Breastfeeding During the COVID-19 Pandemic: Personal and Professional Reflections

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I was 7 months pregnant with our fourth child when the Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease Outbreak[1] was issued. Despite uncertainty, I continued seeing patients up to the day I delivered. I labored mostly at home to avoid unnecessary exposures and arrived at the hospital only minutes prior to delivering. I was discharged as quickly as possible, even before my daughter was 1 day old. Thankfully – as had been the case with my older children – she had no trouble breastfeeding.

As the pandemic continued, I considered breastfeeding to be one of the best gifts I could give my baby, so I pumped and stored up gallons of excess milk for her. Recognizing her dependence upon my own immune system, I signed up to receive the vaccine as soon as it was available, grateful for my physician status. Before vaccines had been approved for children, I gave samples of immune-laden breastmilk to my older children, assuming – as we now know – that it could afford some immune protection. Although there were other factors at play, the early pandemic clearly affected my decisions about breastfeeding.

PATIENT BREASTFEEDING EXPERIENCES

I work as a family physician with an emphasis on obstetric and newborn care in an urban Federally Qualified Health Center. Several research partners and I evaluated the impact of the COVID-19 pandemic on patient breastfeeding experience. Perhaps more importantly, however, I lived through these experiences with my patients.

Some parents, already home with their children, found that the pandemic neither affected their daily routine nor their breastfeeding, though perhaps they felt lonelier. Some parents expressed gratitude for flexible parental leave, the ability to breastfeed or pump in the workplace, and greater freedom to work from home. I spoke with several who invited grandparents to come to stay or hired in-home childcare to avoid risks associated with attending daycare centers and to provide more flexibility for breastfeeding during the workday.

Yet, many faced significant challenges during the pandemic due to limited family, employer, and social support. One mother chose to breastfeed her daughter during the pandemic but later had to resign from her work due both to pumping restrictions and challenges with her childcare provider. There was a new immigrant couple who so strongly desired to breastfeed but who ultimately had to stop due to the lack of family support and insufficient time off. Many mothers who started breastfeeding, but soon added formula into their feeding plan or transitioned entirely to formula because pumping did not fit the demands of their work.

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WHAT WE LEARNED AND THE PATH FORWARD

Social and health care changes during the pandemic only highlighted longstanding issues with lactation support. Even those clinicians who do not work directly in prenatal, postpartum, pediatric, or lactation care interact with breastfeeding patients or colleagues. Although the recently passed PUMP Act[2]—which protects time and space for lactation in the workplace—is a step forward, there is still work to do. As such, we physicians should advocate for greater lactation support through health and social policies. To that end, we ought to con-

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sider health care systems-based and community-based strategies.

For instance, the Academy of Breastfeeding Medicine has proposed several recommendations for a breastfeeding-friendly health care office.[3] A first step can be as simple as writing an organization-specific office policy and periodically communicating with staff about it. Additional steps could be to include signage in support of breastfeeding throughout the office or to avoid marketing material for breast milk substitutes. This short but effective protocol proposes many ideas that offices could reasonably implement.

For those who provide prenatal, postpartum, and pediatric care, there are other strategies to consider. First, infant feeding should be discussed early in prenatal care visits – ideally at the first visit or within the first trimester–to understand feeding goals and how other medical, social, and cultural factors affect feeding choices. This approach also would allow clinicians to tailor their counseling throughout the pregnancy as needed. Second, prenatal lactation visits with trained personnel should be offered as a standard of care, particularly given the growing evidence that more education prenatally about breastfeeding improves breastfeeding uptake, knowledge, and self-efficacy.[4] Third, it should be a priority to fund staff members trained in lactation to provide early and frequent lactation phone calls and in-person visits, which would allow them time to address challenges, such as pain, difficulty with latch, engorgement, and anything else that could lead to early weaning. Similarly, clinicians should be given time and support to complete evidence-based lactation training. Those who do not work directly in lactation should be able to direct patients to quality lactation support as needed.

Finally, it is worth mentioning that, in addition to anatomical challenges, many stop breastfeeding due to depression, anxiety, and insufficient social support. A key component of breastfeeding aid involves supporting the transition to parenthood and addressing postpartum mood and changes. Routine evaluation and management of parents' well-being—including mood disorders—is vital for better lactation support and infant care.

Although the official COVID-19 Public Health Emergency has ended, other public health priorities will continue to emerge. As we face each of these, I strongly urge all clinicians to consider how they are supporting infants and their families by building a healthy foundation for life through breastfeeding.

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