



**COVID-19
RESPONSE**



COVID-19 Technical Brief Package for Maternity Services

Interim Guidance: Update 2: July 2020





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Technical Brief Package for Maternity Services

Part 1: Delivery of Facility Based Maternity Services

Interim Guidance: Update 2: July, 2020



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Background:

It is anticipated that COVID-19 (the disease caused by the novel coronavirus named SAR-CoV-2) will occur in most, if not all countries.

A key fact about COVID-19 is that the vast majority of infections will result in very mild or no symptoms. Not everybody is at risk of severe disease. Persons of advancing age and those with existing respiratory, cardiac and/or metabolic disorders and immunodeficiencies are at higher risk of moderate to severe disease¹. There is limited evidence on the impact of COVID-19 on pregnancy and the newborn. A recent US based study reported that pregnant women with COVID-19 are more likely to need hospital admission and are at increased risk for intensive care admission and mechanical ventilation compared with nonpregnant women². However, the evidence is still very sparse and much remains unknown about this disease.

The impact on acute care services in settings with under-resourced health systems is likely to be substantial. **Maternity services should continue to be prioritized as an essential core health service**, and other sexual and reproductive health care such as family planning, emergency contraception, treatment of sexually transmitted diseases, post-abortion care and where legal, safe abortion services to the full extent of the law, also need to remain available as core health services. Early data suggests a drop in facility-based care in many countries and projections of rising maternal mortality. We need to actively reach out to women and encourage continued health seeking behaviours, taking every chance to provide respectful compassionate and meaningful care.

Maternity care providers (including midwives and all other health care workers providing maternal and newborn care), whether based in health facilities or within the community, are essential health care workers and must be protected and prioritized to continue providing care to childbearing women and their babies.

Deploying maternity care workers away from providing maternity care to work in public health or general medical areas during this pandemic is likely to increase poor maternal and newborn outcomes. **Maternity care providers have the right to full access for all personal protective equipment (PPE), sanitation and a safe and respectful working environment.**

Maintaining a healthy workforce will ensure ongoing quality care for women and their newborns; without healthy midwives and other maternity care providers there will be limited care for women and newborns³.

The UNFPA response to the COVID-19 pandemic within maternity care involves a 3-pronged approach:

- 1. Protect maternity care providers and the maternal health workforce**
- 2. Provide safe and effective maternity care to women**
- 3. Maintain and protect maternal health systems**

Detailed practical recommendations across these 3 prongs are outlined for antenatal care, intrapartum and postnatal care. The aim of these recommendations is to provide interim guidance to reduce the

risk of infection from the mother/newborn to the maternity care provider and from the maternity care provider to mother/newborn in the immediate clinical care situation.

These recommendations are provided as an interim resource for UNFPA staff and health professionals based on a combination of WHO guidelines, good practice and expert advice based on the latest scientific research. The situation with COVID-19 is evolving rapidly and the guidance will continue be updated if and when new evidence or information becomes available.

KEY FACTS:

Who is at risk of COVID-19?

- Although all human beings are at risk of infection, only some persons are at high risk of moderate to severe disease. These include persons of advanced age, and persons with pre-existing disease (e.g. HIV/ malaria, anemia, past tuberculosis, diabetes or other cardiac, respiratory and/ or metabolic conditions).
- It is expected that the large majority of pregnant women will experience only mild or moderate symptoms similar to the cold or flu, or sometimes no symptoms at all. However, pregnant women are potentially at increased risk of complications from any respiratory disease due to the physiological changes that occur in pregnancy. These include reduced lung function, increased oxygen consumption and changed immunity.

There is no evidence at present of an increased risk of miscarriage, teratogenicity (abnormalities of physiological development) or in-utero (vertical) transmission of the COVID-19 virus. There is no evidence demonstrating transmission by breastfeeding however, research is underway to investigate this further.

- There is no clear evidence of risk of preterm birth. Studies are ongoing to determine if this might be increased with COVID-19.
- Persons infected with coronavirus but who have very mild symptoms or no symptoms at all, can still be infectious to others. Babies born to mothers with coronavirus can potentially become infected with the virus after birth (through droplet exposure), however the risk of transmission can be minimized through general infection control practices. Most babies who become infected will likely only experience mild illness.
- Products of conception, the placenta, amnion etc. have **not been shown to have congenital coronavirus** exposure or infection, and do not pose risk of coronavirus infection. They need to be treated as infectious of standard blood-borne pathogens and dealt with in accordance with standard waste management practices. Research into these areas is ongoing.
- For further information and training on COVID-19, a WHO online course can be accessed here: <https://openwho.org/courses/introduction-to-ncov>

GENERAL PROTECTIVE MEASURES THAT APPLY TO ALL EPISODES OF PATIENT CONTACT

- a)** All staff and patients need to have access to hand washing facilities and be encouraged to do so as they enter the health facility. Ensure supply of clean water (even from a bucket, or “tippy tap” if running water is unavailable), in every location or room where staff work and in waiting areas for patients.
- b)** Ensure availability of simple soap at every wash station in the health facility and a clean cloth or single use towel for drying hands.
- c)** Midwives providing direct patient care need to wash their hands with soap and water frequently: Hands need to be washed with soap and water thoroughly for at least 20 seconds. Wash before every new woman is seen and again before physical examination. Wash again immediately after examination and once the woman leaves. Wash hands after cleaning surfaces. Wash hand after coughing or sneezing. Hand sanitizer can also be used, particularly as a backup for where there is an unreliable water source.
- d)** Avoid touching the eyes, nose and mouth.
- e)** Advise all persons (patients and staff) to cough into a tissue or their elbow and to wash hands after coughing and sneezing.
- f)** Midwives need to maintain social distancing of 2 arms lengths for as much as possible during any clinical encounter. Physical examination and patient contact needs to be continued as usual for women without suspected/confirmed COVID-19 if hand washing is performed before and after.
- g)** Surfaces used by patients and staff need to be sprayed with a cleaning product (i.e.: 0.5% sodium hypochlorite (bleach)) and wiped down with a paper towel or clean cloth in between patients, followed by hand washing.

RECOMMENDATIONS

1. TRIAGE AND RISK SCREENING FOR COVID-19

- a) Triage and risk screening for COVID-19 exposure and symptoms needs to be undertaken for all women , companions, patients and staff presenting to the health facility. [See ANNEX 1: Triage and Risk Screening for more detailed guidance \(adapted from Queensland Health \(2020\) COVID-19 Guidance for Maternity Services – Statewide maternity and neonatal clinical network. Queensland, Australia\)](#)
- b) All women and accompanying persons need to be screened for infection by asking about general wellbeing, underlying medical conditions (e.g. rheumatic heart disease, past tuberculosis, diabetes or other cardiac, respiratory or metabolic conditions), presence of respiratory symptoms and have their temperature checked and documented. Any person with a fever or reporting fever and/or respiratory symptoms, needs to be considered as possibly having COVID-19. Pregnant women living in refugee camps, nomadic tribes, high density communities and urban slums will be at particular risk of COVID-19 infection due to a high incidence of communicable disease, overcrowded housing and malnutrition.
- c) A referral pathway and mechanisms to provide emergency transport from BEmONC to CEmONC facilities needs to be in place for the potential transfer of pregnant women experiencing moderate/severe disease and requiring higher level acute care and intervention.

Where possible, maternity staff from the BEmONC facility should inform the CEmONC facility about the transfer of the woman in advance of her departure. As with all patient transfers, ensure that the women is stabilized before departure to the CEmONC facility.

When preparing for emergency transfer:

- o Prepare transport equipment and drugs in anticipation of medical emergencies that may occur en-route, such as sudden cardiovascular collapse or hypotension.
- o All transport staff should be mask-fitted for N95 respirators (where available) or surgical masks as a secondary option. All transport staff to don PPE prior to transport.
- o Put on surgical mask for patient during transport (if not done on facility admission).
- o If a bag valve mask (BMV) is required during transport, ensure all people in the vehicle are equipped with full PPE as BMV is an aerosol generating procedure.
- o Avoid unnecessary breathing circuit disconnection during transport.

Transport vehicles:

- o Transport vehicle to be cleaned and disinfected internally by cleaning or transport staff in PPE prior to transfer from BEmONC to CEmONC facility.
- o On arrival at CEmONC, transport staff to remove PPE and dispose of this as directed by facility protocol and wash hands.
- o Transport staff to don new PPE prior to the return journey in the same ambulance.

- Staff to remove PPE in the nearest clinical area, for example ambulance bay, upon arrival back at BEmONC and wash hands.
 - Equipment used during transportation to be cleaned and/or sterilized after transport as per facility protocol.
 - Transport vehicle to be cleaned upon arrival when back at BEmONC facility or transport depot.
 - Transport staff will need to doff, decontaminate and don new PPE prior to transporting another patient in the now decontaminated, resupplied vehicle.
- d)** If your country has community transmission of COVID, all patients, companions and women who present for care should have a cloth face mask (<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/when-and-how-to-use-masks>). Denying care for lack of a cloth face mask is NOT appropriate.
- e)** Women with suspected COVID-19 need to be provided with a surgical facemask and treated in a dedicated treatment area separate from other patients where possible. Medical equipment needs to stay in these dedicated treatment areas and not be shared amongst general patients where possible. Through cleaning of equipment is required before it is used for other patients. All patients need to receive education from the maternity care provider on proper hygiene practices as part of the admission procedure.
- f)** Personal Protective Equipment (PPE): Maternity care providers involved in the direct care of patients must have access to PPE. See CDC guidance and videos regarding correct donning and doffing of PPE: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>

For maternity care providers delivering care to women with suspected or confirmed cases of coronavirus in a health facility, the following PPE needs to be worn:

a long sleeve gown, surgical mask (for all patient interaction) or an N95/P2 mask (if the maternity care provider is directly involved in aerosol performing procedures such as suctioning airway secretions, administering nebulizing medication or CPR), eye protection and non-sterile gloves.

- g)** For maternity care providers delivering care to women without symptoms of coronavirus in a health facility: The WHO recommend that PPE needs to be used according to standard precautions and risk assessment. Wearing PPE for all patient contact will be dependent on availability of PPE within individual facilities and individual judgement of the exposure risk by the maternity care provider.

Gloves and a plastic apron need to be worn during the delivery of care that may involve exposure to blood, body fluids, secretions, excretions, touching oral mucosa, or medication assistance (including: taking blood or vaginal swabs, performing a stretch and sweep and first stage of labour).

During second and third stage of labour, in addition to hand washing, a surgical mask, plastic apron, eye protection, a plastic apron and gloves need to be worn.

