally came up with a continuum amongst those behaviors of what the men were not willing to do, what the men were willing to do but not able to do, and what the men were willing and able to do. So those behaviors that the men were willing to do became the focus area of our male involvement program.

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So, what you see here are some of the examples of these supportive behaviors. The top row is looking at the care of children and women were really interested in men and not only inquiring about the child's welfare when the child was sick but to do much more, and also to facilitate transport and make it easier for these women to take the children to health facilities.

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So, in designing the campaign, we decided to call it in Indoda Emadodeni Campaign. Indoda Emadodeni is Ndebele for a "man amongst men". We felt that positioning this with the masculinity of being a man amongst men would heighten the prospect of acceptance and also show the importance of being supportive and able to take part in infant and young child feeding, rather than leaving this to be the sole concern of women. We decided to pilot our intervention in three wards in Bulidima district and three wards in Cholocho districts. And we began by selecting community volunteers we called "main champions" to be trained in infant and young child feeding and after being trained, these men were then tasked with recruiting at least 10 men from their villages and then, either one-on-one or through group sessions, hold discussions each month on one key topic on a relevant subject on infant and young child feeding; from exclusive breastfeeding, continued breastfeeding, water, sanitation and hygiene issues, diet diversity and so forth. We also encouraged these men to form soccer teams as a group and supplied them with footballs in order to heavily leverage the campaign on soccer, to keep the interest in the campaign and also as a tool to recruit more men within the villages to join the campaign. Periodic tournaments were also held where these men showcased what they are about and the importance of being supportive in infant and young child feeding, and a male champion group was pitted against male champion group and it became quite a novel and big village affair.

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So, this campaign ran for six months in 2016 and at the end, we decided to evaluate it and we only evaluated it post-tests. Sadly, we did not do a baseline on this. In evaluating it, we focused on women's satisfaction with male partner support in IYCF, this being leveraged individually by the different facets of IYCF. So, there would be satisfaction in terms of the man's performance in terms of supporting exclusive breastfeeding, it could be in WASH issues or complementary feeding and so forth. So, we came up with a score of this week of women's satisfaction which we took as proxy for male involvement and showed the magnitude of a man's involvement in infant and young child feeding.

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So, what we learned in this small evaluation was that men in the pilot communities were much more likely to adopt their recommended supportive behaviors and at the same time women in the pilot areas were much more satisfied with the support they received from their male partners than women from the control areas. And we were encouraged by these findings and increased coverage

of the campaign to 56 percent of the project's area and added a different module to the curriculum in introducing men only cooking demonstrations, focusing on the preparation of nutritious meals for children under five.

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At the end of Amalima, we did a more robust study that looked at the campaign against exclusive breastfeeding outcome. This was more quasi experimental in nature with a larger sample size of 826 women. And what we found was that there was a significant relationship between high women satisfaction with male partner support for IYCF and the adoption of exclusive breastfeeding. In the intervention area, the women who reported high satisfaction were five times more likely to practice exclusive breastfeeding than women who reported low satisfaction. However, in the control area, women with high satisfaction were three times more likely to EPF than those who reported low satisfaction. And in both cases what we see is that, high satisfaction with support is associated with the adoption of exclusive breastfeeding.

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What you see here are a couple of milestones from our campaign and the top row shows men doing a different activities that are considered not masculine and probably taboo. And below you see the meals that the men cooked during these sessions. Thank you for listening. That is what I have.

Alexandria Schmall

Thank you very much Mackson for the excellent presentation. I will now move on to the next piece which is about our formative research in the context of COVID-19 in Zimbabwe. These are disclosures, you know the funding is coming from the USA Bureau for Humanitarian Assistance. Mackson described the Male Champions approach from Amalima and the follow-on to that is called Amalima Loko. And just to mention the presenters are employees of these organizations and I wanted to mention that this is Alexandria Schmall, I am presenting this project based on the USAID-funded Amalima project located in Zimbabwe but I do not identify as being part of the communities in the project areas in Zimbabwe.

So, for this presentation, follow on to Mackson's excellent remarks, I would like to present a little bit about our formative research in the context of covid-19 which is an adapted nutrition causal analysis to inform the Amalima Loko project. The Amalima Loko project is a five-year USAID Bureau for Humanitarian Assistance funded resilience food security activity. It started in 2020 and will go until 2025. Amalima Loko is located in the Matabeleland land north province of Zimbabwe and the project aims to improve the livelihoods of nearly seventy thousand vulnerable households across five districts in Matabeleland north. The three goals of the project are related to improving livelihoods, resilience and promoting nutrition sensitive initiatives, as well as improving watershed infrastructure and practices to improve long-term resilience and ad-based livelihoods among the communities. Amalima Loko uses a unique approach called ‘community visioning’. There is more information on the project website. As mentioned, related to nutrition and health, the Amalima project aims to improve the adoption of improved care, nutrition health and WASH practices for women of reproductive age in children under five years of age. The project also aims to improve nutritional adequacy specifically among women of reproductive age and children under five. The technical lead is IMC but all organizations listed here are working together on this project.

