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Facilitators, Barriers, and Best Practices for In-Person and Telehealth Lactation Support During the COVID-19 Pandemic

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ABSTRACT

Objective: To explore the perspectives of lactation support providers delivering breastfeeding education via in-person and telehealth consultations and assess the impact of COVID-19 on the provision of breastfeeding education.

Design: Qualitative descriptive study using purposive sampling.

Setting: Massachusetts-based lactation support providers who provided in-person and/or telehealth consultations in various practice settings (e.g., inpatient; outpatient; private practice; and the Special Supplemental Nutrition Program for Women, Infants, and Children).

Participants: Fourteen Massachusetts-based lactation support providers, ages 36 to 68 years.

Measurements: Participants completed an online demographic and employment characteristics survey and virtual key informant interviews, from which six main themes were defined.

Results: The six main themes included Common Questions Asked by Clients, Prenatal and Postpartum Consultation Topics, Facilitators for Telehealth Versus In-Person Consultations, Barriers for Telehealth Versus In-Person Consultations, Best Practices, and COVID-19 Adaptations. From participant interviews, common subthemes emerged. The primary adaptation due to COVID-19 was shifting to telehealth. Content in lactation consultations was similar via in-person and telehealth sessions. Typical content areas included breast pumping and mother’s milk supply. A notable difference was the lack of physical examinations for women and newborns in telehealth sessions. Scheduling flexibility was a key facilitator of telehealth consultations, whereas the inability to provide hands-on assistance and chaotic home environments were common barriers. In-person facilitators included weighing newborns to assess feeding success and insurance billing coverage, whereas unsupportive family members were noted as a barrier. Diversity, equity, and
Although breastfeeding is considered the most beneficial form of nutrition for infants and is recommended by the World Health Organization and the American Academy of Pediatrics, rates of breastfeeding in the United States remain low, with only 25.6% of mothers breastfeeding exclusively for 6 months and 35.3% participating in any breastfeeding up to 12 months (American Academy of Pediatrics, 2012; Centers for Disease Control and Prevention [CDC], 2019). Human milk consumption provides infants with enhanced immunity, including a decreased risk of gastrointestinal and respiratory infections (Frank et al., 2019) and improved cognitive development (Ottolini et al., 2020). Maternal health benefits include decreased risk for postpartum bleeding (Saxton et al., 2017), breast (Unar-Munguía et al., 2017) and ovarian cancer (Babic et al., 2020) when breastfeeding up to 12 months. The protective nature of human milk is enhanced by increased breastfeeding duration (Issa et al., 2019). Breastfeeding initiation and duration can be directly affected by education and outside influences (Sutter et al., 2018). Professional support from health care providers as well as social influences from family, friends, and peers can also affect breastfeeding choices and sustainability (Sutter et al., 2018).

One source of professional support for breastfeeding individuals in the prenatal and postpartum period is provided by lactation support providers (LSPs). An international board-certified lactation consultant (IBCLC) practices the clinical management of breastfeeding and lactation education and provides breastfeeding support (International Lactation Consultant Association, n.d.). Researchers from the U.S. Lactation Consultant Association found that approximately 52% of IBCLCs hold an additional registered nurse certification (Harmon, 2020). Researchers found that mothers who had access to an IBCLC through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program had 37%, 68%, and 118% greater odds of breastfeeding at 2, 6, and 12 months postpartum, respectively, when compared to mothers who had no access to IBCLCs (Gleason et al., 2020). Researchers from the International Lactation Consultant Association report that LSP education and care improve breastfeeding rates, help improve health outcomes for breastfeeding mothers and infants, and contribute to lower health care costs overall (Patel & Patel, 2016). LSPs are now able to reach a wider client base via video teleconferencing, which is an additional tool that may increase individuals’ confidence in breastfeeding (Demirci et al., 2019; Friesen et al., 2015).