See the WHO guidance regarding by whom, when and where PPE should be worn : [https://www.who.int/publications/i/item/rational-use-of-personal-protective-equipment-for-coronavirus-disease-\(covid-19\)-and-considerations-during-severe-shortages](https://www.who.int/publications/i/item/rational-use-of-personal-protective-equipment-for-coronavirus-disease-(covid-19)-and-considerations-during-severe-shortages)

For further guidance specifically on the use of masks see WHO guidance:

[Annex 2 and](#)

[https://www.who.int/publications-detail/advice-on-the-use-of-masks-in-the-community-during-home-care-and-in-healthcare-settings-in-the-context-of-the-novel-coronavirus-\(2019-ncov\)-outbreak](https://www.who.int/publications-detail/advice-on-the-use-of-masks-in-the-community-during-home-care-and-in-healthcare-settings-in-the-context-of-the-novel-coronavirus-(2019-ncov)-outbreak)

h) During any episode of patient contact, maternity care providers are recommended to use routine infection prevention and control practices, such as handwashing.

Handwashing will substantially reduce the risk of infection from coronavirus.

i) Cleaning surfaces with a cleaning product (i.e.: 0.5% sodium hypochlorite (bleach)) and wiping surfaces down with a paper towel or clean cloth in between patients is recommended. Cleaning needs to be followed by hand washing.

j) In addition to routine infection control practices, maternity care providers need to maintain a physical distance of 2 arms lengths for as much as feasibly possible during any clinical encounter to further reduce the risk of infections. However, physical examination should be maintained, with hand washing before and after patient contact.

k) Maternity care providers and other staff also need to maintain a distance of 2 arms lengths from one another as much as possible, even when no patients are present.

2. ANTENATAL CARE

ORGANIZATION OF CARE:

- Develop a sustainable ANC service delivery model for the country's context, which defines how services will be organized to deliver a core ANC package, specifically which set of interventions will be provided at each ANC contact and by whom (cadre), where (system level), and how (platform).
- Define mechanisms to ensure that there is coordination of care across ANC contact points, including community-to-facility linkages and supportive oversight of community-based services, activities, and auxiliary health workers.
- Support reorganization of ANC services and/or client flow, as needed, to reduce wait times and contacts with other patients, improve efficiency of service delivery, and satisfaction among clients and providers.
- Encourage women to wait outside or in designated, marked areas that show women where to stand for ANC, and maintain social distancing of 2 arms lengths wherever possible.

- Discourage groups of more than 20 women from attending ANC at any one time - consider use of an appointment/queuing system (either phone based booking system or numbered tickets/sign in sheet available for women as they arrive outside the ANC facility).
- All women should be triaged and screened for symptoms of COVID-19 before entering the health facility, this includes having their temperature checked and documented (refer to Annex 1)

FOR WOMEN WITH SYMPTOMS OF COVID-19:

- **If the woman meets the ‘stay at home’ guidance (see section below), the ANC appointment should be rebooked for after the isolation period ends.**

The woman can stop home isolation under the following 3 conditions: She has had 3 full days of no fever without the use of medicine that reduces fever and, other symptoms have improved (i.e.: *shortness of breath or cough*) and, at least 7 days have passed since her symptoms first appeared. Women need to be advised to seek medical help if the condition is worsening or if symptoms are not improving after 7 days.

If the woman has access to testing facilities, she may leave home after home isolation under the following 3 conditions: The woman no longer has fever and other symptoms have improved and she has had two negative tests in a row, 24 hours apart.

- **Women who have symptoms of COVID-19 and are experiencing any pregnancy related complications** need to be seen separately from others in an isolated room if possible or at the beginning or end of clinic when no other patients remain, to lower the chance of transmission to the maternity care provider and other women attending for care.

Women with symptoms need to wear a mask and maternity care providers should wear PPE as per WHO recommendations.

FOR ALL WOMEN:

- a) Wherever possible, provide ANC away from general patients presenting for emergency/other outpatient care. Continuity of care models of midwifery care provided throughout the pregnancy, birth and postnatal period will reduce the number of caregivers in contact with the woman and her birth partner and decrease the chances of COVID-19 spread in hospitals.
- b) The health information session provided by the midwife or other maternity care provider at the beginning of an antenatal clinic should include reminders about social distancing during the clinic session (i.e.: sitting 2 arm's length apart from each other) and key messages about the virus (*such as symptoms, procedures for home isolation, emergency signs etc.*).
- c) This information session can be used as an opportunity to minimize women's fear about the impact of COVID-19 on pregnant women and newborns and encourage ongoing contact with the health service. **Specific precautions/guidance regarding COVID-19 for pregnant women remain the same as for the general population.**
- d) Restrict attendance for ANC visits to include only the women, an asymptomatic companion of choice and the maternity care provider. Wherever possible, children, other family members and other companions should not accompany the women into the clinic visit. All should be wearing a cloth face mask/covering.
- e) Continue physical contact and clinical examination as normal during ANC visits but pay extra attention to infection control measures. All women need to wash their hands upon arrival to waiting area, upon entering clinical rooms, upon leaving clinical rooms and upon leaving clinic.
- f) Maternity care providers need to wash their hands before every new woman is seen and again before physical examination. Gloves are only required if doing a physical exam. Wash again immediately after examination and/or once the woman leaves. Wash hands after cleaning surfaces. Wash hands after coughing or sneezing.
- g) When in-person appointments are required (e.g. for blood tests, maternal examination or ultrasound scans, vaccines, OGT), these should be arranged alongside other face-to-face maternity appointments to limit repeated clinic attendance. Consider supplying women with enough iron, folic acid, calcium etc. to help avoid facility visits just to obtain supplies.
- h) An alternative schedule of antenatal care contacts whereby some of these contacts are provided by telehealth, may be appropriate for some women to minimize overcrowding in clinics and the risk of virus transmission, as long as the minimum of 4 face to face visits is maintained and there are no risks or danger signs. ANC that is not provided in person at the facility, can be undertaken on the phone, via whatsapp, sykpe, facetime (where available) and is best utilized for occasions when the woman does not require physical clinical assessments and/or tests/investigations. (See COVID-19 Technical Brief Package for Maternity Services, Part 2: ANC Services for further details on telehealth)
- i) The specific content of ANC remains unchanged in the context of COVID-19. However, maternity care providers need to be aware of the **increased risk of antenatal anxiety and depression and domestic violence due** to the economic and social impacts of the COVID-19 pandemic.

These issues add to the normal stresses of pregnancy and maternity care providers need to have guidance/referral mechanisms in place to support these women.

- j) Additional education during ANC should include COVID symptoms, importance of breastfeeding, home care, safe home care of others and when to seek medical care.

3. INTRAPARTUM CARE

FOR ALL WOMEN:

- a) Triage and screening needs to take place for all women and their birth companion before entering the health facility as outlined in previous sections.
- b) Routine infection control precautions need to be instituted for care during every labour and birth. It is important to remember in lower risk groups; corona virus (SAR-CoV-2) leads to mild infection whereas acute complications unrelated to COVID-19 that can occur during pregnancy and childbirth, can carry high mortality for the mother and newborn. In the case of obstetric and newborn emergencies, care to the mother or newborn should not be delayed.

Labor Room Preparedness

The majority of women presenting in labour will not have respiratory symptoms, and the labour room should continue to provide services as before. However, the attention to infection prevention practices should be higher:

- Have sufficient supplies of all PPE supplies (masks, gloves, goggles, gowns, hand sanitizer, soap and water, cleaning supplies) in the labour room
- All surfaces should be cleaned thoroughly with spray and a clean cloth after any contact by patient or staff
- Staff should follow regular hand hygiene practices – handwashing before and after examining each patient.

- c) All women need to be encouraged to call the health facility (where possible) for advice in early labour and to inform the maternity care provider of any respiratory or other COVID-19 related symptoms, which can then assist in planning further care or potential referral.
- d) All women maintain their right to be treated with compassion, dignity and respect. Every woman has the right to receive information, provide consent, refuse consent and to have her choices and decisions respected and upheld, and this includes mobility during labour and birth position of choice.

- e) One asymptomatic birth partner should be allowed to stay with the woman, through labour and birth, wearing a cloth mask.** Continuous support by a known birth partner increases spontaneous vaginal birth, shortens labour and decreases caesarean births and other medical interventions. If birth partners are symptomatic, they should remain in self-isolation and not attend the birth. Women should be advised when making plans about their birth to identify potential alternative birth support if needed.

FOR WOMEN WITH SYMPTOMS CONSISTENT WITH COVID-19 INFECTION:

- f)** Following triage and assessment, women identified as having symptoms consistent with the coronavirus (SAR-CoV-2) and requiring admission to the facility, need to be cared for in a single/isolation room where possible. Consider reducing the amount of equipment to absolute essential in isolation rooms given the additional cleaning of all equipment that is required after the admission. All care should ideally continue in the same isolation room for the entirety of the woman's stay. Efforts need to be made to minimise the number of staff members entering the room and maternity services should develop a local policy specifying essential personnel for emergency scenarios.
- g)** Women with an acute respiratory illness should be given surgical masks and staff should be provided with PPE for the duration of care. Women presenting at a BEmONC facility with severe respiratory symptoms requiring respiratory support should be stabilized and transferred to a CEmONC facility.
- h)** Where women do not have access to a single room, it is still essential to find a way of separating sick women from well women either by clustering alike women within a shared room or bay to reduce the risk of virus transmission – this also applies for any admission throughout pregnancy and the postpartum period.
- i)** Care during labour should not differ from usual, however given the association of COVID-19 with acute respiratory distress syndrome, women with moderate-severe symptoms of COVID-19 should be monitored using hourly fluid input-output charts, plus efforts targeted towards achieving neutral fluid balance in labour, in order to avoid the risk of fluid overload. Saturation monitoring should also be undertaken where this is appropriate and oxygen therapy is available.
- j)** Elective obstetric procedures (e.g. caesarean birth, tubal ligation) planned for women with suspected/confirmed COVID-19 should be scheduled at the end of the operating list. Emergency procedures for women with suspected/confirmed COVID-19 should be carried out in a second obstetric theatre, where available, allowing time for a full postoperative theatre clean as per national health protection guidance.

For detailed clinical guidance on operative birth during COVID-19 and management of the operating theatre refer to:

<https://www.rcog.org.uk/globalassets/documents/guidelines/2020-06-04-coronavirus-covid-19-infection-in-pregnancy.pdf>

- k)** There is no evidence to suggest that steroids for fetal lung maturation, when they would usually be offered, cause any harm in the context of COVID-19. Steroids should therefore be given where indicated. As is always the case, urgent delivery should not be delayed for their administration.

4. POSTNATAL CARE

- a)** Visitors need to be limited from visiting health facilities during the current pandemic. Many health facilities have instituted a no-visitor policy. If your facility does permit visitors, it is recommended that visitors are screened for infection. Anyone with acute respiratory symptoms or possible COVID-19 infection or contact, should be excluded from the health facility.
- b)** All visitors need to follow infection control procedures, wear a cloth mask, and wash their hands with soap and water on entering and leaving the room where the woman and her newborn are being cared for. Hand washing should take place again upon leaving the health facility.