For the formative research, since the Amalima project recently started, we are doing an adapted nutrition causal analysis in the context of covid-19 in Zimbabwe. This mixed message research is really to understand the underlying causes of under nutrition of the target groups of women of

reproductive age and children under five in the project areas. We are specifically interested as well in infant and young child feeding within this research. We will be having a consultant leading this research starting up soon, we have had some COVID-19 adapted delays and the project research is aiming to start in July of this year and finish in October. We aim to have preliminary findings by October around the key aspects related to child nutrition and related child feeding, and infant and child feeding behaviors that need to be improved upon. And our formative research will inform us to better be able to design behavior change components within the Amalima Loko project, as well as other project activities, to improve diets and nutrition among the target populations. In particular, we will be specifically looking at risk factors for under nutrition among children under five, specifically looking at that first thousand days period as well, and also looking at the key behaviors of interest to improve. Similar to what we did in Amalima. And using those research findings, we are trying to design activities within the project to improve infant, young child feeding behaviors as well as diets and nutrition among the women of reproductive age and children under five. So while we have the children under five as the focus area, we are particularly interested with the infant and young child feeding period, within the first two years of life. In the context of COVID-19 in Zimbabwe, this is a little bit of information, our research is adapting some of the government required regulations related to limiting social gatherings, making sure that there is no gatherings of over 50 people, instituting social distancing, mask wearing, sanitation, so the Amalima Loko project is implementing all of these regulations and our research is also adapted to ensure that we follow these guidelines. And we are also trying to have a reduced sample size in order to be able to follow these guidelines of the government of Zimbabwe in this COVID-19 adapted environment. So with our formative research, we are specifically following these regulations in addition to hopefully finding out more data on the nutrition and health behaviors ongoing in the COVID-19 context in Zimbabwe. There is very little data on how COVID-19 has impacted nutrition as well as infant and young child feeding and breastfeeding in Zimbabwe. So we are hoping that our research is able to elucidate further information on this area. That is the end of the presentation. So, I would like to thank you and as noted, we will have questions after all presentations and thank you very much.

Jennifer Yourkavitch

Thank you so much to the team from CFNA. Let us move on to the next presentation. This is from Kailey Snyder about social support during COVID-19, "Perspectives of Breastfeeding Mothers". Dr. Snyder is an assistant professor in the School of Pharmacy and Health Professions at Creighton University in Omaha, Nebraska. Her research interests primarily focus on breastfeeding, maternal physical activity and pelvic floor dysfunction. Dr. Snyder believes a healthier mother means a healthier future and will welcome your questions at the end of the presentation block. Okay over to you Dr. Snyder.

Dr. Kailey Snyder

Can you hear me?

Jennifer Yourkavitch

Yes, thank you.

Dr. Kailey Snyder

Thank you very much for having me today. I am looking forward to sharing some work that was actually done rather early on in the pandemic last year. I would like to acknowledge that this work was in a publication previously that can be found in Breastfeeding Medicine. It was also funded through internal research funds from Creighton University and I would acknowledge that at the time the research was conducted, I was a breastfeeding mother in the state of Nebraska where the research took place, so I was a member of the group whose information I was presenting and also took substantial due diligence to focus on some removal of biases related to being a member of the group that I was studying. So, this study was related to social support theory. As many of you, I am sure are familiar with, the four key constructs related to social support theory that we are focused on or that kind of guided the methodology were: appraisal, informational support, emotional support and instrumental. And we were really looking early on in the pandemic to explore perceptions of social support among breastfeeding mothers in the state of Nebraska. We utilized a cross-sectional phenomenological design, interviews took place over the phone back in April and May of 2020. About a month after, substantial lockdown had occurred in the state of Nebraska in March. 29 mothers were interviewed and we utilized a deductive thematic analysis and again to try and reduce biases, peer debriefing and a reflexive activity journal was also kept throughout. The 29 participants were primarily Caucasian, one piece that is not on here is we did have a good diversity in the geographic sample. So a split between rural mothers living in populations less than 50 000 and then mothers living in more urban areas of Nebraska. We had 31 percent that did report working in healthcare, 24 percent were currently unemployed and 38 percent of the participants did identify as weak participants. So, when looking at the specific types of support related to social support theory, what we found was mothers stating is they were receiving emotional support from husbands and families through in-person listening or over-the-phone online discussions but they were really missing those in-person listening peer-to-peer support opportunities. Mothers also reported utilizing family and social media such as Facebook and Pinterest which is in line with previous research we have done to get information and advice about breastfeeding, but they also again really were wanting more reputable sources and then also, that in person, that was a big common denominator and what we kept hearing is "I wish that I could be in person". Instrumental support was being provided by families friends and sometimes, for those moms especially in healthcare that were working during the pandemic, they did feel the workplace was supporting them through either assistance with errands, time for pumping. But there was still barriers related to access to child care, an inability to take a child into a store with them when the lockdowns were occurring and then with appraisal support, people did report getting encouragement from friends, co-workers, families, their lactation counselors, but again it was that desire for in-person discussions.