Understanding the barriers and facilitators experienced by LSPs in telehealth and in-person settings may improve the quality of breastfeeding education provided to mothers. Researchers have qualitatively assessed perceived barriers to providing breastfeeding consultations (Anstey et al., 2018). However, researchers have not explored the perspectives of LSPs on barriers, facilitators, and best practices of providing in-person and telehealth breastfeeding education and support. An additional factor that has not been examined is the impact of SARS-CoV-2 (COVID-19), a very contagious viral infection, on the provision of breastfeeding education and support. The governor of Massachusetts declared a state of emergency on March 10, 2020, in response to COVID-19, causing health care providers to shift from in-person care to mostly telehealth delivery (Commonwealth of Massachusetts, 2020). The state of emergency ended on June 15, 2021. Further research is needed to determine the consequences of this pandemic and the subsequent challenges and strategies surrounding the provision of breastfeeding education now and in the future when confronted with similar health crises.

In this qualitative descriptive study, we aimed to explore the perspectives of lactation support providers regarding facilitators and barriers to delivering breastfeeding education to mothers prenatally/postnatally via video teleconferencing compared to interperson consultations. In addition, we sought to understand the impact of COVID-19 adaptations on the provision of breastfeeding education.

Methods

**Design**

This descriptive study, which used a qualitative research design, allowed us to collect in-depth information regarding LSPs’ perceptions and experiences (Berkwits & Inui, 1998). This study design was reviewed and deemed

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study were sent via e-mail. Participants provided electronic informed consent before completing the survey. The demographic survey questions collected information about age, race, ethnicity, level of education, and sex. Questions related to age, race, and ethnicity were adapted from the National Health and Nutrition Examination Survey (2020), and education level was adapted from the U.S. Census Bureau (Centers for Disease Control and Prevention, 2019). Questions about employment characteristics were newly created by the research team. Questions assessed work setting, work schedule, credentials, and mode of patient interaction (i.e., telehealth or in person). The survey was pretested by graduate students to determine flow and readability clarity. The full survey can be found in Supplementary Figure S1.

Understanding the barriers and facilitators experienced by LSPs in telehealth and in-person settings may improve the quality of breastfeeding education provided to mothers

Once the surveys were completed, verbal and electronic written consent for interview participation and recording were given by participants before we conducted key informant interviews via Zoom. A gap in the literature precipitated the need to develop a novel interview guide to address the proposed research question. In the context of the COVID-19 pandemic, there was a need to establish the distinctions between telehealth and in-person lactation practice and the provision of breastfeeding education during the prenatal and postpartum periods. Interview questions were determined based on these exploratory topics. Experienced qualitative nutrition researchers were consulted to assess the integrity of the interview guide before mock interviews. Mock interviews were completed with three nonparticipants. This group consisted of two IBCLCs and one certified lactation consultant who helped determine the clarity and relevance of the interview guide before conducting interviews for data collection. Edits were made to the interview guide after feedback from these mock interviews to improve flow and understandability. The main interview segments covered general practice, prenatal consultations, postpartum consultations, COVID-19 adaptations, and best practices. Within each segment, questions regarding in-person, telehealth, group, and one-on-one consultations were addressed. The full qualitative interview guide can be found in Supplementary Figure S2. During each interview, one research team member led the interview, and a second team member was present to observe and take notes. Transcription software, provided by Zoom, was used to transcribe interview recordings.

CLINICAL IMPLICATIONS

- Best practices for in-person and telehealth consultations include meeting mothers where they are and focusing on mothers’ goals when counseling.
- Unique best practices for telehealth consultations include having a support person, creating a comfortable atmosphere for the mother, and collecting accurate medical history.
- Unique best practices for in-person consultations include offering one-on-one support, knowing your audience, and using the Baby-Friendly Hospital Initiative Ten Steps to Successful Breastfeeding.