POSTNATAL CARE IN INFECTED MOTHERS

- c)** There is currently no evidence that a woman with symptoms consistent with COVID-19 infection who has recently given birth, needs to be separated from her baby. In some countries this is occurring. The risk of separating the mother and baby to reduce infection transmission, and potentially mild illness in the baby, may considerably outweigh the benefits of keeping mothers and babies together given the evidence supporting immediate skin to skin contact and early initiation of breastfeeding for thermal regulation, prevention of hypoglycemia and reduced sepsis and death in infants. It may also increase the baby's exposure to COVID from multiple caregivers rather than just the mother. This applies especially to low birth weight infants in low-resourced settings.

All mothers and babies regardless of their COVID-19 status need support to remain together to practice rooming-in, establish breastfeeding, practice skin to skin contact or kangaroo mother care.

- d)** Women with symptoms consistent with COVID-19 infection need to avoid contact with other mothers and babies, undertake hand washing before and after contact with the baby and consider wearing a mask when feeding, providing skin to skin or kangaroo mother care for her baby. Routine cleaning and disinfecting of all surfaces that the mother has had contact with, should also be undertaken at regular intervals.
- e)** Breastmilk from infected mothers has been shown to be negative for COVID-19 so breastfeeding is not contra-indicated. Maternity care providers need to support the mother's

intention to breastfeed and where a woman is unwell, provide support for the woman to express breastmilk and feed this to her baby.

- f)** The few neonatal infections that have been reported were acquired in the postnatal period and the infants were not significantly unwell. Fetal distress and early neonatal complications when present, were considered due to maternal illness or prematurity. Newborns born prematurely or sick may require additional medical support in the health facility. However, every newborn has the right to access his or her mother or parent. No mother should be separated from her baby without her informed consent.

POSTNATAL CARE IN NON-INFECTED MOTHERS

- g)** Care in health facilities for mothers and newborns should extend to a minimum of 24-hours following birth. For women who leave the health facility early after birth or gave birth at home or outside the facility, access to the first PNC contact should be ensured within 24 hours postpartum.

FOR ALL WOMEN:

- h)** Breastfeeding needs to be encouraged and supported by maternity care providers.
- i)** Postnatal anxiety and depression are common for mothers and also many new fathers. This may be exacerbated by the social isolation and financial impact on the family and wider community, resulting from the COVID-19 pandemic.

New parents need to be encouraged to interact with other parents, friends and family via the phone or other online resources where available. They also need to be given appropriate advice, referral to specialist services and contact information for a known maternity care provider, community health worker and emergency services, to call if they are not coping.

- j)** Prioritize PNC contacts with women and newborns during the first week after birth, including PNC contact within the first 24 hours after birth in the case of a home birth; prioritize follow up of high-risk women and newborns.
- k)** Where feasible and appropriate, telephone and or/video follow up in the postnatal period may be considered in place of facility based postnatal care visits and if no tests, procedures or physical examinations are expected (**Guidance for delivery of telehealth for postnatal care is outlined in the COVID-19 Technical Brief Package for Maternity Services, Part 3: Postnatal Care Services**).
- l)** Where in-person PNC visits are necessary, provide all relevant care in a single visit. Offer 2–3 months of recommended micronutrient supplements, insecticide treated nets and contraceptives. Consider offering long-acting reversible contraception. Ensure that emergency plans are adapted to take into account changes to services.

- m)** Plan for catch up of missed PNC contacts or essential elements, including administration of vitamin K and birth dose immunizations for newborns.

- n)** Plan for catch-up of incomplete home-based records

See: WHO guidance regarding community-based health care during COVID-19 for further details:
<https://www.who.int/publications-detail/community-based-health-care-including-outreach-and-campaigns-in-the-context-of-the-covid-19-pandemic>

For the care of small or sick newborns:

- o)** Limit the number of caregivers providing Kangaroo Mother Care support to one or two trained in IPC with PPE. Develop strategies to enable support to continue KMC in the home and provide family with a known care provider at the health facility to provide phone-based support/guidance if needed.
- p)** Consider early discharge home with follow up of stable preterm or low birth weight newborns receiving KMC. Ensure that the mother or care giver has a booked appointment for follow up prior to discharge from the facility and the contact number of a known care provider at the facility to call if there are any questions or concerns.

Admissions to Special Care Nursery or Neonatal Intensive Care:

- q)** Ensure parents or care givers are appropriately screened for COVID-19 and have access to handwashing facilities prior to entering the nursery.
 See: WHO guidance regarding maintaining essential health services for further details:
 operational guidance for the COVID-19 context Interim guidance 1 June 2020

See ANNEX 3 for frequently asked questions about pregnancy and the postpartum period.

5. PERSONAL HEALTH AND SAFETY

- a)** Your own health and safety and that of your family is very important. Before leaving the maternity facility and going home, or before entering home: wash your hands, and change clothes and wash them with soap and water.

During stressful events, your own health can be easily compromised. Maternity care providers need to **self-monitor for signs of illness** such as fever, shortness of breath, cough and sore throat and self-isolate and report illness to managers, if it occurs.

Staff with symptoms of COVID-19 should not come to work.

You can stop home isolation under the following 3 conditions: You have had 3 full days of no fever without the use of medicine that reduces fever and, other symptoms have improved (i.e.: shortness of breath or cough) and, at least 7 days have passed since your symptoms first appeared. Medical help should be sought if the condition is worsening or if symptoms are not improving after 7 days.

If you have access to testing facilities, you may leave home after home isolation under the following 3 conditions: You no longer have fever and other symptoms have improved and you have had two negative tests in a row, 24 hours apart.

- b) Fatigue, burn out and stress related to the environmental, family and economic effects of COVID-19 can all impact upon mental and physical health. Advise management and seek help if you are feeling signs of undue stress or have mental health challenges that require supportive interventions.
- c) **Maternity care providers over the age of 65, those who have cardiac, respiratory or metabolic conditions, and possibly persons with immune deficiency including acquired immune deficiencies, need to avoid clinical contact with any patient (not only those suspected of having COVID-19) and consider non-clinical duties** if at all possible.
- d) Health care providers in their last trimester of pregnancy or with underlying health conditions such as heart or lung disease in any stage of pregnancy, are recommended to avoid direct contact with patients.
- e) Health facilities should have strategies in place to mitigate staff shortages. The following tools and resources can be adapted for workforce planning during COVID-19:
 - WHO: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/covid-19-critical-item>
 - CDC: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>

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ADDITIONAL KEY RESOURCES:

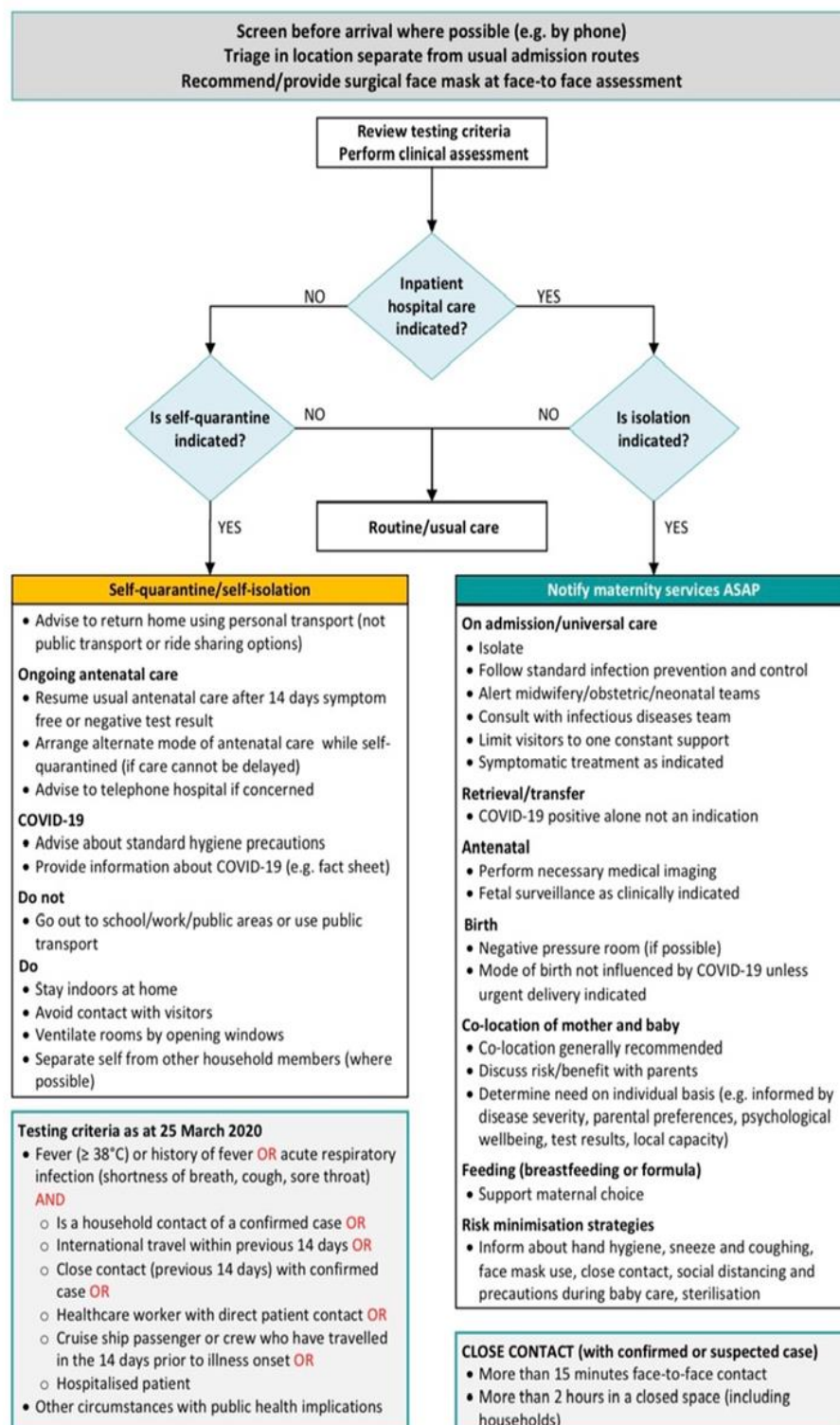
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ANNEX 1: TRIAGE AND RISK SCREENING

***Clinical assessment during the triage process is recommended to include checking temperature**

Flowchart: Triage and risk assessment of suspected or confirmed COVID-19 woman



ANNEX 2

WHO revised mask guidelines for HCW:

Table 1. Type of mask for use by health workers depending on transmission scenario, setting and activity*

COVID-19 Transmission scenario	Who	Setting	Activity	What type of mask*
Known or suspected community transmission	Health worker or caregiver	Health facility (including primary, secondary, tertiary care levels, outpatient care, and LTCF)	In patient care area – irrespective if patients are COVID-19 suspect/confirmed	Medical mask (targeted continuous medical masking)
	Personnel (working in health care facilities but not providing care for patients, e.g. administrative staff)	Health care facility (including primary, secondary, tertiary care levels, outpatient care, and LTCF)	No routine activities in patient areas	Medical mask not needed. Medical mask should be considered only if in contact or within 1m of patients, or according to local risk assessment.
	Health worker	Home visit (for example, for antenatal or postnatal care, or for a chronic condition)	When in direct contact or when a distance of at least 1m cannot be maintained.	Consider using a medical mask
	Health worker	Community	Community outreach programs	Consider using a medical mask
Sporadic transmission or clusters of COVID-19 cases	Health worker or caregiver	Health care facility (including primary, secondary, tertiary care levels, outpatient care, and LTCF)	Providing any patient care	Medical mask use according to standard and transmission-based precautions (risk assessment)
	Health worker	Community	Community outreach programs	No mask needed
Any transmission scenario	Health worker or caregiver	Health care facility (including primary, secondary, tertiary care levels, outpatient care, and LTCF)	When in contact with suspect or confirmed COVID-19 patient	Medical mask
	Health worker	Health care facility (including LTCF), in settings where aerosol generating procedures (AGP) are performed	Performing an AGP on a suspected or confirmed COVID-19 patient or providing care in a setting where AGPs are in place for COVID-19 patients.	Respirator (N95 or N99 or FFP2 or FFP3)
	Health worker or caregiver	Home care	When in close contact or when a distance of at least 1 m cannot be maintained from a suspect or confirmed COVID-19 patient	Medical mask

*This table refers only to the use of medical masks and respirators. The use of medical masks and respirators may need to be combined with other personal protective equipment and other measures as appropriate, and always with hand hygiene.

