UNICEF UK BABY FRIENDLY INITIATIVE
INFANT FEEDING CARE DURING COVID-19

Initial findings from Survey #1, collated May 2020

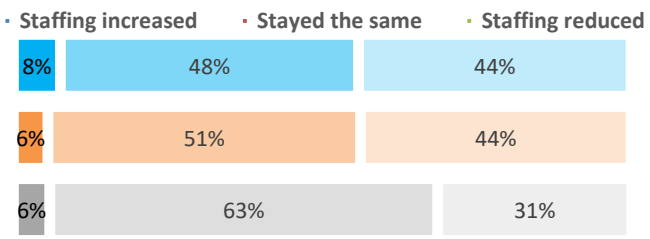
The coronavirus (Covid-19) crisis has created new challenges for health professionals to navigate, from reduced staffing and redeployment to the replacement of face-to-face consultations with virtual care. As the effects of the crisis continued to unfold, the Unicef UK Baby Friendly Initiative aimed to better understand how infant feeding provision across maternity, neonatal and community services was affected by conducting a survey via the National Infant Feeding Network (NIFN) in April 2020, of which a total of **274** infant feeding specialists responded. This paper sets out the initial findings of this first survey. A follow-up survey is in place to examine the impact of these changes going forward.

Summary of results

- During the pandemic, many services have been operating with **reduced staff numbers.**
- Most services have **adopted social distancing measures** and provided virtual support via video and/or telephone. At times, this virtual method of support provided new, additional advantages for some mothers compared to before the pandemic. However, **policy and technology barriers** prevented some services from offering any/limited virtual support.
- Services who had not yet established a specialist breastfeeding pathway and/or a Baby Friendly team found it hardest to maintain the progress made. Where trust leads were **already prioritising breastfeeding** and Baby Friendly support services, staff were retained and better able to continue to deliver infant feeding support.
- The reduction in breastfeeding support and tongue-tie services and the **reduced opportunity for parents to build a relationship** with their baby on the neonatal unit and postnatal ward may impact mother-infant attachment and breastfeeding rates over this period. Some services noted that having **more contact with mothers** through virtual communications seemed to be impacting breastfeeding initiation rates positively.
- **Future research** will be required to understand the true impact of the pandemic on breastfeeding rates, access and visiting policies for parents and families, the availability and delivery of support and the effects of mothers and their partners being at home more throughout lockdown.

Staffing

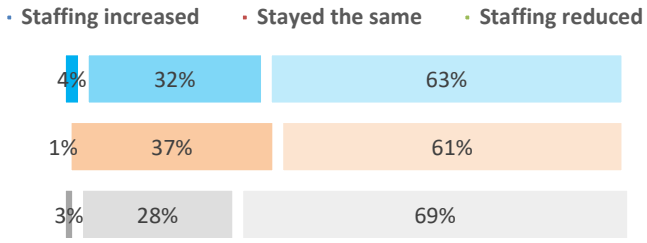
Nearly half of **maternity** and **health visiting** services and nearly a third of **neonatal** services had seen reductions in infant feeding staff due to redeployment and shielding. Staff numbers were protected where breastfeeding was recognised as a priority by managers.



"The whole team has been redeployed to community nursing or a community hospital to work as a health visitor on the telephone single point of access." – Health Visiting

Peer support staff

Around two-thirds of peer support services in respondents' local areas had seen a reduction in staff. Face-to-face peer support had typically stopped, but some services had found creative ways to provide support online or over the phone. Others were unable to overcome governance, technical or capacity barriers.



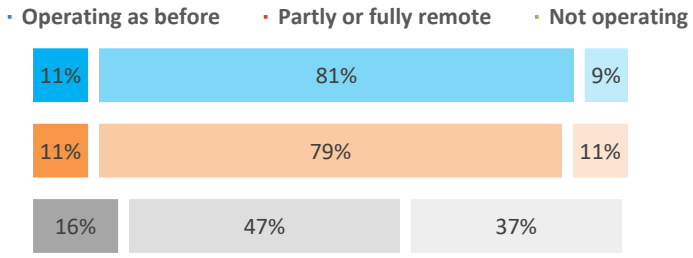
"One of our team has created a Zoom peer support group in lieu of her weekly support group in a local playgroup. La Leche League have offered their support and have well-established virtual peer support running each week." – Maternity

"We have suspended the service as groups and clinics have stopped. As the volunteers are...supervised by a midwife or health visitor [whilst] supporting families, we have no governance [to] offer support [such as] calls or social media." – Health Visiting

Specialist breastfeeding pathway

One in ten **maternity** and **health visiting** services and a third of **neonatal** services suspended their specialist breastfeeding pathway, while four in ten services stopped referrals for tongue-tie since the start of the pandemic. The majority of services have adapted their pathway to operate remotely while retaining face-to-face support for mothers and babies with more complex needs.