Study Setting and Sampling

Lactation support providers who had practiced breastfeeding education in person and/or via telehealth in various practice settings (private practice, outpatient clinics, private medical clinics, WIC, inpatient hospital) in Massachusetts were recruited to participate. Inclusion criteria were individuals who were certified as an IBCLC, certified lactation consultant, and/or certified lactation educator. Participants were required to be 18 years of age or older and currently practicing in Massachusetts. Providers outside of these certifications and those who worked for less than 1 year were excluded. Our recruitment process consisted of nonprobability purposive and snowball sampling to accrue our list of interviewees. Primary contacts were gathered through professional work relationships. The Massachusetts WIC Coordinator, a collaborator on this study, disseminated study recruitment materials through professional channels. The study was also advertised through the following organizations using informational flyers: the Massachusetts Breastfeeding Coalition, Boston Breastfeeding Coalition, and Massachusetts Lactation Consultant Association. Primary contacts gathered through direct e-mail invitations or through advertising were asked to identify secondary contacts to interview who fit within our inclusion criteria. Secondary contacts were also asked to assist with tertiary contacts, and so on and so forth, until the total possible participant count was met and saturation was achieved. Frequent and repetitive responses to interview questions indicated that saturation was met in the context of a limited sample population.

Data Collection

E-mail invitations and study information sheets were sent to potential study participants identified through the snowball sampling technique. Recruitment occurred from January 2021 to March 2021. Once participants contacted the research team expressing interest in the study, an interview time slot was established. The consent form, information sheet, and a link to the online demographic and employment exempt by the university institutional review board (21-008). Data were collected from February 8, 2021, to March 15, 2021.

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Data Analysis

Demographic survey results were entered into SPSS to evaluate participant characteristics (see Table 1) and were stored in a password-protected shared drive that was accessible only to the researchers and their faculty advisors and kept anonymous.

Verbatim transcripts were imported into Delve (Twenty to Nine, 2022) for coding. We began with an a priori descriptive coding framework based on the questions from our qualitative interview guide. These categories included barriers and facilitators to in-person and telehealth breastfeeding education delivery, best practices, and COVID-19 adaptations. When coding transcripts, team members iteratively revised the coding framework to reflect emergent concepts. A thematic analysis as described by Vaismoradi et al. (2013) was conducted to distill the data into subthemes. Codes were assessed for the most frequently addressed topics, which were marked as subthemes. All transcripts were double coded by two distinct members of the research team and reviewed, and any coding discrepancies were resolved among three members of the research team. A codebook was created highlighting interview themes and subthemes along with representative quotations.

Following the criteria established by Lincoln and Guba (1985), the research team used techniques to establish credibility, dependability, confirmability, and transferability. Credibility was established through peer debriefing and member/participant checking. During the interview process, two team members were always present. At the conclusion of each interview, the study team member leading the interview would reiterate the topics discussed during the session back to the study participant to confirm accurate understanding, thereby providing member checking. Multiple passes of the data were conducted, from transcription through coding, to ensure that any biases, perspectives, and assumptions from individual team members were

| TABLE 1 DEMOGRAPHICS AND EMPLOYMENT CHARACTERISTICS |
|-----------------------------------------------|
| Characteristics                                | M ± SD |
| Years in practice                             | 16.29 ± 0.29 |
| Age, years                                    | 54.64 ± 10.14 |
| Sex                                           |        |
| Female                                        | 14     |
| Non-Hispanic Black or African American        | 1      |
| Hispanic, Latino/a, Spanish origin            | 1      |
| Mixed race/ethnicity                          | 2      |
| Non-Hispanic White                            | 10     |
| Highest education level                       |        |
| Associate’s degree                            | 1      |
| Bachelor’s degree                             | 7      |
| Master’s degree                               | 3      |
| Doctoral degree                               | 1      |
| Lactation consultant certification            |        |
| International board-certified lactation consultant | 12  |
| Certified lactation consultant                | 2      |
| Certified lactation educator                  | 1      |
| Other professional credentials                |        |
| Registered nurse                              | 9      |
| Nurse practitioner                            | 1      |
| Other                                         | 3      |
| No other credential                           | 1      |
| Employment status                             |        |
| Full time                                     | 6      |
| Part time                                     | 8      |
| Per diem                                      | 1      |