WHO revised guidelines for mask use by general public:

Table 2. Examples of where the general public should be encouraged to use medical and non-medical masks in areas with known or suspected community transmission

Situations/settings	Population	Purpose of mask use	Type of mask to consider wearing if recommended locally
Areas with known or suspected widespread transmission and limited or no capacity to implement other containment measures such as physical distancing, contact tracing, appropriate testing, isolation and care for suspected and confirmed cases.	General population in public settings, such as grocery stores, at work, social gatherings, mass gatherings, closed settings, including schools, churches, mosques, etc.	Potential benefit for source control	Non-medical mask
Settings with high population density where physical distancing cannot be achieved; surveillance and testing capacity, and isolation and quarantine facilities are limited	People living in cramped conditions, and specific settings such as refugee camps, camp-like settings, slums	Potential benefit for source control	Non-medical mask
Settings where a physical distancing cannot be achieved (close contact)	General public on transportation (e.g., on a bus, plane, trains) Specific working conditions which places the employee in close contact or potential close contact with others e.g., social workers, cashiers, servers	Potential benefit for source control	Non-medical mask
Settings where physical distancing cannot be achieved and increased risk of infection and/or negative outcomes	Vulnerable populations: • People aged ≥60 years • People with underlying comorbidities, such as cardiovascular disease or diabetes mellitus, chronic lung disease, cancer, cerebrovascular disease, immunosuppression	Protection	Medical mask
Any setting in the community*	Persons with any symptoms suggestive of COVID-19	Source control	Medical mask

*This applies to any transmission scenario

ANNEX 3: FREQUENTLY ASKED QUESTIONS

Advice for Pregnant and Lactating Women on COVID-19 **Frequently asked questions**

1. Are pregnant women at higher risk of getting COVID-19? If they become infected, will they be more sick than other people?

Pregnancy alters a woman's immune system, making them more susceptible to infections. However, at present there is no evidence suggesting that pregnant women are more likely to be affected by COVID 19 than the general public nor whether they are more likely to have serious illness as a result.

Pregnant women experience changes in their bodies that may increase their risk of some infections. It is always important for pregnant women to protect themselves from illnesses, and report possible symptoms (including fever, cough or difficulty breathing) to their healthcare provider.

2. How can pregnant women protect themselves from getting COVID-19?

Pregnant women should do the same things as the general public to avoid infection. Pregnant women without any symptoms of cough or fever and no history of contact with a confirmed COVID case should take following precautions to prevent any infection:

General advice:

1. Wash your hands frequently with soap and water
2. Cover your mouth and nose with handkerchief or tissue or with your elbow while coughing or sneezing. If you use a handkerchief, wash it frequently. If use a tissue, dispose of the used tissue immediately.
3. Keep social distancing – do not go to crowded places, avoid use of public transport
4. Avoid contact with persons who are suffering from fever or cough, or with anyone who is coughing or sneezing
5. Avoid touching your eyes, nose and mouth as much as possible.
6. Clean/disinfect contaminated surfaces such as tables, door knobs/handles, mobile phones and other everyday objects.
7. If you have cough, fever or breathlessness, immediately contact your doctor. Call before going to a health facility, and follow the directions of your local health authority.

Antenatal care:

8. Go for your antenatal care visits regularly and follow all instructions of your maternity care provider.

3. Should pregnant women go for routine antenatal care or avoid going to hospitals?

Pregnant women should continue to go for their routine antenatal care visits and health facility birth. Although it is advised that unnecessary hospital visits should be avoided at the time of Corona virus pandemic, it is important that women have their antenatal visits and deliver in a health facility in order to have the best outcomes for themselves and their babies. Some ANC contacts can be provided through telehealth – see Parts 2 and 3 of the Technical Brief Package for further details.

4. If a pregnant woman develops symptoms such as cough, fever or breathlessness, what should she do?

Pregnant women concerned about exposure or symptoms indicating possible infection with COVID-19 should visit the nearest health centre:

- They should avoid using public transport and call for an ambulance or private transport. Inform the ambulance driver immediately so that he can take appropriate preventive steps and inform the hospital in advance.
- They should use a mask or cover their nose and mouth while interacting with ambulance driver or staff at hospital
- Notify the health centre or hospital prior to arrival, if possible, so the facility can make appropriate infection control preparations before their arrival.
- They should immediately inform the reception area or health provider about the symptoms/ risk of exposure / contact.
- They should avoid contact with other patients and their attendants and wait till the advice of health staff on where to wait/ or attend OPD/emergency person.
- If it is an emergency (they have labour pains/ any problem such as bleeding / convulsions etc.), they should immediately inform the health staff about it.

5. Can COVID-19 cause problems for a pregnancy?

The available evidence at this time does not suggest that COVID-19 would cause any additional problems during pregnancy or affect the health of the baby after birth.

6. Can COVID-19 be passed from a pregnant woman to the fetus or newborn?

We still do not know if a pregnant woman with COVID-19 can pass the virus to her fetus or baby during pregnancy or delivery. To date, the virus has not been found in samples of amniotic fluid or breastmilk.

7. Do pregnant women with suspected or confirmed COVID-19 need to give birth by caesarean section?

No. WHO advice is that caesarean sections should only be performed when medically indicated. Having COVID 19 does not make any difference to the mode of delivery.

8. Can a Mother Confirmed or suspected for COVID-19 breastfeed her baby?

Much is unknown about how corona virus spreads. Person-to-person spread is thought to occur mainly via respiratory droplets produced when an infected person coughs or sneezes, similar to how other respiratory infections spread.

Breast milk is the best source of nutrition for most infants and provides protection against many illnesses. Breastfeeding women should not be separated from their newborns, as there is no evidence to show that respiratory viruses can be transmitted through breast milk. The mother can continue breastfeeding, as long as the necessary precautions below are applied:

- Symptomatic mothers well enough to breastfeed should take the following precautions while breastfeeding:
 - Wear a mask while handling the baby and breastfeeding the baby
 - Wash her hands before touching the baby
 - Keep all surfaces clean
- If a mother is too ill to breastfeed, she should be encouraged to express milk that can be given to the child using all the above precaution and use a clean cup and/or spoon to give expressed milk.

9. Can a mother touch and hold her newborn baby if she has COVID-19?

Yes. Close contact and early, exclusive breastfeeding helps a baby to thrive. You should be supported to

- Breastfeed safely, wear a mask while handling the baby, providing kangaroo mother care and breastfeeding the baby;
- Wash hands before touching the baby and hold your newborn skin-to-skin; and
- Share a room with your baby.

You should wash your hands before and after touching your baby, and keep all surfaces clean.



**COVID-19
RESPONSE**



COVID-19

Technical Brief Package For Maternity Services

Part 2: Antenatal Care Services

April 2020



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Antenatal Care during COVID-19

Introduction

It is anticipated that that COVID-19 (the disease caused by the novel coronavirus named SAR-CoV-2) will occur in most, if not all countries. A key fact about COVID-19 is that the vast majority of infections will result in very mild or no symptoms. Not everybody is at risk of severe disease. Persons of advancing age and those with existing respiratory, cardiac and/or metabolic disorders and immunodeficiencies are at higher risk of moderate to severe disease.

Limited data are available on COVID-19 in pregnancy, but the studies published to date do not show an increased risk of severe disease in late pregnancy or substantial risk to the newborn. Congenital infection has not been found, and the virus has not been detected in expelled products of conception. These findings are reassuring, and are quite different from other recent pandemics, like the 2009 H1N1 influenza A pandemic which resulted in more severe disease in pregnant women, or Zika virus which is teratogenic. Information on the impact of COVID-19 on early pregnancy outcomes remains unavailable at the time of writing. Non-pregnant women of childbearing age are also at low risk of severe disease [1].

The impact on acute care services in settings with under-resourced health systems is likely to be substantial. Maternity services should continue to be prioritized as an essential core health service, and other sexual and reproductive health care such as family planning, emergency contraception, treatment of sexually transmitted infections, and where legal safe abortion services, to the full extent of the law, also need to remain available as core health services.

Maternity care providers (including midwives and all other health care workers providing maternal and newborn care), whether based in health facilities or within the community, are essential health care workers and must be protected and prioritized to continue providing care to childbearing women and their babies. Deploying maternity care workers away from providing maternity care to work in public health or general medical areas during this pandemic is likely to increase poor maternal and newborn outcomes.

Maternity care providers have the right to full access for all personal protective equipment (PPE), sanitation and a safe and respectful working environment [2]. Maintaining a healthy workforce will ensure ongoing quality care for women and their newborns; without healthy midwives and other maternity care providers there will be limited care for women and newborns.

As part of [COVID-19 Pandemic UNFPA Global Response Plan](#), the UNFPA response involves a 3-pronged approach for Maternity care:

1. Protect maternity care providers and the maternal health workforce
2. Provide safe and effective maternity care to women
3. Maintain and protect maternal health systems

Detailed practical recommendations across these 3 prongs for antenatal care, intrapartum and postnatal care have been outlined in: UNFPA COVID-19 Technical Brief Package for Maternity Services: Part 1: Delivery of Facility Based Maternity Services [3].

This document provides interim guidance on providing phone based antenatal care (ANC) in the immediate clinical situation during COVID-19. These recommendations are provided as a resource for UNFPA staff based on a combination of WHO guidelines, good practice and expert advice based on the latest scientific evidence. The situation with COVID-19 is evolving rapidly and the guidance will continue to be updated if and when new evidence or information becomes available. An interim guidance on postnatal care is currently being developed and will be available shortly.