So these are just a few example quotes to share the voices of the mothers that we interviewed. When it came to emotional support, we heard things like "you can't really go anywhere, it's one thing to talk over the phone or on the computer, and it's just more difficult that way". Instrumental support, "you don't always feel comfortable asking someone to come here to help, always just a little worried". Another mother noted "if I wanted to go back to work right now, I can't because of the baby and none of the daycares are taking new babies so that part is really frustrating". We had a split with moms regarding where they were receiving their information. Some would say things like "honestly I look up a lot on Pinterest just for articles, I know that's not probably the most reliable". Others would say "everyone still has been available via telehealth option or via phone conferences. So, I don't think these resources have lessened at all". Interestingly, first-time mothers were more likely to not be bothered by the telehealth and tele-lactation options, whereas mothers that possibly had received in-person support with previous children reported more of a discomfort or disliked the tele options more so. Appraisal support, "I just feel really isolated so that kind of discourages me from breastfeeding because I am just so

exhausted because I like have formula to make food, I could just form some formula and be done even though I know that is not what is best for him".

An additional thematic analysis was looked at beyond just the factors associated with social support and we really came across a few common themes across all of the interviews. One being just the smaller network for support. So, many mothers were reporting that the number of individuals that they could reach out to for information or advice or encouragement was just smaller. One teacher noted "It was hard for me to know if it was because of COVID-19 but I really didn't get help at all in the hospital. She did latch on pretty easily but no one came in to help or anything like that. I never got any support at the hospital". This was something we often heard related to quicker discharges postpartum that were happening early on and may still be happening in some places. Moms just really didn't feel like they were having the chance to initiate breastfeeding successfully because they kind of felt like they were just being pushed to get home.

There was also obviously an elevated stress component reported by many mothers. One mother noted "mainly it was probably a lot more stressful. I don't know if that has anything to do with my supply going down and like work all included in there, I'm not sure how that affected it but it's a lot more stressful, I know that because for the longest time I was just really not wanting to leave the house and if I had like any kind of symptom, like if I had a little itch in my throat I'm like oh my goodness, do I have something? Am I going to pass it on to her through breastfeeding"?

Thankfully, we only heard the concerns about passing COVID-19 through breast milk very minimally and this was interesting as it was so early on in the pandemic. We only heard it from one to two mothers that even brought it up as a discussion point. And then a silver lining, this was another theme that came out and it really related to mothers stating that because they had more opportunity to possibly have an extended maternity leave, possibly return to work while their baby was at home with them while they were working from home, did give them the opportunity to overcome some of the obstacles that they were facing. So one mother noted "To be honest, the pandemic really started at the end of my return maternity leave and it's been somewhat of a blessing in Scotland because my job allowed me to work from home and so it just feels like it's been a maternity leave and I feel like it's given me a lot of time to be home and be at a slow pace and have a longer period of time to figure out my baby, and nursing has just become so much easier and I think it helped just having so much time just to practice instead of having to figure it out in the workplace at such a quicker pace and so I've honestly enjoyed the time that I've had at home these last few months because of that". Another mother said "it's impacted me personally for the better just because I haven't been able to return back to work and I've been able to breastfeed on demand which is easier than pumping and trying to come up with milk to feed.

And then there was a need for previous knowledge. So many mothers were reporting, second time mothers or beyond, that if this had been their first child, they really feel like they would have had a much harder time. One teacher noted "If this was my first baby, I definitely think it would have been a lot harder and just with the whole pandemic in general. I mean it's been challenging because of the pandemic and I thought it would have been a lot more challenging if it would have been our first baby." Another physical therapist noted "with my other one having that support and weekly consultation with the lactation consultant and everything was really what probably got me through our journey and kept me nursing. If I would have had that problem with my first one and not having that support, then I probably would have stopped by now to be honest". So while I think that it is important to recognize obviously the limitations of this being specific to Nebraska breastfeeding mothers, and that this happened a year ago and that our world has had substantial change in the past year with the access to resources in person, I think these conversations can still be pertinent with us understanding how to support mothers moving forward. I think that continuing to utilize diverse channels to communicate the benefits that we are continuing to see

more and more in the research with vaccination and breast milk transmission, utilizing different avenues because we know mothers are utilizing many different avenues for their information support including things like social media, sharing opportunities between providers to enhance telehealth best practices. We heard from a lot of mothers the one piece of telehealth that they really struggled with was latch, they felt like they could get help from a lot in a lot of different areas but latch was a very big struggle, and being able to have someone convey appropriate and helpful advice over without being able to physically touch them or touch the baby can obviously be a challenge. So, trying to find opportunities where lactation providers can share best practices with one another, recognizing the additional barriers that first-time mothers may be experiencing, and then also I think moving forward, what do these silver lining findings mean for future work. COVID-19, I think, is going to forever make modifications and adjustments in the United States related to and beyond, working from home and possibly what that might mean for mothers and their maternity leaves, and is there a possibility to start looking at some length that, well obviously we need - substantially longer maternity leaves. Is there a possibility to look at lengthening maternity leave at …, mothers could perhaps do some part-time and work from home in some capacity while still nursing the infant? These are just a few of the future questions and strategies that might be considered in the future, thank you.