(continued)

| TABLE 1 CONTINUED |
|-------------------|
| Characteristics    | M ± SD |
| Primary practice setting |    |
| Outpatient         | 4     | 28.6 |
| In patient         | 10    | 71.4 |
| Private practice   | 6     | 42.9 |

Note. aLactation consultant certification categories add up to more than 100% because some participants held multiple certifications. bEmployment status categories add up to more than 100% because some participants selected more than one option. Participants worked per diem and part time or worked per diem and full time but did not work full time and part time. cPrimary practice setting categories add up to more than 100% because some participants worked in multiple settings.
addressed. This study provides transferability because of its “thick description,” with detailed discussions of interview content and how these data translate to the field at large. Although similar research is limited, comparisons to other studies contribute to credibility. Additionally, from the collection of raw data to data reconstruction, methodologic notes of the process were kept, providing an audit trail. The robust nature of the study’s results and practical discussion emphasizes transferability.

Results
A total of 14 Massachusetts-based LSPs, ages 36 to 68 years, participated in the key informant interviews (see Table 1). The majority of participants identified as non-Hispanic White (n = 10, 78.7%), and all participants had college degrees. Participants (n = 12, 85.7%) were credentialed as IBCLCs and reported a range of 5 to 30 years of lactation consulting experience. More than 78% (n = 11) of consultants indicated that they exclusively practiced in person before COVID-19. The remaining consultants provided care mostly in person and sometimes via telehealth. Since the implementation of COVID-19 safety guidelines in March 2020, 64.3% (n = 9) of participants remained always or mostly in person, and 21.4% practiced mostly or exclusively via telehealth platforms. The remaining participants (n = 2, 14.3%) spent equal time in both settings.

Working with diverse communities to increase breastfeeding awareness and to reduce breastfeeding disparities among communities of color was highlighted by participants as an important goal to which LSPs should strive

Thematic findings from the key informant interviews are described in the text and supplementary tables along with representative quotes. The initial interview framework included general practice questions received from clients, educational strategies used in prenatal and postpartum consultations, facilitators and barriers to breastfeeding consultations, and best practices, which served as a foundation for the identification of subthemes. Variations between in-person and telehealth practice settings were examined within each theme.

Given the time frame of this study, it was important to explore the influences of COVID-19 on breastfeeding education delivery. COVID-19 disrupted the workflow of health care providers across the United States, including many of the LSPs in our study. Adaptations and challenges to the delivery of breastfeeding education during COVID-19 are discussed within the themes presented. Supplementary Table S1 presents additional information on COVID-19 adaptations by LSPs during postpartum consultations.

Common Questions Asked by Clients
Most questions and concerns clients discussed with LSPs varied slightly between prenatal and postpartum consultations. The most common topics addressed during the prenatal period were preparedness (e.g., skin-to-skin contact, supplies needed, hand expression, frequency of feedings, and what to expect in the first hour of life up to the first 6 weeks), the mother’s medical history (e.g., breast surgery, cancer treatments, anatomic differences of the breast, previous difficulty with breastfeeding, family history of reduced human milk production, and medications that would interfere with breastfeeding), and breast pumping. LSPs discussed how mothers could acquire a breast pump through their medical insurance, breast pump use, and how to establish a milk supply (see Supplementary Table S2).

Topics covered during the postpartum period included latching difficulties, mother’s milk supply, and other troubleshooting issues. Mothers often expressed concerns over discomfort or pain after latching and sufficient milk supply. Sore and cracked nipples, plugged ducts, mastitis, and difficulty being a new mom were additional issues discussed during troubleshooting sessions (see Supplementary Table S3).

Prenatal and Postpartum Consultation Topics
The majority of prenatal breastfeeding education sessions were conducted as in-person group classes or, less frequently, as one-on-one sessions before COVID-19 and transitioned to telehealth platforms after COVID-19 restrictions were imposed. The COVID-19 pandemic introduced new barriers to providing effective lactation care, including limited internet connection for the mother and the LSP. The content of in-person breastfeeding education included mother’s preparedness, breast pumping, and establishing mother’s milk supply (see Supplementary Table S4).