Antenatal Care

The overarching aim of this guidance is to ensure maternity care providers can deliver respectful and individualised antenatal care services that promote the safety of women, families and health professionals during the COVID-19 pandemic.

‘All pregnant women, including those with confirmed or suspected COVID-19 infections, have the right to high quality care before, during and after childbirth. This includes antenatal, newborn, postnatal, intrapartum and mental health care. (World Health Organization, 2020)’.

In the coming weeks and months maternity care providers will try to minimise direct patient contact in non-urgent situations in an attempt to minimise the spread of COVID-19 [1, 4, 5]. Adjustments to the standard antenatal care schedule may occur so that some antenatal appointments are conducted using telehealth², that is virtually by phone or video chat (remote contact)³, to ensure that there is no disruption in service or breakdown in women’s maternity care. Midwives and other key providers of antenatal care will need to use clinical judgement in deciding which women may be suitable for an alternate schedule of face to face care (contacts) that includes remote AN contacts. Primarily this will be women who have reliable mobile phone access are deemed low-risk – bearing in mind that risk status may change as pregnancy progresses so risk assessment must occur at every AN contact.

When it is necessary to physically examine women at an AN contact, the physical part of the examination will be undertaken respectfully but quickly to minimise time spent within the recommended 1-meter distancing [6].

Health services and clinics may:

- Triage and screen all women for symptoms of COVID-19 before entering the facility
- Limit the number of women attending clinics each day
- Change delivery modality scheduled AN contacts (after risk-assessment)
- Move AN clinics from hospital environments to the community and/or where possible recommend a route to the AN clinic that bypasses Emergency or designated Fever Clinics
- Undertake non-physical assessments in open environments (outside)
- Limit attendance of support people such as partners/children (at AN contacts)
- Separate physical assessment from discussion/enquiry part of AN contact

² Telehealth involves the use of telecommunications and virtual technology to deliver health care outside of traditional health-care facilities.

³ Referred to in this document as ‘remote contact’

- Provide a 'one-stop' contact meaning combining services such as USS, medication administration, blood and other tests at the same contact to prevent women having to return as frequently [1, 2, 5-7].

The UNFPA COVID-19 Technical Brief Package for Maternity Services: Part 1: Delivery of Facility Based Maternity Services [3] provides further recommendations about triage, exposure screening and organisation of facility based antenatal care services.

Regardless of where or how antenatal contact occurs, respectful maternity care must be at the forefront of the care provided. In these unprecedented times, women may be scared or anxious for themselves, their babies and their families. This fear and anxiety may be made worse by seeing their care providers in extensive personal protective equipment (PEE) as this can impact on simple actions such as seeing a kind smile. Health professions need to ensure every interaction with every woman is friendly, kind and respectful [8]. Where possible, continuity of midwifery care should be provided throughout the antenatal period, and indeed the birth and postpartum period. This is known to improve positive outcomes and will reduce the number of caregivers in contact with the woman and her birth partner [4, 9, 10].

The following document provides practical guidance on antenatal contacts undertaken remotely (phone/messaging application/telehealth). This guidance provides direction for services to continue to provide essential and respectful antenatal care during the COVID-19 pandemic. It is intended to support services in adjusting to a different way of delivering antenatal care but does not replace usual policies and protocols regarding antenatal care provision. Services should revert to the *WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience* [10] guidance once the pandemic status is lifted.

Prior to commencing telehealth services:

- Develop a facility or health system strategy such as a health information management system, to introduce and monitor changes in AN contacts
- Provide staff with technology, training and systems to provide remote AN contacts including sufficient resources for midwives to undertake phone contacts (access to mobile phone, charger, pre-paid phone credit and sim card or money for purchasing phone credit)
- Obtain and document informed consent from the woman for remote AN contacts

Alternate Delivery of Antenatal Contacts

Unfortunately, data suggests that many countries are currently not meeting the WHO eight AN contact guidance and less than 65% of women receive at least four AN contacts [11]. Whilst this information does not change recommendations, it needs to be considered in light of potential disruption to usual services and may mean the resources, in already low-resource settings are diverted for the COVID response. This guidance, in no way supports disruption to, or reduction of sexual and reproductive services but understands that during the current COVID pandemic different ways of working may need to be considered to ensure all women, at the very least, have access to evidence-based antenatal care. Once the pandemic status is lifted it is vital that countries continue striving to provide the WHO recommended level of antenatal care.

Wherever possible **the current WHO schedule of eight AN contacts should be provided and maintained** [10, 12]. Where technology and services are available, some of these contacts may be a remote AN contact. The schedule below offers guidance on which contacts might best be undertaken face-to-face and which might suit a remote contact (Table 1.).

Regardless of type of contact ALL women need to have:

- Assessment for, and information on, possible COVID-19 symptoms*
 - If women report symptoms or contact with suspected/confirmed COVID provide country-specific information on mandatory self-isolation and advise phone contact or rescheduling where possible (if urgent need, follow Facility/Country recommendations for seeking care)
- Information on Danger Signs** in pregnancy and Birth Preparedness*** discussion [13]
- Ongoing pregnancy risk assessment – including emotional wellbeing and personal safety
 - If risk assessment identifies potential or actual complications more frequent contacts need to occur and these may need to be face-to-face
- Adequate documentation of care provision to ensure appropriate care planning

If necessary, services must develop a process for integrating remote contact documentation in women's hand-held records.

* COVID-19 Symptoms – fever, tiredness, dry cough, aches and pains, nasal congestion, runny nose, sore throat or diarrhea (World Health Organization, 2020)

**Danger signs include: Vaginal bleeding; Convulsions/fits; Severe headache and/or blurred vision; Fever and too weak to get out of bed; Severe abdominal pain; Fast or difficult breathing (World Health Organization, 2017)

*** Birth Preparedness planning includes knowing Danger Signs; planned birth place, skilled birth attendant and transport; identifying companion (World Health Organization, 2016)

Alternate Delivery of Contact during COVID-19 Tables

Table 1. Antenatal Contacts – Remote Contact available

Current WHO Recommended Antenatal Contacts	Alternate Modality of Antenatal Contact – where remote contact available (must have COVID-19 Symptoms, Danger Signs** and Birth Preparedness *** information)
1 – 12 weeks	<u>Face to Face</u> Comprehensive history and plan for care BP/ Blood tests USS – where available Initial risk assessment
2 – 20 weeks	Remote contact – including ongoing risk assessment
3 – 26 weeks	Remote contact – including ongoing risk assessment
4 – 30 weeks	<u>Face-to-Face</u> BP/Blood tests and Abdominal Palpation including FHR. Ongoing risk assessment
5 – 34 weeks	Remote contact - including ongoing risk assessment
6 – 36 weeks	<u>Face-to-Face</u> BP/Blood tests and Abdominal Palpation including FHR. Ongoing risk assessment Birth planning
7 – 38 weeks	Remote contact – unless risk factors for hypertension in pregnancy or growth restriction identified previously
8 – 40 weeks	<u>Face-to-Face</u> BP/Blood tests and Abdominal Palpation including FHR. Ongoing risk assessment Birth planning

* COVID-19 Symptoms – fever, tiredness, dry cough, aches and pains, nasal congestion, runny nose, sore throat or diarrhea (World Health Organization, 2020)

**Danger signs include: Vaginal bleeding; Convulsions/fits; Severe headache and/or blurred vision; Fever and too weak to get out of bed; Severe abdominal pain; Fast or difficult breathing (World Health Organization, 2017)

*** Birth Preparedness planning includes knowing Danger Signs; planned birth place, skilled birth attendant and transport; identifying companion (World Health Organization, 2016)

Country-specific protocols that may require consideration

Each country or practice setting may have protocols, policies and treatment regimens that need to be considered when altering standard AN contacts schedule and delivery modality. These may include but are not limited to:

- Regimes for, and supply of, Iron; Folic Acid; Calcium; and, other context-specific recommended supplementation
- Preventative measures/treatments such as:
 - anthelmintic prophylaxis and treatment
 - vaccination programs including tetanus toxoid
 - Malaria prophylaxis and treatment
 - antiretroviral therapy and HIV pre-exposure prophylaxis
 - routine disease and/or infection screening and treatment

Procedures for follow-up interventions, provision of supplies, and, compliance monitoring will need to be considered. Clear procedures are also required for documentation/record keeping and emergency referral processes.

Remote Antenatal Contacts Checklist

The following guidance is for remote antenatal contacts – standard practice should continue for all face-to-face visits. Where necessary, refer to local guidance on what should occur at usual antenatal contacts. This is not a comprehensive guide to content of antenatal visits – it is a guide to how remote visits might be structured.

Remote Antenatal Contacts Checklist
ALL contacts regardless of method should include:
Respectful Maternity Care – includes: ✓ Treating all women with dignity and respect ✓ Maintaining confidentiality and privacy ✓ Freedom from discrimination ✓ Supporting women’s right to information and informed autonomous decision making
Suggested actions at every contact: ✓ Introduce yourself and greet the woman in a friendly manner ✓ Assessment for possible COVID-19 symptoms (both woman and any support persons) and refer to country/facility guidance or pathway for care if symptoms identified ✓ Enquire about the woman’s general health and wellbeing ✓ Consider physical, social, emotional and cultural wellbeing ✓ Ask about pregnancy progress ✓ Undertake routine observation and assessment ✓ Explain all tests and procedures and obtain consent ✓ Review history and undertake ongoing assessment of risk factors ✓ Discuss danger signs • Vaginal bleeding • Convulsions/fits • Severe headache and/or blurred vision • Fever and too weak to get out of bed • Severe abdominal pain • Fast or difficult breathing ✓ Offer time for questions – take time to answer ✓ Provide gestation and pregnancy-specific information and education ✓ Undertake consultation and referral where necessary ✓ Discuss plan for emergency transport from the woman’s home to a health facility if needed ✓ Plan for next AN contact and ongoing care ✓ Document assessments, discussions and plans for continued care