Comments suggest that some services have found some positives in having this dual approach.

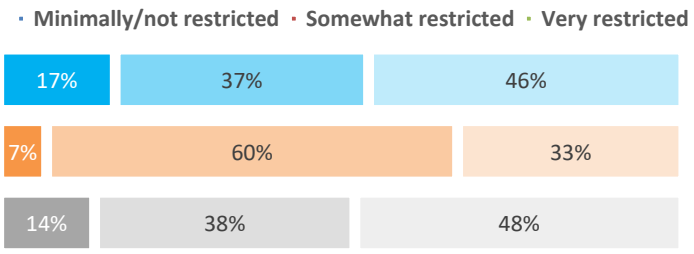


"In addition to our specialist breastfeeding pathway, we opened an infant feeding advice line. We found that while some GPs are using the usual specialist team, others ask mothers [with complex problems] to self-refer via the advice line." – Health Visiting

"We are seeing clients virtually via WhatsApp or web calling. We can see face-to-face at new maternity hubs, however here the mum is alone. When we call virtually, we can speak with partners. A mixture of the two works best." – Maternity

Parental access to wards

More than eight in ten respondents said that parental access to wards had been somewhat or very restricted. Restrictions typically included allowing one parent at a time, no siblings or wider family and reduced visiting hours. Concerns were raised about the effects on bonding, establishing breastfeeding and parents' ability to support each other, particularly on neonatal units.



"Women may visit for two hours a day but must wear PPE and cannot hold their babies unless they are in a cot and they can lift themselves. Fathers are not permitted to visit." – Neonatal

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Initial findings from Survey #2, collated October 2020

In April 2020, the Unicef UK Baby Friendly Initiative conducted **an initial survey** via the National Infant Feeding Network (NIFN) to better understand the changes to infant feeding provision across maternity, neonatal and community services as a result of the Covid-19 pandemic. To gain comparative data and examine the impact of these changes moving forward, a follow-up survey **(Survey #2)** was conducted in September 2020. A total of **135** infant feeding specialists responded, comprised of 64 maternity and 58 health visiting respondents and the remainder from other services.

The findings indicate that services which introduced new, remote support by telephone, video call, virtual groups or social media were more likely to be successful in supporting mothers to breastfeed. Findings also show that, in some areas, virtual support can be delivered in a way that is well received, cost-effective and promotes breastfeeding. However, services are complex and have different types of service provision and different population needs. It is also important to consider the impact of virtual support on feelings of social isolation for women and sometimes also for the staff.

Impact on breastfeeding rates

Three-quarters of services have been collecting data on breastfeeding rates that allow them to assess whether there have been changes since the coronavirus outbreak. Of these, 46% said there had been an increase in breastfeeding rates, 29% had seen no change and 25% had seen a reduction.

To try and understand what may have contributed to the increases, we can explore what support was in place in those areas that have seen increases compared to those that have seen no change or have seen decreases. The numbers are not huge, so we cannot draw firm conclusions from this, but they could provide indications of places that warrant further exploration.

Services which saw an **increase** in breastfeeding rates were **more likely** to have the following:

- Antenatal telephone support for all/most women (72% compared with 52% among those who saw a decrease in rates)
- Virtual antenatal breastfeeding classes for some or all women (56% compared to 38% among those who saw a decrease in rates)
- Postnatal 1-2-1 peer support via video or telephone for all/most women (51% vs 23%)
- Video group calls for peer infant feeding support for all/most women (44% vs 14%)
- Signposting to social media for infant feeding support for all/most women (97% vs 76%)
- Delivered or planned training and support on face-to-face care during coronavirus (74% vs 43%).