Jennifer Yourkavitch

Thank you so much Dr. Snyder. Again, please feel free to put questions in the chat. Our next speaker is Dr. Scott Ickes, he is an associate professor in the department of Applied Health Science at Wheaton College and an affiliate faculty member in the Department of Health Services and Nutritional Sciences at the University of Washington School of Public Health. His research examines the sociocultural, behavioral and structural causes of poor nutrition and seeks to identify and evaluate strategies to improve nutrition and health in low resource contexts. He is also a visiting scientist with the Kenya Medical Research Institute. Over to you Scott.

Dr. Scott Ickes

Thank you very much. Can everyone see my screen? Is it the right one? Okay good. Well, it is a pleasure to be with you all today and if I do need to stop my video, I may do so because of bandwidth concerns as well. My name is Scott Ickes and I want to talk about a proposed study that falls onto a study conducted in Kenya, where I am currently, around maternal employment and breastfeeding and this proposed supplement study will focus on breastfeeding knowledge, attitudes and practices due to COVID-19 in Kenya. I want to acknowledge that I am not a member of the population for whose information I represent but I do live half time in the Naivasha community where I am today. So I really enjoy the opportunity to work with healthcare workers especially in understanding some of the challenges and opportunities for breastfeeding but do not represent the community of mothers that I am discussing today. I wanted to acknowledge my collaborators going left to right down Ruth Nduati is a professor of pediatrics at the University of Nairobi, Judd Walson and Cary Farquhar at the University of Washington in the Department of Global Health. Benson Singa, Dr. Singa is at KEMRI, Kenya Medical Research Institute and Donna Denno is at University of Washington. Aunchalee Palmquist and Stephanie Martin, they are shown in the middle right and lower middle are at the University of Chapel Hill and Dr. Angeline Ithondeka is the medical superintendent at the Naivasha district hospital and Joycelyn Kinyua's picture's not here but she is another collaborator that has helped implement this research.

So, as I just post supplement under review right now to a parent study which is called "Identifying risk factors to sub-optimal breastfeeding and opportunities for breastfeeding promotion among

mothers who are employed in Kenya" and this research study is in its fourth year. We have published a couple of papers so far to document that employment has some important effects on exclusive breastfeeding on working mothers in Kenya. So, let me explain a little bit of the context of Naivasha, Kenya and Kenya as a society related to breastfeeding promotion.

Kenya is really a global leader in low and middle-income country contexts and perhaps globally just in general for legislation to protect breastfeeding. The Kenya bill of health in 2017 made provision for three months paid maternity leave and also required that employers established lactation spaces which would be adequately provided with necessary equipment facilities to support lactation and employers should grant nursing employees break intervals. And this is required for any employer that employs over 50 mothers. Naivasha - Kenya in the rift valley about two hours north of Nairobi and it is home to a very large floriculture industry that supplies about one-third of all sales to the European Union and these are cut flowers, mainly roses. About two-thirds of the employees in this industry are women. There are things like the agricultural growers union and fair trade Africa that help negotiate implementation of national policies and improve working conditions for mothers. This industry has been subject for international concern and journalism to highlight some of the negative working conditions. But I do want to emphasize that there are a number of farms that are making efforts to provide health care benefits and increasingly better working conditions for mothers. So, as a result of some of this international pressure and organization.

Women in this industry are very low wage and represent a marginalized pollution with some unique challenges to health and to breastfeeding. In the parent study that I want to supplement to understand how COVID-19 has affected breastfeeding, we had close to 1,200 mothers at four postpartum time points from three health centers. These mothers were essentially formally employed, most of whom were employed at commercial flower farms or self-employed, informally employed or non-employed. Most mothers are doing some type of employment in this context but it would be … they were considered a separate category if they were self or informally employed. Informal employment represents like contractual employment over 30 hours a week for our study. And we measured breastfeeding cessation at the first cessation of exclusive breastfeeding. What we found in the parent study was that, and these are unadjusted comparisons, first was that formal and non-formally employed mothers initiate breastfeeding at the same rates, early initiation is very high, exclusive breastfeeding is almost universal at childbirth and it remains high at six weeks. And in fact the formally employed mothers in unadjusted comparisons were more likely to exclusively breastfeed at six weeks. Maternity leave in this case lasts mostly for 12 weeks and so you can see that at 14 and 24 weeks - I am just going to check the chat here. Oh okay, I just wanted to make sure my connection was still good. At 14 and 24 weeks, the formally employed population has a lower problem of exclusive breastfeeding compared to the non-formally employed population. This is again with an unadjusted and now in the next slide adjusted regression comparisons. And these models control for maternal age, education, HIV status, the type of delivery; cesarean verses normal, child morbidity, the number of children a mother has had, a delivery setting; facility based or not. We survey what was the primary reason for exclusive breastfeeding cessation, we found going to work was the number one self-reported reason for exclusive breastfeeding stations and a perception, that it was time to introduce other foods according to the child's age or perceive no insufficiency. So, following on to this study and there was another qualitative study that followed the one I just presented, we wanted to understand how COVID-19 has affected attitudes and practices, as well as the implementation of these policies which are kind of midstream in process. The pandemic came right midstream during the implementation process of the Canyon bill of health. So disruptions to the health systems are expected to exacerbate all forms of malnutrition and I wanted to emphasize that we have made a 6.7 million in increase in the number of children experiencing child wasting and about a fifth of these are expected to live in Sub-Saharan Africa. So,