ANNEX 1: Face to Face Contact 1, and Remote Contacts 2 and 3		
Initial Face-to-Face Contact 1 (12 weeks)		
12 weeks (First trimester)	Standard first AN contact In addition to the standard first AN contact, assessments /activities need to ensure: • Information about telehealth and schedule of AN contacts and obtain consent for phone/video calls. Confirm correct phone number for the woman and also a backup phone number • Ensure the woman has a contact number for midwife/practitioner providing remote AN contact or hospital/health service contact • Ensure woman enough iron, folic acid, calcium etc. to help avoid facility-based AN contact just to obtain supplies	
Remote Contacts 2 and 3 (20 and 26 weeks)		
Suggested actions at every contact: ✓ Introduce yourself and greet the woman in a friendly manner ✓ Assessment for possible COVID-19 symptoms (both woman and any support persons) and refer to country/facility guidance or pathway for care if symptoms identified ✓ Enquire about the woman's general health and wellbeing ✓ Consider physical, social, emotional and cultural wellbeing ✓ Ask about pregnancy progress ✓ Undertake routine observation and assessment ✓ Explain all tests and procedures and obtain consent ✓ Review history and undertake ongoing assessment of risk factors ✓ Discuss danger signs • Vaginal bleeding • Convulsions/fits • Severe headache and/or blurred vision • Fever and too weak to get out of bed • Severe abdominal pain • Fast or difficult breathing ✓ Offer time for questions – take time to answer ✓ Provide gestation and pregnancy-specific information and education ✓ Undertake consultation and referral where necessary ✓ Discuss plan for emergency transport from the woman's home to a health facility if needed ✓ Plan for next AN contact and ongoing care ✓ Document assessments, discussions and plans for continued care		
20 and 26 weeks (Second trimester)	Introduce self and friendly greeting	☐
	• Respectful Maternity Care	
	How are you feeling today?	☐
	Calculate and confirm gestation with woman	☐
	How is your pregnancy going so far?	☐
	• Discuss any results from previous AN contact(s)	

	Were any problems identified at your initial AN contact? • Ongoing risk assessment	☐
	Do you feel your baby/self getting bigger? • Maternal impression on growth	☐
	Tell me about how your baby moves? • Discuss expected patterns of movement as pregnancy progresses	☐
	Are you eating and drinking well? • Consider dietary advice	☐
	Are you taking any medications (Iron/parasite etc)? • Discuss routine supplementation/medications	☐
	Are you having any trouble going to the toilet? • Signs of UTI? • Constipation?	☐
	Have you noticed any danger signs? • Vaginal bleeding • Convulsions/fits • Severe headache and/or blurred vision • Fever and too weak to get out of bed • Severe abdominal pain • Fast or difficult breathing If danger sign present – consult or refer as per usual practice/policy	☐
	What would you do if you did have any danger signs? • Start Birth Preparedness discussion • Include where and how to seek help	☐
	Would you be able to get to the nearest health service? How? • Access to transport • Finances	☐
	Are you worrying a lot about anything? • Emotional assessment	☐
	Are you having trouble sleeping? • Emotional assessment	☐
	Do you feel safe at home? • IPV/GBV assessment • Provide information on services and contact number (where available)	☐
	Have you got some people who can provide you with support or help you if you need help? • Emotional support • Safety planning	☐
	Consider Health Promotion education • Breastfeeding and early skin-to-skin • Family planning and Birth Spacing • Preventative treatments used in context of practice	☐
	Depending on schedule of contacts: • Make next appointment	☐

	Do you have any other questions? Or Is there anything you want to talk about?	☐
	Remind the woman of importance of antenatal care, keeping her next AN contact and the process to follow if she has concerns regarding pregnancy or any danger signs.	☐

Consider:

- ✓ Is this woman due for any routine testing – can it be delayed until the next face-to-face AN contact?
- ✓ What information or education does this woman need at this gestation?
 - Discuss signs of preterm labour and what to do if she thinks labour is starting
 - Discuss fetal movements and what to do if she notices a change in the movement pattern
- ✓ Have you identified any new risk factors? If so,
- ✓ Does this woman need a face-to-face AN contact?
- ✓ Does this woman know the referral pathway for accessing hospital services during COVID-19 (i.e.: Do pregnant women need to be seen in a different location to usual at the hospital? Where do they go for triage and initial exposure risk screen etc?)
- ✓ How/where will you document this contact?
- ✓ Document date and details of previous phone contact in woman's hand held record

ANNEX 2: Face to Face Contact 4, and Remote Contact 5		
Face-to-Face Contact 4 (at approximately 30 weeks)		
30 weeks (Third trimester)	Standard subsequent AN contact	
Remote Contact 5 (34 Weeks)		
Suggested actions at every contact:		
✓ Introduce yourself and greet the woman in a friendly manner ✓ Assessment for possible COVID-19 symptoms (both woman and any support persons) and refer to country/facility guidance or pathway for care if symptoms identified ✓ Enquire about the woman’s general health and wellbeing ✓ Consider physical, social, emotional and cultural wellbeing ✓ Ask about pregnancy progress ✓ Undertake routine observation and assessment ✓ Explain all tests and procedures and obtain consent ✓ Review history and undertake ongoing assessment of risk factors ✓ Discuss danger signs • Vaginal bleeding • Convulsions/fits • Severe headache and/or blurred vision • Fever and too weak to get out of bed • Severe abdominal pain • Fast or difficult breathing ✓ Offer time for questions – take time to answer ✓ Provide gestation and pregnancy-specific information and education ✓ Undertake consultation and referral where necessary ✓ Discuss plan for emergency transport from the woman’s home to a health facility if needed ✓ Plan for next AN contact and ongoing care ✓ Document assessments, discussions and plans for continued care		
34 weeks (Third trimester)	Introduce self and friendly greeting • Respectful Maternity Care	☐
	How are you feeling today?	☐
	Calculate and confirm gestation with woman	☐
	How is your pregnancy going so far? Or How have you been going since the last AN contact? • Discuss any results from previous AN contact(s)	☐
	Have you had any problems identified that might affect your pregnancy? • Ongoing risk assessment • May require prompting – bleeding, diabetes, blood pressure etc	☐
	Was your baby’s growth measured at your last AN contact – did the midwife have any concerns? Do you feel your baby has grown since then? • Maternal impression on growth	☐

	Tell me about how your baby moves? • Discuss normal patterns of movement as pregnancy progresses • Provide information on what to do if she feels her baby is moving less or differently to usual	☐
	Are you eating and drinking well? Do you feel like you are gaining weight? • Consider dietary advice	☐
	Are you taking any medications (Iron/parasite etc)? • Discuss any routine supplementation/medications	☐
	Are you having any trouble going to the toilet? • Signs of UTI? • Constipation?	☐
	Have you noticed any danger signs? • Vaginal bleeding • Convulsions/fits • Severe headache and/or blurred vision • Fever and too weak to get out of bed • Severe abdominal pain • Fast or difficult breathing If danger sign present – consult or refer as per usual practice/policy	☐
	What would you do if you did have any danger signs? • Start Birth Preparedness discussion • Include where and how to seek help	☐
	Tell me some signs that might indicate your labour is starting? • Discuss preterm labour and when to seek help • Discuss spontaneous rupture of membranes and when to seek help	☐
	Who will be your companion in labour? • Discuss importance of companion in labour	☐
	Would you be able to get to the nearest health service? How? • Access to transport • Finances	☐
	Are you worrying a lot about anything? • Emotional assessment	☐
	Are you having trouble sleeping? • Emotional assessment	☐
	Do you feel safe at home? • IPV/GBV assessment	☐
	Have you got some people who can provide you with support or help you if you need help? • Emotional support • Safety planning	☐
	Consider Health Promotion education • Breastfeeding and early skin-to-skin • Family planning and Birth Spacing	☐

	Preventative treatments used in context of practice	
	Depending on schedule of contacts: Make next appointment	☐
	Do you have any other questions?	☐
	Remind the woman of importance of antenatal care, keeping her next AN contact and the process to follow if she has concerns regarding pregnancy, onset of labour or any danger signs.	☐

Consider:

- ✓ Is this woman due for any routine testing – can it be delayed until the next face-to-face AN contact?
- ✓ What information or education does this woman need at this gestation?
 - Discuss signs of preterm labour and what to do if she thinks labour is starting
 - Discuss fetal movements and what to do if she notices a change in the movement pattern
 - Discuss birth preparedness
- ✓ Have you identified any new risk factors? If so,
- ✓ Does this woman need a face-to-face AN contact?
- ✓ How/where will you document this contact?
- ✓ Document date and details of previous phone contact in woman's hand held record

Annex 3: Face to Face Contact 6, Remote Contact 7, Face to Face Contact 8

Face-to-Face Contact 6 (at approximately 36 weeks)		
36 weeks (Third trimester)	Standard subsequent AN contact	
Remote Contact 7 (38 Weeks)		
Suggested actions at every contact:		
✓ Introduce yourself and greet the woman in a friendly manner ✓ Assessment for possible COVID-19 symptoms (both woman and any support persons) and refer to country/facility guidance or pathway for care if symptoms identified ✓ Enquire about the woman’s general health and wellbeing ✓ Consider physical, social, emotional and cultural wellbeing ✓ Ask about pregnancy progress ✓ Undertake routine observation and assessment ✓ Explain all tests and procedures and obtain consent ✓ Review history and undertake ongoing assessment of risk factors ✓ Discuss danger signs • Vaginal bleeding • Convulsions/fits • Severe headache and/or blurred vision • Fever and too weak to get out of bed • Severe abdominal pain • Fast or difficult breathing ✓ Offer time for questions – take time to answer ✓ Provide gestation and pregnancy-specific information and education ✓ Undertake consultation and referral where necessary ✓ Discuss plan for emergency transport from the woman’s home to a health facility if needed ✓ Plan for next AN contact and ongoing care ✓ Document assessments, discussions and plans for continued care		
38 weeks (Late third trimester)	Introduce self and friendly greeting • Respectful Maternity Care	☐
	How are you feeling today?	☐
	Calculate and confirm gestation with woman	☐
	How is your pregnancy going so far? Or How have you been going since the last AN contact? • Discuss any results from previous AN contact(s)	☐
	Have you had any problems identified that might affect your pregnancy? • Ongoing risk assessment • May require prompting – bleeding, diabetes, blood pressure etc	☐
	Was your baby’s growth measured at your last AN contact – did the midwife have any concerns? Do you feel your baby has grown since then? • Maternal impression on growth	☐

	Tell me about how your baby moves? • Discuss normal patterns of movement as pregnancy progresses • Provide information on what to do if she feels her baby is moving less or differently to usual	☐
	Are you eating and drinking well? Do you feel like you are gaining weight? • Consider dietary advice	☐
	Are you taking any medications (Iron/parasite etc)? • Discuss any routine supplementation/medications	☐
	Are you having any trouble going to the toilet? • Signs of UTI? • Constipation?	☐
	Have you noticed any danger signs? • Vaginal bleeding • Convulsions/fits • Severe headache and/or blurred vision • Fever and too weak to get out of bed • Severe abdominal pain • Fast or difficult breathing If danger sign present – consult or refer as per usual practice/policy	☐
	What would you do if you did have any danger signs? • Birth Preparedness discussion • Include where and how to seek help	☐
	Tell me some signs that might indicate your labour is starting • Discuss spontaneous rupture of membranes and when to seek help	☐
	Who will be your companion in labour? • Discuss importance of companion in labour (WHO recommendation) and the need to ensure the companion is well and free of COVID symptoms - discuss local restrictions if present • Discuss the need to plan for an alternate birth companion	☐
	Would you be able to get to the nearest health service? How? • Access to transport • Finances	☐
	Are you worrying a lot about anything? • Emotional assessment	☐
	Are you having trouble sleeping? • Emotional assessment	☐
	Do you feel safe at home? • IPV/GBV assessment	☐
	Have you got some people who can provide you with support or help you if you need help? • Emotional support • Safety planning	☐