Many LSPs reported that the content of breastfeeding education was relatively similar in the telehealth setting. However, there were noted differences when switching from an in-person setting to a telehealth setting. Group meeting participants were less willing to speak up or ask questions, and LSPs recognized that everyone was “Zoom weary” by the end of the day making it difficult to gauge how well their clients were receiving the information.

For in-person and telehealth sessions, LSPs used educational videos, props (baby doll, a knit or crocheted breast), and tools (hand pumps, nipple shields, breast pumps, and syringes) when delivering breastfeeding education. Handouts and pamphlets were unique to the in-person setting and frequently had QR codes to videos for common concerns. Text messaging, phone calls, and e-mails were more often used
Facilitators and Barriers for Telehealth Versus In-Person Consultations

**In person.** Weight assessments for infants, ease of insurance billing, and establishing a comfortable space for mothers allowed LSPs to provide reliable care. The ability to conduct pre- and postfeeding weights allowed consultants to assess the volume of milk the infant was getting per feeding. This was lost during telehealth visits. In addition, weights were helpful to plot the infant’s long-term growth for clients who were seeing their LSPs across multiple visits. Ease of insurance billing was noted exclusively among participants working in a clinical hospital setting. Establishing a comfortable space for the mother included the physical practice setting (i.e., home, office, hospital room) and establishing a trusting relationship with the client. Oppositely, LSPs noted that the lack of a comfortable space could instead act as a barrier to effective care (see Supplementary Table S11).

Some LSPs noted that family members acted as barriers when trying to deliver breastfeeding education to mothers. This was attributed to differing goals of mothers versus their support persons. For example, some mothers preferred not to breastfeed; however, their partners strongly encouraged breastfeeding. Alternatively, some mothers wanted to pursue breastfeeding, but their partners encouraged bottle- or formula-feeding (see Supplementary Table S12).

**Telehealth.** Scheduling flexibility was helpful for mothers and LSPs who used a telehealth platform. For example, if a newborn was sleeping and not feeding during the scheduled appointment time, reconnecting at a later time that day to evaluate the feed was possible without the need to travel back and forth. During these telehealth feeding assessments, the majority of participants cited having a second person with a smartphone camera as a facilitator to ensure LSPs could see all angles of the latch and positioning. A smaller majority noted the need for adequate lighting to see the infant’s mouth, latch, and general appearance (see Supplementary Table S13).

Participants repeatedly expressed frustration because of the inability to be “hands-on” with clients to assist with latch
and positioning in the postpartum period. The participants also noted the potential for chaotic environments during calls. The clients or LSPs may have had other children, pets, or a noisy home environment that did not lend itself to a productive call. One of the largest barriers to effective telehealth communication was technology access—specifically, the lack of a reliable internet connection for mothers and consultants (see Supplementary Table S14).

**Diversity, equity, and inclusion barriers for lactation consultants.** Language barriers, limited financial resources, technology accessibility, and a lack of reflective diversity were discussed in the majority of participant interviews. When faced with clients who did not speak English, some LSPs expressed feeling unprepared to provide effective care. A smaller group of LSPs indicated concern over finding a translator to assist in their practice. LSPs found that patients who had difficulty affording the out-of-pocket expense for consultations were often unable to receive professional breastfeeding support. Having limited access to technology and a stable internet connection was also a barrier for some clients.

A handful of participants cited concerns that group support spaces alienated mothers who were non-White because of the lack of reflective diversity among the LSPs. One participant also noted that when breastfeeding peer counselors were members of the communities they served, group enrollment increased and diversified (see Supplementary Table S15).

**Best Practices**

When participants were asked about what they considered to be best practices for in-person and telehealth consultations, their responses included meeting mothers where they are and focusing on mothers’ goals. The former reflects the counseling concept of never assuming what the client’s intentions are and not pressuring them to adopt practices that they are not comfortable with. The latter explicitly asks what the client does in fact want out of their time with the lactation support provider. Other best practices for telehealth consultations included having a support person to obtain additional camera angles, creating a comfortable environment for mothers in the virtual space, and collecting an accurate medical history. Best practices for in-person consultations also included offering one-on-one support, knowing your audience, and using the Baby-Friendly Hospital Initiative Ten Steps to Successful Breastfeeding (World Health Organization, 2018) for mothers in the hospital (see Supplementary Table S16).