this unprecedented global shock is so consistent with the World Health Organization roadmap for COVID-19 related research. There is a critical need to address drivers of fear, anxiety and rumors and stigma associated with COVID-19 infection. And despite the robust evidence that we have, that there's limited maternal to child transmission of COVID-19 via breast milk, there is perceived ambiguity about the safety and feasibility of these needs to inform health system communications regarding the risks and knowledge gaps. So, we have been consistent with most studies, the first examines how COVID-19 has affected employment, food security and infant feeding practices and this is a qualitative aim, so we know that obstetric and neonatal health has been affected by the pandemic and Dr. Snyder's presentation really highlighted some of that for us especially in the US context. And I think that that context is representative in many ways, probably some of the same sort of large impacts that COVID-19 has had on the obstetric experience, counseling changes, social support changes due to lockdowns, due to spacing within the health care facility, were really affecting the counseling and education experience and the social support experience of others.

Aim one will look at this and we hypothesize that COVID-19 pandemic will have created an additional challenge to suppress speeding including reducing social closure to breastfeeding counselling. These are the four participant groups that we will sample, managers at commercial flower farms and to some extent hotels in the tourism industry, healthcare providers understand how the pandemic has affected the health act implementation, we also want to know from healthcare providers how health communication regarding infant feeding in the context of COVID-19 has gone and we want to understand health care workers' perception of mother's feeding attitudes and practices. And then secondly, we want to assess how the economic and health impacts of COVID-19 have influenced the implementation of these policies and we hypothesize that the pandemic will have impeded the implementation of breastfeeding support policies. Finally, we will administer a survey to a similar survey to the baseline survey to understand quantitatively how attitudes and perceptions of breastfeeding, as well as practices, has been in the pandemic. So, we have a sample to estimate breastfeeding prevalence that was concluded in 2019 and now we have an opportunity a year into the pandemic to estimate breastfeeding prevalence. And consistent with Dr. Snyder's work as well as our first, what really all of ours is, I want to look at how what I call caregiver capabilities such as social support, maternal agency, postpartum depression and experience of domestic violence might modify the experience of the COVID-19 pandemic on breastfeeding outcomes. So, we hypothesize that these factors will serve as a modifier to potentially attenuate some of the impact of the pandemic. The methods and just say that by leveraging comparison with recent pre-pandemic studies, we hope to identify pandemic-related declines in exclusive breastfeeding, if there are any, and also to document misinformed perceptions about breastfeeding in the context of COVID-19. This is a picture of the parliamentary floor where legislation was passed for this county bill of health and a more recent and specific breastfeeding mother's bill, and so as a global leader for breastfeeding promotion and protection, this research I think will provide some useful contextual information for the global leader about breastfeeding and COVID-19. Thanks for your time and feel free to email me with any questions.

Jennifer Yourkavitch

Thanks Dr. Ickes and will you be able to stay until the end of the session?

Dr. Scott Ickes

I can, yes, I can.

Jennifer Yourkavitch

Okay, great. So, there may be some questions coming to you live later on.

Dr. Scott Ickes

All right, thank you.

Jennifer Yourkavitch

Thanks so much and our last speaker is Jennifer Schindler-Ruwisch, an assistant professor of public health at Fairfield University. Dr. Schindler Ruwisch's breastfeeding research has focused on breastfeeding barriers particularly among weak populations, and she hopes to continue this line of breastfeeding work and highlight external factors and biases that drive inequity. Over to you Dr. Schindler Ruwisch.

Dr. Schindler Ruwisch

Thank you so much and thanks so much for having me today. It has been really fascinating to hear all of the research, and in this important and timely area. Can everyone see the screen okay? Great! So, I am going to tell you a little bit today about my work on breastfeeding during a pandemic. "The impact of COVID-19 on lactation services from the perspective of lactation providers". So, a financial disclosure that this work was supported by an internal research grant from Fairfield University, a personal disclosure is that I am a breastfeeding researcher and advocate but I am not a lactation professional myself. I do have personal prior breastfeeding experience but cannot speak directly to receiving these services during a pandemic or lived experiences described herein. So I do want to acknowledge I am not a member of that specific population whose information I am presenting today. The purpose of this work was to better understand the changes to breastfeeding landscape that was occurring during the pandemic according to the perspectives of trained lactation providers and also to look at the strengths and limitations of telehealth and related services during this challenging time. So, this was an online survey that was developed, mixed methods, a combination of multiple choice and short answer questions hosted by Qualtrics. And it was also not like Dr. Snyder's work done toward the beginning of the pandemic, about three months, in June of 2020 looking at a provider perspective. So, an email recruitment letter was sent to key gatekeepers at WIC agencies, la Leche leagues, local breastfeeding coalitions and hospitals. Providers were eligible if they currently provided breastfeeding services as part of their work, had formal training to do so and were over the age of 18. All participants received a brief minor monetary compensation for their time, the study was approved by the IRB and electronic consent was collected from all participants. The sample was relatively small, 40 lactation providers, 95 percent of whom served WIC recipients in some capacity, mostly Connecticut but some tri-state area, based northeast regional providers, CLCs, IBCLCs, peer counselors etc.