	Consider Health Promotion education - Breastfeeding and early skin-to-skin - Family planning and Birth Spacing - Preventative treatments used in context of practice	☐
	Make next appointment	☐
	Do you have any other questions?	☐
	Remind the woman of importance of antenatal care, keeping her next AN contact and the process to follow if she has concerns regarding pregnancy, onset of labour or any danger signs.	☐
Consider: ✓ Is this woman due for any routine testing – can it be delayed until the next face-to-face AN contact? ✓ What information or education does this woman need at this gestation? - Discuss signs of labour and what to do if she thinks labour is starting - Discuss importance of a skilled birth attendant for labour and birth - Discuss fetal movements and what to do if she notices a change in the movement pattern - Discuss birth preparedness - Discuss what the woman needs to bring with her when she comes in for the birth - Discuss breastfeeding and immediate skin-to-skin contact - Discuss potential for early discharge / modified schedule of in-person PN AN contacts in context of COVID-19 ✓ Have you identified any new risk factors? If so, ✓ Does this woman need a face-to-face AN contact? ✓ How/where will you document this contact? ✓ Document date and details of previous phone contact in woman's hand held record		
Face-to-Face Contact (39-40 weeks)		
39-40 weeks (Late third trimester)	Standard subsequent AN contact If further AN contacts required beyond 40 weeks, these must be face-to-face	

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COVID-19

Technical Brief Package For Maternity Services

Part 3: Postnatal Care Services

May 2020



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Postnatal Care during COVID-19

Introduction

It is anticipated that COVID-19 (the disease caused by the novel coronavirus named SAR-CoV-2) will occur in most, if not all countries. A key fact about COVID-19 is that the vast majority of infections will result in very mild or no symptoms. Not everybody is at risk of severe disease. Persons of advancing age and those with existing respiratory, cardiac and/or metabolic disorders and immunodeficiencies are at higher risk of moderate to severe disease.

Limited data are available on COVID-19 in pregnancy, but the studies published to date do not show an increased risk of severe disease in late pregnancy or substantial risk to the newborn. Information on the impact of COVID-19 on early pregnancy outcomes remains unavailable at the time of writing. Non-pregnant women of childbearing age are also at low risk of severe disease [1, 2].

The impact on acute care services in settings with under-resourced health systems is likely to be substantial. **Maternity services should continue to be prioritized as an essential core health service, and other sexual and reproductive health care such as family planning, emergency contraception, treatment of sexually transmitted infections, access to gender based violence support services and where legal safe abortion services, to the full extent of the law, also need to remain available as core health services.** [3]

Maternity care providers (including midwives and all other health care workers providing maternal and newborn care), whether based in health facilities or within the community, are essential health care workers and must be protected and prioritized to continue providing care to childbearing women and their babies. Deploying maternity care workers away from providing maternity care to work in public health or general medical areas during this pandemic is likely to increase poor maternal and newborn outcomes.

Maternity care providers have the right to full access for all personal protective equipment (PPE), sanitation and a safe and respectful working environment [3]. Maintaining a healthy workforce will ensure ongoing quality care for women and their newborns; without healthy midwives and other maternity care providers there will be limited care for women and newborns.

As part of **COVID-19 Pandemic UNFPA Global Response Plan**, the UNFPA response involves a 3-pronged approach

1. Protect maternity care providers and the maternal health workforce
2. Provide safe and effective maternity care to women
3. Maintain and protect maternal health systems

Detailed practical recommendations across these 3 prongs for antenatal care, intrapartum and postnatal care have been outlined in: UNFPA COVID-19 Technical Brief Package for Maternity Services: Part 1: Delivery of Facility Based Maternity Services [4].

This document serves as an adjunct to the Technical Brief to provide interim guidance on providing telehealth postnatal care (PNC) in the immediate clinical situation. These recommendations are provided as a resource for UNFPA staff, maternity care providers and other agencies, based on a combination of WHO and other maternity-based organizations' guidelines, good practice and expert advice based on the latest scientific evidence. The situation with COVID-19 is evolving rapidly and the guidance will continue to be updated when new evidence or information becomes available.

Postnatal Care

The overarching aim of this guidance is to ensure maternity care providers can deliver respectful and individualised care services that promote the safety of women, babies, families and health professionals during the COVID-19 pandemic.

'All pregnant women, including those with confirmed or suspected COVID-19 infections, have the right to high quality care before, during and after childbirth. This includes antenatal, newborn, postnatal, intrapartum and mental health care. [5].

In the coming weeks and months maternity care providers will try to minimise inpatient length of stay and direct patient contact in non-urgent situations in an attempt to minimise the spread of COVID-19 [1, 5]. As a result, standard health facility postnatal care routines and follow-up community contacts may change. Well women and their babies may be discharged from health services earlier depending on changes to local policies, and some postnatal contacts may be undertaken using telehealth⁴, that is virtually by phone or video chat (remote contact)⁵, to ensure that there is no disruption in service or breakdown in women's maternity care. **Some contacts with the health facility might be replaced by home visits by appropriately trained health care workers.** Midwives and other key providers of postnatal care will need to use clinical judgement in deciding which women may be suitable for an alternate care pathway involving early discharge and some remote contacts. Primarily this will be women who have reliable mobile phone access and are deemed to be at low-risk of complications

When it is necessary to physically examine women during a contact, the physical part of the examination will be undertaken respectfully but quickly to minimise time spent within the recommended 1-meter distancing [5].

Health services and clinics may:

✓ Triage and screen all women and companions for signs and symptoms of COVID-19⁶ before entering or leaving the facility

1. (See *UNFPA COVID-19 Technical Brief Package for Maternity Services*, for further recommendations about triage, exposure screening and organisation of facility based and remote antenatal/ postnatal care services) [4].

⁴ Telehealth involves the use of telecommunications and virtual technology to deliver health care outside of traditional health-care facilities.

⁵ Referred to in this document as 'remote contact'

⁶ COVID-19 Symptoms – fever, tiredness, dry cough, aches and pains, nasal congestion, runny nose, sore throat or diarrhoea

- ✓ Restrict attendance for PNC visits to include only the women, an asymptomatic companion of choice and the maternity care provider. Wherever possible, children, additional family members and companions should not accompany the women into the clinic visit.
- ✓ Change delivery modality for scheduled postnatal contacts (after risk-assessment)
- ✓ Separate physical assessment from discussion/enquiry part of postnatal contact [1, 4, 6, 7]

Regardless of where or how postnatal contact occurs, respectful maternity care must be at the forefront of the care provided [4, 7]. In these unprecedented times, women may be scared or anxious for themselves, their babies and their families. This fear and anxiety may be made worse by seeing their care providers in extensive personal protective equipment (PPE) as this can impact on simple actions such as seeing a kind smile. Health professions need to ensure every interaction with every woman is friendly, kind and respectful.

Where possible, continuity of midwifery care should be provided throughout the postpartum period. This is known to improve positive outcomes and will reduce the number of caregivers in contact with the woman and her baby [3, 8].

The following document provides practical guidance on postnatal contacts undertaken remotely (phone/messaging application/telehealth). This guidance provides direction for services to continue to provide essential and respectful postnatal care during the COVID-19 pandemic. It is intended to support services in adjusting to a different way of delivering postnatal care **but does not replace** usual policies and protocols regarding postnatal care provision. Services should revert to the *WHO recommendations on postnatal care of the mother and newborn* guidance once the pandemic status is lifted [9].

Prior to commencing telehealth services:

- ✓ Develop a facility or health system strategy such as a health information management system, to introduce and monitor changes in postnatal contacts
- ✓ Provide staff with technology, training and systems to provide remote postnatal contacts including sufficient resources for midwives to undertake phone contacts (access to mobile phone, charger, pre-paid phone credit and sim card or money for purchasing phone credit)
- ✓ Obtain and document informed consent from the woman for remote postnatal contacts and ensure the woman is able to contact the health service if any concerns

Alternate Delivery of Contact during COVID-19

Postnatal care should be individualized in accordance with the woman and newborn needs. The WHO minimum recommended number of postnatal contacts is four [9]. Remote contact can be suitable for women and newborn who are considered low risk. When determining if women are suitable for remote contact, the maternity care provider needs to consider support available for the women and her parity – for example a low-risk, multiparous woman who has a history of successful breastfeeding may be suited to more remote contacts than a primiparous woman with minimal home support.

Face-to-face contact should be prioritized for women and/or newborn who have:

- ✓ Known or are at risk of social and emotional vulnerabilities, including gender-based violence and mental health issues
- ✓ Complicated or operative births
- ✓ Prematurity/low-birth weight
- ✓ Other maternal or newborn complexities. This may include issues with infant feeding that can't be adequately assessed remotely [1]

At each contact, regardless of the type, ALL women and newborn need to have:

- ✓ Assessment for, and information on, possible COVID-19 symptoms*
- ✓ If women report symptoms or contact with suspected/confirmed COVID provide country-specific information on mandatory self-isolation and advise phone contact or rescheduling where possible (if urgent need, follow Facility/Country recommendations for seeking care)
- ✓ Newborn Danger Signs** and Maternal Complications*** information and discussion
- ✓ Ongoing risk assessment – including emotional wellbeing and personal safety
- ✓ If risk assessment identifies potential or actual complications more frequent contacts need to occur and these may need to be face-to-face
- ✓ Adequate documentation of care provision to ensure appropriate care planning

If necessary, services must develop a process for integrating remote contact documentation in women's hand-held records.

Table 1. Postnatal Contacts – Remote contact available

Current WHO 2013 Postnatal Minimum Contact Recommendations [9]	Alternate modality of postnatal contact – where remote contact available (must have COVID-19 symptoms*, Newborn Danger Signs** and Maternal Complications*** information and education)	
Birth – 24 hours	<u>Face-to-Face</u> Assess infective risk and ensure recommended PPE worn Routine face-to-face assessment and pre discharge checklist**** if applicable. Ensure provision of adequate routine and prescribed medication to avoid unnecessary visits to health services Facility birth – discharge according to current, local guidelines. Ensure that women who are being discharged earlier than usual can be well supported at home and there are systems in place for ongoing home based and/or telephone support by a maternity care provider Birth at Home – should have face-to-face assessment by Skilled Birth Attendant within 24 hours	
Day 3 (48-72 hours)	<u>Remote Contact</u> Includes ongoing risk assessment	Modality can be swapped depending on individual woman's need
Week 2 (7-14 days)	<u>Face-to-Face Contact</u> Assess infective risk and ensure recommended PPE worn Includes ongoing risk assessment	
Week 6 (~42 days)	<u>Remote Contact</u> Includes ongoing risk assessment Ensure contraceptive needs have been discussed and addressed	

* COVID-19 Symptoms – fever, tiredness, dry cough, aches and pains, nasal congestion, runny nose, sore throat or diarrhoea [5].