These services were **also more likely to**:

- Report a largely positive response to changes from parents (68% vs 33%)
- Agree that use of online or telephone appointments allows them to offer more support to more women (74% vs 48%)

- Agree that online or telephone appointments are often all that women need following transfer home (36% vs 5%)
- Agree that online or telephone appointments are a cost-effective way to provide support (69% vs 43%)
- Strongly agree that they would like to see some form of virtual or telephone support continuing after Covid-19 restrictions are lifted (51% vs 14%).

Services which saw an **increase** in breastfeeding rates were **less likely to**:

- Report staff capacity as a barrier to change (59% vs 86%)
- Report lack of knowledge or skills as a barrier to change (13% vs 38%)
- Agree that moving to more online appointment means that some women will be unable to access the support they need (51% vs 86%)
- Agree that women are less likely to access peer support that is only offered remotely (28% vs 62%).

The impact of virtual support

- 80% of respondents felt that there had been innovations in response to Covid-19 that could offer **improved support to families** even after the pandemic.
- Patterns of innovations were remarkably similar across both health visiting and maternity services, except for traditional **face-to-face breastfeeding information antenatally**, which was more likely to be reported by maternity respondents (44% vs 10%).
- The bulk of innovations concentrated on **virtual group or one-to-one support**. Many respondents were careful to say that virtual support should accompany – not replace – face-to-face support. However, the availability of virtual support, typically by video calls, was felt to offer many benefits:
    1. It could be offered **quicker** following a referral, and in some cases the same day
    2. It was **more accessible** to some women, particularly new mothers who did not feel ready to leave the house, women in rural areas with poor public transport, or those without cars
    3. It allowed more women to be seen **in their home environment**, which offered some opportunities to identify and overcome breastfeeding challenges
    4. It was more likely to be **attended by partners**
    5. In some cases, it allowed access for women **outside of normal working hours**
    6. One respondent commented that it guaranteed 'hands-off' care which could be **better for a mother's confidence**
    7. It required **less staff time** since there was no travel, allowing more women to be seen.
- One important observation was that virtual support may be reaching women who were **not being well-served by support groups**. This might be about personal preference, ability to travel to groups, or other reasons. Comments which stated that more women have been supported under the changed provision suggest that the previous provision was not meeting all women's needs.
- A common view was that after the pandemic, telephone or video support could continue to be used as a triage or as an **immediate source of support**, particularly where there would be a delay in face-to-face support. It could also ensure that face-to-face support was targeted towards those women who would most benefit from it.
- A smaller number of respondents also highlighted the benefits of having more telephone support, including staff making **more proactive calls** to women after discharge and **24-hour helplines**.
- Online resources and **Facebook page** communities were also felt to be beneficial.

Feedback from the infant feeding leads:

"We have offered virtual one-to-one support, virtual postnatal support groups and virtual antenatal information sessions. As a team, we have discussed maintaining these offerings post-COVID, on top of the normal face-to-face support and groups, as [the] feedback we have received has been positive and ***we have seen 250% more women during the pandemic than we usually did face-to-face due to taking out the need to travel*** *(us and the families we support)." – Health Visiting, London*

"Phone calls support background information & triage into video calls or essential face-to-face with PPE. Some of the triage can be continued to make the face-to-face more effective. ***We've also seen more diversity and reached out to more families...*** *Women have appreciated the support. These conversations have also supported wellbeing and mental health which I'm not sure has been captured, so going forward its recognising we are a support beyond feeding." – Health Visiting, London*

"Locally, additional breastfeeding feeding support has been provided in drop-in breastfeeding groups with only very limited support at home (due to capacity of the infant feeding team). Since closure of the groups in Covid-19, all contacts are from professional referral with IF team contacts made by phone/video call and limited essential face-to-face. We have also had many direct referrals from midwives, other London IF teams, GPs and dieticians. ***This means we have had much greater access to very small and/or premature babies, twins, vulnerable babies, and a much more diverse population than usually will attend the groups.*** *We plan to keep up this work by continuing this referral pathway and making use of video calling for families who would not usually be able to access group support." – Health Visiting, London*

"The virtual specialist breastfeeding clinic has been a success and ***may well continue beyond the pandemic as it allows us to reach a greater number of women than the face-to-face clinic alone.*** *It also enables supporting women via video call in their own environment, which helps with any positives or negatives around positioning that can be considered."– Health Visiting, South East*