At this time again, about three months into the pandemic, the majority of providers about 70 were using all online and telehealth for their breastfeeding service provision. A small percentage, 15 or so percent, were doing all in-person visits and this was largely individuals working in a hospital-based setting. There was another small percentage doing a bit of both. Not all of the providers surveyed indicated the virtual platform that they were utilizing but the majority of WIC providers were providing phone only support as their primary method of breastfeeding service provision during this time. Only two of the providers surveyed indicated that they were using a HIPAA compliant platform like my chart or another telehealth platform. Most of the providers said that

they were using whatever was available to the patients that they were working with: FaceTime, duo, zoom, email, house party app, WhatsApp, whatever they could use that would help improve access and visibility for the consult. So, that being said, it's not very surprising that many of the providers felt that the virtual lactation support was only moderately effective compared to the in-person support.

Some themes came out when looking at some of the qualitative short answer responses related to weaknesses and strengths of the virtual lactation support that I would like to highlight. So, some of the themes are similar to what we heard in Dr. Snyder's research but from the perspective of the moms versus the providers, so the providers were saying the difficulty assisting with latch and positioning, unable to see the latch up close, unable to describe things as they would in person. For those few providers that were doing in-person service provision, they also had similar difficulties using a mask not being able to demonstrate a latch with their lips or what it may look like. So, that was mitigated online but there were still related difficulties, technical difficulties not having the necessary virtual applications to offer the support, logistical challenges so this provider said it very aptly, virtually, the screen is small, I am at the mercy of the person holding the phone for the video for the mother baby. I must use a cloth model breast to demonstrate how to hold and position, I have to verbally direct over the phone, there are interruptions on both sides, dogs, children, other calls etc. Reporter body language limitations were also mentioned especially with phone only support, so over the phone it is harder to read the non-verbal cues that you would in person and then concerningly unable to get accurate weights and gross in order to assist with other diagnostic issues. So, difficult to visualize oral anatomy dependent on a good camera person which may or may not exist. There were some benefits that were mentioned particularly related to safety, not having that COVID-19 exposure and rest, but also other things that may translate into the future reducing travel time inconvenience. It made it easier in terms of time constraint, babysitting travelling etc. Flexible immediate and continuous support was often available compared to having to call and schedule an in-person appointment and travel, and at times there was a faster response - so a phone appointment may be more readily available. Increased comfort in the patient's own home, so the patient rather than having to travel to an office and trying to set up in a space that they are not as comfortable in, being able to set up in their home environment where they are breastfeeding normally reduces some of those barriers. And then finally new communication strategies, which may be something that can carry forward. This provider described the positive is that we have sharpened our communication skills to create simple visual analogies and images to ensure the assimilation of the information. In general, we should be hands off particularly peer counsellors. When we are with our mothers, they urge us to help and it's everyone's natural inclination to provide physical support and so I think some of these adaptive communication strategies that have been implemented may have many adaptive uses moving forward. About a quarter of the providers indicated that not all the women they were working with had access to a device to receive such virtual support, so they may not have had any device at all, limitation on minutes, not having a smartphone or being able to use or download apps and not able to use video conferencing, which could greatly impact the accessibility and equity of lactation support during this time. We also saw a statistically significant decrease in reported frequency of lactation visits prior to and during the pandemic. You can see that during the pandemic in June, there was a much higher frequency of one to two visit lactation consults and a statistically significant decrease in three to four or five or more lactation visits. About a quarter of the providers surveyed conducted breastfeeding support groups during the pandemic, in some cases they were offered less frequently, in other cases they were offered more frequently but with lower attendance at each. As we all well know the virtual format can be limiting for discussion, quite a few providers noted they have converted their groups to one-on-one support or shared pre-recorded videos, which obviously is not exactly the same as that in-person dynamic. Again, not very surprisingly, a large majority of the providers reported that the groups are less effective now. Some of the pros was

that given a lot of the COVID-19 isolation, the lack of peer support, some parents were more interested in this virtual engagement but obviously it is less personal, it is harder to have that engagement. One provider described it very clearly "I think that the groups are slightly less effective, you lose the moving around ability that you usually have in a regular in-person meeting. In an in-person meeting, if one has to stand to bounce a baby or get on the floor to change a diaper, conversational flow can continue unimpeded. If you are using a laptop or stationary device, attendees have to go off camera to catch up with a toddler on a mobile device it could be like watching the Blair witch project. Also, there is a tendency to talk over others that would be minimized in person and then of course there is the open mic problem. So like you know, Dr. Snyder touched on this as well for these online peer supports being so important, but of course virtually there were a lot of limitations.

Levels of hospital and pediatrician support.

About half the providers surveyed felt women were receiving sufficient in-hospital support during COVID-19, which means the other half thought that they were receiving insufficient support. Oftentimes, this was due to shorter duration in the hospital, less time to see a lactation provider, less contact, sometimes the provider had to wait the COVID-19 testing for the patient prior to going in, in hot person hospital groups were suspended, most of them still are. A provider described in her survey "I think hospitals have been trying but at some point, mothers were having a much shorter stay which was less opportunity for support, there was also conflicting messages on COVID-19 positive mothers and infant separation. Some hospitals were testing all women and then keeping a baby and mom separated while waiting for results often to the detriment of a successful start to feeding including some instances of giving formula which probably wouldn't have happened pre-covid. When it came to beyond the immediate postpartum period, about 64 percent of the providers surveyed felt women were receiving insufficient pediatrician support, so that the follow-up was less frequent often via telehealth, again, routine baby weights were not being taken as much, so it is harder to ascertain weight gain, they perceive more referrals to formula. Lactation providers themselves that may have often had a warm handoff from a pediatrician were less available, only available via telehealth or taking on different roles due to the pandemic.