** Newborn Danger Signs include: stopped feeding well; convulsions; fast breathing (rate $\geq$ 60/min); severe chest indrawing; no spontaneous movement; fever (temp $\geq$ 37.5); low body temperature (temp $<$ 35.5); any jaundice in first 24hrs or yellow palms/soles at any age [9].

***Signs or symptoms of postpartum haemorrhage; pre-eclampsia/eclampsia; infection; and, thromboembolism

**** If available, use existing or consider introducing e.g. https://www.healthynewbornnetwork.org/hnn-content/uploads/PNC-Checklist_Asia-1.pdf [10]

This table is based on the minimum recommended number of postnatal visits. Many women would benefit from more intensive support in the postnatal period and this may include more remote or face-to-face contacts. The number of contacts should be based on each woman's individual needs.

For face-to-face contacts ensure appropriate PPE as per WHO guidelines [11, 12]. For further details see: https://apps.who.int/iris/bitstream/handle/10665/331498/WHO-2019-nCoV-IPCPPE_use-2020.2-eng.pdf and [https://www.who.int/publications-detail/advice-on-the-use-of-masks-in-the-community-during-home-care-and-in-healthcare-settings-in-the-context-of-the-novel-coronavirus-\(2019-ncov\)-outbreak](https://www.who.int/publications-detail/advice-on-the-use-of-masks-in-the-community-during-home-care-and-in-healthcare-settings-in-the-context-of-the-novel-coronavirus-(2019-ncov)-outbreak)

Remote Postnatal Contacts Checklist

The following guidance is for remote postnatal contacts – standard practice should continue for all face-to-face visits. Where necessary, refer to local guidance on what should occur at routine postnatal contacts. This is not a comprehensive guide to content of postnatal visits – it is a guide to how remote visits might be structured.

Discuss support resources/network at home and any changes that may have occurred (i.e: family who can no longer travel to support the woman at home, childcare providers who are no longer available). Connect the woman to community support resources where available.

Discuss when and how the woman can contact their postpartum midwife or maternity care provider, especially in the case of an emergency.

Discuss family planning/birth spacing - all methods of contraception, including long acting reversible contraceptives, should be discussed in context of how provision of contraception may change within the limitations of decreased postpartum in-person visits. Discuss risks of failure of traditional methods of birth spacing. Discuss how and where to obtain contraceptive services if these have changed with COVID and aim to provide contraceptive of choice prior to discharge from health facility where feasible, or otherwise during postnatal face to face visits.

Remote Postnatal Contacts

Remote Postnatal Contacts Checklist
ALL contacts regardless of method
Respectful Maternity Care – includes: ✓ Treating all women with dignity and respect ✓ Maintaining confidentiality and privacy ✓ Freedom from discrimination ✓ Supporting women’s right to information and informed autonomous decision making
Suggested actions ✓ Introduce yourself and greet the woman in a friendly manner ✓ Assessment for possible COVID-19 symptoms (both woman, baby and household contacts) and refer to country/facility guidance or pathway for care if symptoms identified ✓ Enquire about the woman’s general health and wellbeing ✓ Consider physical, social, emotional and cultural wellbeing ✓ Enquire about the baby’s wellbeing – include input, output and activity ✓ Undertake routine observation and assessment – both woman and baby ✓ Explain all assessments, tests and procedures and obtain consent ✓ Review pregnancy, birth and history to date and undertake ongoing assessment of risk factors ✓ Discuss newborn danger signs: • stopped feeding well • convulsions • fast breathing (rate≥60/min) • severe chest indrawing • no spontaneous movement • fever (temp ≥37.5) • low body temperature (temp <35.5) • any jaundice in first 24hrs or yellow palms/soles at any age ✓ Discuss maternal postnatal complications signs and symptoms: • postpartum haemorrhage • pre-eclampsia/eclampsia • infection • thromboembolism • mastitis ✓ Discuss family planning/birth spacing ✓ Offer time for questions – take time to answer ✓ Provide individualised information and education ✓ Undertake consultation and referral where necessary ✓ Discuss plan for emergency transport from the woman’s home to a health facility if needed ✓ Plan for next postnatal contact and ongoing care ✓ Document assessments, discussions and plans for continued care

Initial Face-to-Face Contact Birth – 24 hours	
✓ Routine initial assessments, education and discharge planning ✓ In addition to the standard first postnatal contact assessments/activities, need to ensure: Information about telehealth and schedule of postnatal contacts and obtain consent for phone/video calls. ✓ Confirm correct phone number for the woman and a backup phone number ✓ Ensure the woman has a contact number for midwife/practitioner providing remote postnatal contact or hospital/health service contact ✓ Ensure woman has enough iron, folic acid and other medications to help avoid facility-based postnatal contact just to obtain supplies	
Remote Contact Guidance - Modality can be swapped depending on individual woman's need	
Introduce self and friendly greeting Respectful Maternity Care	☐
How are you feeling today? Assessment for possible COVID-19 symptoms (both woman, baby and household contacts) and refer to country/facility guidance or pathway for care if symptoms identified	☐
Confirm date, time and mode of birth Check if this is a first or subsequent child	☐
Were any problems identified during your pregnancy or at the time of the birth? Ongoing risk assessment	☐
Emotional Wellbeing Assessment	
How are you recovering from the labour and birth? Discuss labour and birth and allow debrief	☐
Are you getting some sleep? Emotional assessment Discuss newborn sleeping patterns	☐
Are you worrying a lot about anything? Emotional assessment Discuss coping strategies	☐
Tell me about your moods? Have you noticed any changes? Emotional assessment Discuss mood fluctuations and common postnatal feelings Include early emotions – should be resolving by Day 10 Use depression screening tool if in use in context Discuss signs/symptoms of Postnatal Depression and referral where appropriate	☐
Do you feel safe at home? IPV/GBV assessment Provide information on services and contact number (where available)	☐
Do you have some people who can provide you with support or help you if you need help? Emotional /physical support Safety planning	☐
Physical Wellbeing Assessment	
Are you eating and drinking well? Consider dietary advice	☐
Are you taking any medications (Iron/parasite etc)? Discuss routine supplementation/medications	☐
Are you worried about your bleeding? If Yes, Tell me about how much bleeding you have?	☐

How often do you need to change your sanitary napkin? What colour is the bleeding? Are any clots present? Does it have an unpleasant smell? Discuss normal physiological changes postpartum and expected lochia loss up to 4-6 weeks after birth Discuss when to seek urgent care for abnormal postpartum bleeding If concerns, consult or refer as per usual practice/policy	
Are you having any trouble going to the toilet? Urinary incontinence or retention Constipation/Faecal incontinence	☐
Did you have any tears or stitches? How does that area feel? Rate pain scale 0-10 – (zero no pain, 10 extreme pain) Are you able to walk and sit without too much pain? What are you doing to keep the area clean? Discuss perineal hygiene and care and pelvic floor exercises If concerns, consult or refer as per usual practice/policy	☐
Are you mobilizing regularly? Discuss venous thromboembolism prevention	☐
Have you noticed any danger signs/symptoms such as: Increased vaginal bleeding or clots? Smelly discharge? Severe headache and/or blurred vision? Fever and too weak to get out of bed? Severe pain? Fast or difficult breathing? Flu-like symptoms with painful or reddened breasts? Painful and/or swollen calves? If signs/symptoms present – consult or refer as per usual practice/policy	☐
What would you do if you did have any of these signs/symptoms? Include where and how to seek help	☐
Would you be able to get to the nearest health service? How? Access to transport Finances	☐
Infant Feeding Assessment	
Are you breastfeeding? If yes, How are your breasts and nipples feeling? Breasts – comfort, fullness, pain, redness. Nipples – intact, cracked, bleeding. Discuss care of nipples and management of breast engorgement/hand expressing Is the baby waking regularly for feeding? Does the baby latch well and suck well? Discuss signs of a good latch and sucking pattern How often does the baby breastfeed? Discuss normal expected breastfeeding patterns for age (48-72 hours, 7-14 days and around 6 weeks) How many wet/dirty nappies (diapers) has the baby had in the last 24 hours? Discuss normal output for age Are you keeping your baby skin-to-skin as much as possible? Discuss benefits of skin-to-skin	☐

Discuss importance of exclusive breastfeeding and strategies to ensure ongoing adequate milk supply Provide information and contact details on community services for support with breastfeeding (if available)	
If formula feeding: Discuss importance of handwashing before formula preparation, sterilising equipment and following instructions for mixing formula with clean drinking water If relevant, discuss initiation of breastfeeding if woman is open to discussion or if delaying initial breastfeeding due to culturally influenced beliefs	☐
Newborn Assessment	
How is your baby going? General newborn wellbeing. Discuss normal infant behaviours/sleep patterns and settling techniques	☐
Are you worried about anything to do with your baby? Maternal assessment of baby	☐
Have you noticed any of the following danger signs? Has your baby stopped feeding well? Has your baby's movements or activity levels decreased? Has your baby had any convulsions/seizures? Is your baby difficult to wake up or very sleepy all the time? Has your baby felt too hot or too cold for no reason? Discuss appropriate clothing – 1 or 2 more layers than adults only Have you noticed your baby breathing much faster than usual or does baby's chest draw-in when breathing? Does your baby have yellow discolouration of baby's palms or soles of feet? If Danger Signs present – consult or refer as per usual practice/policy Discuss seeking health care early if they notice any of these signs	☐
Newborn feeding and output - addressed above in Infant Feeding	☐
What does your baby's cord stump look like? Discuss cord care if advised in your setting	☐
Discuss importance of hand washing and general hygiene in preventing infections in newborns	☐
Consider any maternal conditions that may require additional care/treatment in the newborn, such as: HIV Untreated Syphilis or other STIs in pregnancy	☐
Give opportunity to discuss any concerns/questions	☐
Health Promotion/Education Topics	
Consider Health Promotion/Education counselling Exclusive Breastfeeding Discuss common issues such as concerns regarding not enough milk, ensuring adequate supply and breast health Integrate Lactational Amenorrhoea Method (LAM) criteria Family planning and Birth Spacing LAM as above Discuss modern methods and contraception options Ensure desired method commenced or provided before discharge after birth or during postpartum health facility contact. Ensure appropriate referral if contraceptive methods not available at time of postpartum contact. Discuss resumption of sexual relations and safe sex Nutrition information	☐

Context specific counselling such as: Malaria precautions	
Depending on schedule of contacts: Make next appointment	☐
Do you have any other questions? Or Is there anything you want to talk about?	☐
Remind the woman of importance of postnatal care, keeping her next postnatal contact and the process to follow if she has concerns regarding herself or her baby.	☐
Consider: Have you identified any new risk factors? If so, Does this woman need a face-to-face postnatal contact? Does this woman know the referral pathway for accessing hospital services during COVID-19? How/where will you document this contact?	

Reference List

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