**Discussion**

Previous researchers have explored barriers to in-person lactation support (Anstey et al., 2018) and the strengths and limitations of virtual lactation support (Schindler-Ruwisch & Phillips, 2021). However, we explored facilitators and barriers for in-person and telehealth lactation support and the necessary adaptations required because of COVID-19 safety guidelines. Common prenatal and postpartum questions and concerns, such as pumping and latching, are consistent with findings from previous researchers who recruited IBCLCs conducting telehealth consultations (Demirici et al., 2019). Participants in our study identified a mother’s perceived lack of milk supply as the primary area of concern in addition to an infant’s weight gain, echoing findings by Anstey and colleagues (2018).

Educational content covered by LSPs during prenatal and postpartum in-person consultations was similar to topics described by Friesen and colleagues (2015). Participants in our study shared similar information during their in-person and telehealth consultations, although LSPs were unable to perform physical examinations when practicing remotely. In group classes, previous research conducted during the first COVID-19 wave (March–June 2020) also noted poor attendance and limited engagement during postpartum lactation classes (Schindler-Ruwisch & Phillips, 2021), which echo our findings. These shared results suggest that telehealth classes may not provide an equally an engaging experience when delivering breastfeeding education and support.

Previous study investigators have found that text messaging is an effective tool to engage and encourage breastfeeding mothers by providing on-demand assistance for WIC (Martinez-Brockman et al., 2018) and non-WIC participants (Demirici et al., 2019). Some LSPs in our study also felt that text messaging was an effective platform to communicate with clients to offer anticipatory guidance and assistance via video links and instructive text messages.

The shift to telehealth consultations during COVID-19 allowed for continued breastfeeding education and support. However, participants cited concerns about identifying tongue- or lip-ties (potential causes of nipple pain) via video, which was shown elsewhere in the literature (Ghaheri et al., 2017). One participant described that a higher level of self-efficacy was imparted to some mothers because they had to do everything without assistance, which aligns with another study in which LSPs thought the hands-off nature of video conferencing was beneficial (Demirici et al., 2019). However, a majority of participants in our study felt that the lack of hands-on attention mothers received during a telehealth visit altered the way LSPs delivered care.

At the onset of the COVID-19 pandemic during March through June 2020, other researchers found that mothers who had suspected COVID-19 infections were separated from their newborns (Schindler-Ruwisch & Phillips, 2021). LSPs in our study reported similar separation practices. Additionally, mothers were not allowed to provide expressed human milk for their infants but instead were instructed to “pump and dump” their milk. In a study by Schindler-Ruwisch and Phillips (2021), investigators noted that some mothers did not have the necessary applications to connect virtually and proposed that disparities increased for those without suitable internet connections. Participants in our study reflected a similar sentiment and asserted that lack of a stable, high-speed internet connection made telehealth consultations challenging.
Participants in our study reflect this majority. As noted by Harmon (2020), the prevalence of nurses practicing as LSPs highlights the importance of nurses in the role of breastfeeding educators. LSP participants repeatedly emphasized the support the bedside nurses offered to mothers and how vital their presence is to successful infant feeding practices. In postpartum practice settings, as their primary caregivers, nurses ensure that new mothers are supported and able to meet their breastfeeding goals. They are present to offer emotional support and feeding guidance. When mothers need further help with feedings, nurses who are not LSPs can consult LSPs to offer education and assistance. The best practices outlined by LSPs in this study are tools nurses can use when caring for prenatal and postpartum mothers seeking breastfeeding support. With the influence the COVID-19 pandemic continues to have on the provision of lactation assistance, telehealth recommendations will remain pertinent going forward (see Table 2).