Perceived changes in breastfeeding initiation and duration

So again these are perceived, not actual changes but about 70 percent of providers reported seeing changes in breastfeeding initiation and duration during the pandemic. In terms of promoting initiation, some reported that some moms again of course this is not all, were at home more to establish breastfeeding, some perceived limited availability of formula or they wanted to protect their babies from COVID-19 with immunity. In terms of reducing initiation, those who had to be separated due to potential infection, many fears and uncertainties, limited hospital support and ongoing support could have been deterrence to initiation. In terms of increasing breastfeeding duration, some again, of course not all, parents had longer time at home with the baby in many cases wanting to protect the baby until the pandemic was over and supply improvements with more time at home.

But in terms of reducing duration, providers reported seeing that there was less peer and family support, isolation, lack of in-person provider support of course compounded by the many other stressors that the pandemic brought on for many families. Concerningly, 36 percent providers thought that some groups were disproportionately affected by the pandemic in terms of what support was available and another more than half of providers were not sure the impact that this was going to have on equity. Given that there already exist many racial disparities in both maternal health and rates of COVID-19 perpetuated by a myriad of social ecological multi-level factors including racial discrimination and injustice, there is a critical need for increased attention to the inequitable effects of the shift in lactation care and the cumulative influence of racial disparities on

breastfeeding rates. This was obviously just very small preliminary findings for a specific regional area, lactation providers, not mothers as we heard about before, where the only source of the data. It was an online only newly created instrument so ongoing research is really critical for understanding the actual versus just perceived impact of COVID-19 on breastfeeding in both the short and long term. The fear is that existing breastfeeding disparities may be further exacerbated among those without equitable access to lactation support, and the hope is that innovations and virtual support may impact communication and adoptive options moving forward.

Just to finish with a quote from a provider, "COVID-19 is an opportunity to raise public awareness of the importance of breastfeeding for protecting the health of infants". I just wanted to thank all the hard-working lactation providers, breastfeeding/chestfeeding parents and supporters, my contact information is here and here is the citation for where this research was recently published. I am happy to take any and all questions. Thank you so much.

Jennifer Yourkavitch

Great, thank you Dr. Schindler Ruwisch and thanks to all our presenters today. We had a nice range of populations and research questions and results shared today. Thank you to all. Let us move into the discussion section now. Let us see … you can raise your hand and I know there have been questions in the chat so we will go through those too. I may need to shift screens in order to do that but I don't see any hands, so I will go to the questions or one of my colleagues feel free to read them out if you have them in front of you.

Victoria Anders

Sure, so Maya who has had to leave the call at this point asked Mackson, was there also an evaluation planned many months later once the pilot had stopped? For example, could you measure the sustainability of the satisfaction or changed behavior and attitude among the participants of the program?

Mackson Maphosa

Thank you for that question. We planned to look at sustainability post project end rather than after the pilot. Amalima ended last year and we got an opportunity to go back to those community and look at sustainability issues next year.

Jennifer Yourkavitch

Great, thank you Mackson. Victoria other questions in the chat?

Victoria Anders

Yes, Janice asked Scott the following question. This documentation of lived experiences, preferences, fears etc. is so important. Have the results of your research been used to influence any of the state or local guidance on breastfeeding support or other policies?

Dr. Scott Ickes

Thanks for your question. I wish I could say yes though I am not fully confident and sure I do think that the work that we are doing is hopefully identifying within the flower farm industry. Some of the opportunities and challenges to the implementation of this Kenya health bill since there are many employment sectors and this is an important one with particularly marginalized and vulnerable women and so I think that this work is used to help inform, not the development of the legislation and the policy, but hopefully the implementation. And I again do hope that the COVID-19 related information will be useful.

Jeniece Alvey

Okay Scott, maybe I will just come on and I might actually tap Nigel a bit as well but it was just interesting hearing so much rich qualitative information today and I think it was interesting to comment. I heard recently about how important even the qualitative information that the United States breastfeeding committee collected through their story collector tool about experiences during the pandemic and so I think it is really wonderful to have so much qualitative information on experiences, fears etc. in the literature, and I say Nigel because I think when especially even WHO is looking at developing guidelines, this qualitative information is part of what is considered in terms of how those affected might think about the interventions for support. And so it is important to have that qualitative information, to draw upon and to have it from diverse geographic areas. And so it is also just really interesting to hear from you all if or how you have been trying to advocate with your local leaders on how to use this more. I was just curious and maybe others could also speak to that or if Nigel wants to add on to that as well thanks.

Jennifer Yourkavitch

Go ahead Nigel.

