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Short Communication

Learning Lessons from Covid-19: Our Experiences of Supporting Breastfeeding During the Early Phase of the Pandemic

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The COVID-19 pandemic created many challenging conditions in healthcare. In the early stages, little was known about how the virus was transmitted. In maternity services, concerns led to COVID-positive mothers being separated from their babies, interrupting mother-baby bonding and breastfeeding. I argue that there may be lessons to be learned from this experience that could be useful in future health crises.

Background

The COVID-19 pandemic was caused by the novel coronavirus SARS-CoV-2, which was identified around December 2019. Since then, the pandemic has affected almost every aspect of life around the world [1]. Virus transmission occurs through respiratory droplets and mainly when in close contact. The proposed global health measures to reduce the spread of COVID-19 have included social distancing, self-isolation and lockdowns [2]. Some of these measures have resulted in the separation of mothers and infants after birth, particularly for mothers with suspected or confirmed cases of COVID-19 [3]. This has resulted in the interruption of mother-baby bonding, and disrupted breastfeeding [4].

Breast milk is the best source of nutrition for most infants and provides protection against many illnesses [5]. In addition to the broad scientific consensus on the advantages of breastfeeding, there could be some added benefit from the transfer of specific protective antibodies and other elements with antiviral properties to the infant through breast milk [5]. The best way to promote successful breastfeeding is to ensure that mothers and infants can remain together and encourage and support skin-to-skin contact [6]. If skin-to-skin contact happens immediately after birth, the infant's microbiome can develop from the mother's flora, which is even more important during a pandemic [7]. Skin-to-skin contact also increases blood glucose levels 75 - 90 minutes after birth, improves cardiorespiratory stability [8] and significantly reduces stress levels in both infant and mother [9].

In the early days of the COVID-19 pandemic, breastfeeding practices were challenged because of fear among both parents and healthcare workers. This occasionally resulted in mothers and newborns being separated [1]. There are many factors that might affect breastfeeding. These include culture and sociodemographic conditions, and also the immediate physical and mental environment peri- and postnatally [10]. For example, some of the measures taken to reduce viral spread could physically affect mother-infant bonding. Information on social media about the virus plus the separation from family members during isolation resulted in an environment that was not conducive for developing a healthy mother-infant relationship [1].

Our approach

Our hospital in Doha, Qatar, has an average monthly delivery rate of 10 infants. There were 150 births there in 2020. Like many other hospitals, we had no immediate guidelines on how to approach mothers with or suspected of having COVID-19 during and after delivery. We therefore had to develop our own guidelines. The healthcare team from doctors to nurses to support staff such as cleaners all had to go through medical orientations and some motivational preparation. We then approached mothers both prenatally and postnatally, to discuss their situation, and provide them with evidence-based suggestions for how to proceed. There was then little or no evidence about COVID-19, so we based our discussions on the usual approach to viral respiratory droplet infections. We explained to our patients about droplet precautions and shared the unknowns about the new virus. Together with mothers, we discussed the benefits of skin-to-skin contact, and the importance of bonding, and went through all the possible alternatives for feeding, including breastfeeding, expressed breast milk, and formula as a last resort. We maintained mother-baby bonding and breastfeeding even in COVID 19-positive mothers. We decided to encourage what we believed was right, despite all the fears. We were clear that there was and is no evidence that the SARS-CoV-2 virus is transmitted through breast milk to neonates born to mothers with confirmed COVID-19 during the perinatal period [11].

Guidelines confirmed our initial view that breastfeeding should not be interrupted if a breastfeeding mother comes into contact with a person diagnosed with COVID-19, or even for a clinically stable COVID-19-positive mother [12,13]. We believed that mothers should continue to breastfeed while taking all necessary precautions, including wearing a mask while breastfeeding or pumping milk, effective hand washing, and frequent ventilation of the environment [14-16]. We therefore tried to enable this for all mothers in our unit.

We also provided access to direct phone contacts and well-baby clinics after discharge, even during the peak of the pandemic. This enabled us to provide as much support as possible to breastfeeding mothers.

Conclusion

Looking back, there was considerable confusion about the best possible course of action in the early days of the pandemic. This is probably inevitable during outbreaks of novel viruses. In our case, this meant developing a strategy for supporting skin-to-skin contact and breastfeeding in COVID-19-positive mothers [1,11,17]. We have not carried out a full study, and our conclusions are therefore anecdotal at best. However, our experience suggests that it is wise to stick to established medical norms as far as possible until there is clear evidence to suggest otherwise. In this case, this meant taking the usual precautions against droplet infections for COVID-19-positive mothers, but continuing to support breastfeeding and mother-baby bonding.

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