"For some mothers, particularly first-time mothers, it has been easier to access online support for specific breastfeeding challenges. ***However, Zoom support sessions are more difficult for mothers with other children, as getting out with toddlers and getting social support is something they enjoyed****." – Health Improvement, Northern Ireland*

"24/7 postnatal support helpline - the helpline has evaluated very well with mothers. [It is] so helpful to have feeding support in the night-time if needed, reassurance etc. ***[With] managing weight loss at home, mothers feel more relaxed and less anxious about the weight loss [and] they can take better ownership of the feeding plan. Virtual support can help to eliminate the need for face-to-face appointments [and] many mothers are anxious about coming to a clinic with their baby****." – Maternity, South West*

"Continuing with ***virtual 1-2-1 support as well as face-to-face support****. Mums who find it difficult to get out to groups may find this helpful as* ***we can provide immediate support virtually****." – Infant Feeding Community Service, London*

"I feel a tiered approach to support is essential, whilst face-to-face needs to return; for some… ***the option of a virtual appointment may be useful [and] could [be] quicker than a home visit****."– Maternity services, West Midlands*

"Online consultations [are] useful for some, but ***[the] danger is they can be expected to replace face-to-face support, which is much more effective, especially when mothers are anxious****."- Health Visiting, London*

What methods of support were services offering during the pandemic?

The survey shows that services available to individual women varied across the country, from normal (pre-Covid) care to all care being provided online.

Face-to-face support:

- In over 25% of services, face-to-face antenatal appointments were not available to any mothers and in 90%, face-to-face antenatal infant feeding courses were not available
- Postnatally, face-to-face support in mothers' homes was available for all mothers in 35% of services and to some mothers in nearly half of services.

Virtual support:

- Virtual antenatal infant feeding courses were provided to some or all mothers in around 2 out of 3 services
- Nearly all services provided pre-arranged video or telephone appointments with mothers as required postnatally.

Peer support:

- One-to-one peer support was available virtually to some or all mothers in 61% of services
- Group peer support via video calls was available in 52% of services.

Signposting to resources:

- 88% of services were signposting women to social media for infant feeding support
- Nearly all (96%) were signposting women to online resources.

Helplines:

- Telephone or online helplines were available for women in 89% of services.

Support for staff

The survey shows **a mixed picture of training and support for staff** in delivering changed services. Around 47% of staff said they had additional training to support face-to-face care during coronavirus, with 40% of staff saying they had additional training to support the delivery of remote care. Among the additional forms of training and support provided to staff were:

- virtual tongue tie training
- shift of staff meetings to virtual
- Unicef UK Baby Friendly Initiative resources
- new protocol pathways circulated
- mental health and staff wellbeing support.

Many respondents said that training had been suspended during lockdown. In some cases, this was beginning to recommence either face-to-face or virtually. In a few cases, respondents said that staff shortages made it difficult for staff to engage.

Barriers in services to providing new support

The **biggest barriers** identified to providing new support were:

- staff capacity (67%)
- lack of appropriate technology (57%)
- redeployment of staff (46%)
- reluctance among staff (25%)
- governance/data protection concerns (24%)
- lack of knowledge or skills (19%)

The comments suggest that **implementing changes** in the service required willingness and bravery by management in their trusts. Innovation was blocked in some services due to technology or safety concerns, while others were able to implement changes or, in some cases, continue face-to-face support. Feedback from staff:

*"We have the technology, **but local governance issues prevented us from utilising it for a long time. Lack of enthusiasm and uptake from staff despite support available.**" – Maternity, Scotland*

*"We have been using Skype [or] Teams, **but this is either not available or easy to use** with parents. We don't have WhatsApp [and] are not allowed to use Zoom due to [security] concerns." – Health Visiting, South West*

*"Health Visiting and children's centre staff were mostly providing [virtual] support…However, our breastfeeding supporters continued to go into the postnatal wards each day, phone every new mum (and actually we were able to do that better as we [were] able to get the new birth sheet…), increasing the number of one-to-one face to face appointment clinic slots and also continuing home visits to those mothers unable to access effective support otherwise**.** This has made a huge difference to us…**It has been a steep learning curve for all of us doing video calls and online services, but it is worth it**." – Health Visiting, London*

Barriers for women and families

Many respondents said they did not know what had been a barrier for women accessing their services. Of those that did give a view, these were generally felt to be barriers for only a minority of mothers:

- Women's **lack of awareness of available support** was felt to be the most common barrier; 21% of responses felt this was a barrier for most or all women while 54% felt it was a barrier for a minority of women.
- **Limited access to the internet** was felt to be a barrier for a minority of women in over half of responses (51%).
- Mothers **not liking the format** was felt to be a barrier for a minority of women in 57% of responses.
- Mothers **not believing the support would meet their needs** was felt to be a barrier for all women in 13% and a minority of women in 52% of responses.