Further research on mothers’ perspectives of breastfeeding education and support during the COVID-19 pandemic is needed. Direct interviews with mothers would provide further insight into maternal experiences during this time. Given the concerns LSPs in our study expressed over the effectiveness of telehealth breastfeeding education, additional research on the rates of successful breastfeeding initiation, duration, and exclusivity during and after COVID-19 safety precautions could provide beneficial data for the use of telehealth moving forward.

Conclusion

This study offers insight into the facilitators, barriers, and best practices perceived by LSPs in delivering breastfeeding education during the COVID-19 pandemic. Because COVID-19 created a new barrier to providing breastfeeding education, this study adds to a newly emerging body of literature and highlights the impacts of COVID-19 on the provision of breastfeeding education, the mainstream delivery of telehealth services, and the challenges presented in offering telehealth consultations.

Supplementary Materials

Note: To access the supplementary material that accompanies this article, visit the online version of Nursing for Women’s Health at http://nwhjournal.org and at https://doi.org/10.1016/j.nwh.2022.09.003.

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Disclosures

The authors report no conflicts of interest or relevant financial relationships.

### TABLE 2 BEST PRACTICES FOR TELEHEALTH AND IN-PERSON BREASTFEEDING EDUCATION AS STATED BY LACTATION CONSULTANTS DURING KEY INFORMANT INTERVIEWS

| Telehealth                                                                 | In Person                                                                 |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------|
| 1. Meet mothers where they are                                            | 1. Meet mothers where they are                                            |
| 2. Focus on mothers’ goals                                                | 2. Focus on mothers’ goals                                                |
| 3. Have a support person                                                  | 3. Offer one-on-one support                                                |
| 4. Create a comfortable atmosphere for mothers                           | 4. Know your audience                                                     |
| 5. Collect accurate medical history                                        | 5. Use the Baby-Friendly Hospital Initiative Ten Steps to Successful Breastfeeding for mothers in the hospital |

Working with diverse communities to increase breastfeeding awareness and to reduce breastfeeding disparities among communities of color was highlighted by participants as an important goal to which LSPs should strive. In a recent 346-person survey by the U.S. Lactation Consultant Association, the majority of IBCLC and non-IBCLC respondents identified as White and primarily English speaking (Harmon, 2020). Our study population was reflective of this racial demographic breakdown, with greater than 75% of our participants identifying as non-Hispanic White. LSPs in our study also described language differences as a barrier and discussed working with a translator as inconvenient. Some felt that they would not know how to approach a mother who did not speak English. This theme suggests a lack of outreach to non–English-speaking communities.

The strengths of this study include the level of detail provided by the key informant interviews, the diversity of employment settings among participants, and the study’s overall rigor. Limitations include a small sample size of participants from one geographic location and an inability to transfer results beyond the study sample. The experiences of LSPs and mothers in other regions of the country may be different. The study sample lacked racial and ethnic diversity. Additionally, we interviewed only certified LSPs. Other providers offer prenatal and postpartum care, and we did not address their roles in the provision of breastfeeding education.

### Implications for Nursing Practice

Nationwide, statistics reveal the prevalence of LSPs who simultaneously hold nursing degrees and licenses (Harmon, 2020). Participants in our study reflect this majority. As noted by Harmon (2020), the prevalence of nurses practicing as LSPs highlights the importance of nurses in the role of breastfeeding educators. LSP participants repeatedly emphasized the support the bedside nurses offered to mothers and how vital their presence is to successful infant feeding practices. In postpartum practice settings, as their primary caregivers, nurses ensure that new mothers are supported and able to meet their breastfeeding goals. They are present to offer emotional support and feeding guidance. When mothers need further help with feedings, nurses who are not LSPs can consult LSPs to offer education and assistance. The best practices outlined by LSPs in this study are tools nurses can use when caring for prenatal and postpartum mothers seeking breastfeeding support. With the influence the COVID-19 pandemic continues to have on the provision of lactation assistance, telehealth recommendations will remain pertinent going forward (see Table 2).

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