Nigel Campbell

Thanks, it's Nigel here. Am on leave today and I am driving at the moment. It has been very good to listen. I think one of the challenge just being in the context of guidelines is how to bring in qualitative information. I don't want to make it dry in any sense but it is a challenge because so much of it can be contextual but there are also important common themes for presentation and some of them are specific to COVID-19 but some of them are just exaggerated and even more obvious in the context of COVID-19 because you have women who are isolated in all settings. These are substantially spoofy … but there are other reasons for isolation in terms of access and balancing the care for their child as well as they really can do. I think COVID-19 has exposed a lot of that and it is possibly a little bit less in terms of the actual recommendation, but it does speak enormously to the nature of counselling. But one thing that I have really sort of recognized in all of this, with COVID-19 it may not go entirely but it will substantially mitigate. But there are opportunities to improve access through social media and technology that will be there and which we can be thinking about today even way beyond, then perish the thought of a pandemic, then that technology and knowledge will be improved. A couple of years ago in one of the WHO guidelines, there was a recommendation about face-to-face contact and the option of telephone counseling was included but essentially there was very little evidence around it. I would suspect that we have a lot more knowledge about how to more effectively deliver remote support. It still will not replace in-face and in-person but I think we can do it better, over.

Jennifer Yourkavitch

Thank you, Nigel, any comments on that from the speakers, Dr. Snyder, Dr. Schindler?

Dr. Kailey Snyder

Yeah, I could add a little to the social media technology perspective because I agree. I think it was kind of a common thread that we heard and that I have seen in my previous work. What is interesting is that here in Nebraska, we actually have a Facebook group for breastfeeding mothers that has approximately 10 000 members. And from a social support aspect, it is wonderful because women can get instant support and advice and advice. And from an accuracy and provider perspective it is horrifying because it takes one woman to explain how snickers increased her milk supply and you have all these women going and buying snickers, right. And so, we have really been struggling in Nebraska to try and figure out how to, because of the findings of our study in the previous work we understand the value of this, but we have been struggling with how to best utilize social media to our advantage while also putting out the accurate information and allowing that peer-to-peer support but making sure that there is this overarching accurate information there to house them. That is something that we continue to try and find innovative strategies for but it is interesting. Some of the previous work I have done related to like physical activity and healthy eating myths with breastfeeding mothers. When you ask a mother who she wants advice from, she tells you an IBCLC health provider but when you look at the advice she is taking and what she is doing in her health behaviors, she is doing what social media told her even though she will acknowledge "I know it is likely not accurate, I know it is the myth but I can't take the chance. So I am not going to do this or I am not going to do that or I am going to eat this. And so it is just really telling you, and I think in COVID-19 times even more so, how powerful the internet is and how dangerous and beneficial it can be and so how can we continue to find these innovative strategies to not just be the healthcare professional in the room dictating advice but trying to lift up peers with accurate information so they can go and share that in those support systems that we know work. That was a long-winded way of me saying I do not have the answer but…

Jennifer Yourkavitch

Thank you, thanks for the helpful comments. Yes Dr. Schindler-Ruwisch, go ahead.

Dr. Schindler Ruwisch

Yeah, I mean I completely agree, I think there is a lot of good web-based information out there that sometimes we just need to pair out and present in a way that is manageable and tangible and it improves access. We saw a lot of access issues, I think we heard across the board. I think when comparing it to other health contacts, we have seen online support work really well in other ways, we have done phone support for smoking cessation for decades now and it works really well. But breastfeeding is a unique context, it has this additional aspect of the visual of other aspects of support, instrumental support that you may not see in other contexts. I also just think from a policy and a larger social ecological approach, there is a lot of advocacy work that needs to be done in ensuring the device or the bandwidth you have doesn't limit the amount of support you can get from providers or peers etc. and so seeing individuals that weren't able to receive the same level of support is very concerning. I also think language barriers, providers describe not having accurate translation services, insurance which right now varies state to state in the US and I am sure even more broadly across the spectrum, related to what is covered; virtual versus in

person, private lactation versus having a certain qualification. And so how support is reimbursed and compensated and received, can impact someone's experience on whether or not they are able to initiate or sustain breastfeeding in huge ways with grand health implications. So, I think these issues like we mentioned are going to remain, even post-pandemic. So ensuring more equity across the board is certainly something to continue to work towards highlighted and exacerbated by the pandemic for sure.

Jennifer Yourkavitch

Great! Thank you. I think we have one question we did not get to. Kimberly from PATH has agreed to post that to the listserv so that you all can engage in discussion through that medium. I am sorry we did not have time for that today and also feel free to reach out to the presenters directly. They all provided their email addresses. We will post the slides and the recording and we will let you know when that is available. Just going to make a quick announcement but first thanks again our great presenters and all of you for being here in this session. Next month, we will be meeting on July 9th and the topic is vaccines, "The COVID-19 vaccine and infant feeding". Everything from hesitancy to messaging, to practices, anything related to that topic. So if you are interested in sharing your work, please contact Victoria Anders. She can put her email address in the chat but she also is the one who sends the invitations to this meeting so you can respond to that if you would like to get in touch with her about presenting next month. Our website has been listed in the chat. Aaron has linked to that a few times, the recordings of the meetings are there, the way to sign up for the listserv is there and with that I will just thank you all again and say see you next month.

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