Around 44% of respondents said they had gathered feedback from mothers on changes in service provision. Of these, half said they had received a largely positive response and over 40% had received a mixed response. Only one service (2%) said they had received a largely negative response. Comments suggest that many mothers did see benefits from virtual and telephone support put in place and that safety restrictions put on home visits may have made those less acceptable to mothers than previously.

*"…Knowing there was **a daily drop-in session with expert advice was reassuring, even if not needed**. [They] liked not having to leave the house or be dressed…[and could] feel comfortable with in-home surroundings. Not having to wait nearly 2 weeks to get to next local support group session. If [they] had a bad night knew could just log in and chat to someone." – Health Visiting, Northern Ireland*

*"Many mothers have been pleased with the telephone contact…They state [home] visits are short, with many staff waiting on the doorstep whilst mother weighs her baby. Some staff have done home visits to give short breastfeeding support which they have been pleased with, but longer breastfeeding support has been provided in clinics…Mothers said they were **struggling more with a lack of contact from their families and other breastfeeding mothers**." – Health Visiting, East Midlands*

However, other feedback suggests that some mothers felt they were missing out on the benefits of face-to-face support, particularly groups and peer support. A common theme throughout the survey responses is the **loneliness faced by many mothers**, not only because of changes in professional support, but also because of limitations on their social interactions more generally:

*"**Mothers have largely been "upset" that they're unable to access face-to-face support**...and the mother-led support & relationships." – Health Visiting, North West*

*"They have missed the face-to-face...**They have felt alone and unsupported**, despite phone calls/ texts/ offers to virtual groups." – Maternity, West Midlands*

In general, the response suggests that mothers understood the need for restrictions and were grateful to be able to get support in other ways. Some saw benefits in virtual support, however, overwhelmingly there was a sense that some women will need or benefit more from face-to-face support. In the future, options of either virtual or face-to-face was generally felt to be best.

*"Some mothers have been wary about the video calls initially but have seen an enormous benefit...Phone & video calls are brilliant, but can't replace face-to-face for some...**moving forward, we need to encompass [and] embrace all forms to reach out to a wider audience**."*

Conclusions

Overall, it looks as though services that introduced new, remote support by telephone, video call, virtual groups or social media were more likely to be successful in supporting mothers to breastfeed. However, we should be careful with this. The findings are suggestive, but not conclusive. Services have a complex pattern of new and old service provision and different demographics to serve. Other factors should also be considered, including the increased social isolation that removes forms of social support and which could enable a woman to dedicate more time to establishing breastfeeding without having to balance other usual activities. As a minimum, however, our findings show that in some areas, at least virtual support can be delivered in a way that is well received, cost-effective and promotes breastfeeding.

There were clear advantages for some women in accessing support online. In particular, being able to access quicker support following referral from home may be more appealing to some than attending appointments or clinics, particularly in rural areas. Equally, however, we should be careful as the positive responses may be affected by a feeling of gratitude that anything is on offer and an acceptance that face-to-face is not possible. If so, then the same support may not be so acceptable post-pandemic.

It is also clear that virtual support is not always an adequate substitute for face-to-face support. Not all parents liked virtual support, and some could not access it. It may be less effective in supporting women with higher needs, those with safeguarding concerns, or where they are less willing to engage with maternity and health visiting services.

These findings provide some ground for continuing to develop remote services. Further research is needed to understand:

- The strengths and limitations of virtual support and who is most likely to benefit
- What is a good balance between virtual and face-to-face support?
- How to target virtual support effectively
- How to ensure concerns about governance, data protection and staff skills are addressed.

On the basis of such research, a model of integrated virtual and face-to-face support could be developed and robustly evaluated.