



# Suraksha

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During  **COVID-19**  
For Gynaecologists

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## SURAKSHA MODULE – 2

# SAFE DELIVERY FOR PREGNANCIES AFFECTED BY COVID 19

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# Introduction

- All women have right to a safe and positive childbirth experience, irrespective of positive or negative COVID status. In all circumstances, maternity care providers should continue to provide client-centered, respectful skilled care and support.
- The pregnant women coming for delivery may be symptomatic or asymptomatic or high containment area.

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# Evaluation of all pregnant women presenting to the hospital

- All pregnant women should be screened for signs and symptoms of COVID-19, as well as whether they have had close contact with a confirmed case or persons under investigation, before entering the hospital for admission to the labor and delivery unit .
- Screening can include checking temperature and asking about fever and/or new cough, shortness of breath, sore throat, muscle aches, rhinorrhea/nasal congestion, and smell and taste abnormalities and asking about residence in high containment area or travel history.

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## Evaluation of all pregnant women presenting to the hospital

- Once a woman is tested positive for RT-PCR, she must be referred to a hospital specially designed for COVID care facilities identified in the public and private sector.
- These would be large multispecialty hospitals with adequate space, infrastructure and logistics. In such COVID care facilities, three demarcated zones (clean, potentially contaminated, and contaminated), each housing all the needed equipment and services for women and neonates are required for management of suspected and confirmed COVID-19 mothers.
- Every pregnant woman should be triaged at entry and then allotted into one of the zones.<sup>1</sup>

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## Standard operating procedure(SOP) for flow and Management of pregnant mothers at Triage:

- Ensure pregnant women /attendants do not directly go to the labor room without screening and workup
- All pregnant women from high containment area to be taken as COVID positive unless proved otherwise
- Maintain a distance of two meter between the admitted pregnant woman and others.
- **Rapid initial assessment for features of Severe Acute Respiratory Illness will be taken as high COVID suspects and will be admitted in designated COVID hospital.**

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# Standard operating procedure(SOP) for flow and Management of pregnant mothers at Triage:

These include pregnant woman with any one of the following symptoms: **1. FEVER** *with*

- Respiratory Rate  $\geq 30$  bpm
  - Shortness of breath
  - Cough
- SpO<sub>2</sub>  $\leq 93$  % on room air
  - Heart rate  $\geq 100$  bpm
- Altered level of consciousness
- Immediately admit in ICU for COVID suspect/confirmed.

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## Standard operating procedure(SOP) for flow and Management of pregnant mothers at Triage:

- Ask the following questions to screen whether pregnant woman is suspected COVID

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- Does the patient currently have or had in the past any symptoms of Severe Acute Respiratory Illness requiring hospital admission?

- Fever with cough **Yes / No**

- Fever with shortness of breath **Yes / No**

- Does the patient have any one of the following symptoms: Fever or Cough or Shortness of Breath With

- History of travel within the past 14 days **Yes / No**

Or

- History of contact with COVID positive patient. **Yes / No**

Or

- The patient is a healthcare worker **Yes / No**

- Is the patient asymptomatic but a high risk contact:

» Living in the same household with COVID positive. **Yes / No**

» Health care worker providing care to COVID positive **Yes/No**

» Travelling with COVID positive **Yes / No**

- Does the patient belong to hotspots/clusters/ large migration gatherings/ evacuee centres then all symptomatic patients with either

› Fever                      › Cough                      › Sore Throat                      › Runny Nose



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## Standard operating procedure(SOP) for flow and Management of pregnant mothers at Triage

- If no signs and symptoms of COVID, admit in labor room and deliver her in LR with level 2 protection.
- If signs and symptoms suggestive of mild/ moderate COVID admit in isolation ward and deliver in separate designated OT/ LR with level 3 protection.
- If pregnant woman has evidence of SARI admit ICU, with level 3 protection and their delivery will be conducted in Separate designated OT/LR whether vaginal or abdominal with level 3 protection.
- After decision for admission is taken the pregnant woman will be provided with a mask at triage with full instructions about correct usage and to keep the nose covered.
- Complete the documentation. Please ensure name, age, complete address and phone numbers are documented as it may be required later for contact tracing.

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## Strategy for COVID testing for pregnant women in India

- Pregnant women residing in clusters/containment area or in large migration gatherings/evacuees centre from hotspot districts presenting in labour or likely to deliver in next 5 days should be tested even if asymptomatic.
- Asymptomatic pregnant women should be tested in the health facilities where they were expected to deliver and all arrangements should be made to collect and transfer samples to testing facilities. Women should not be referred for lack of testing facility<sup>2</sup>.

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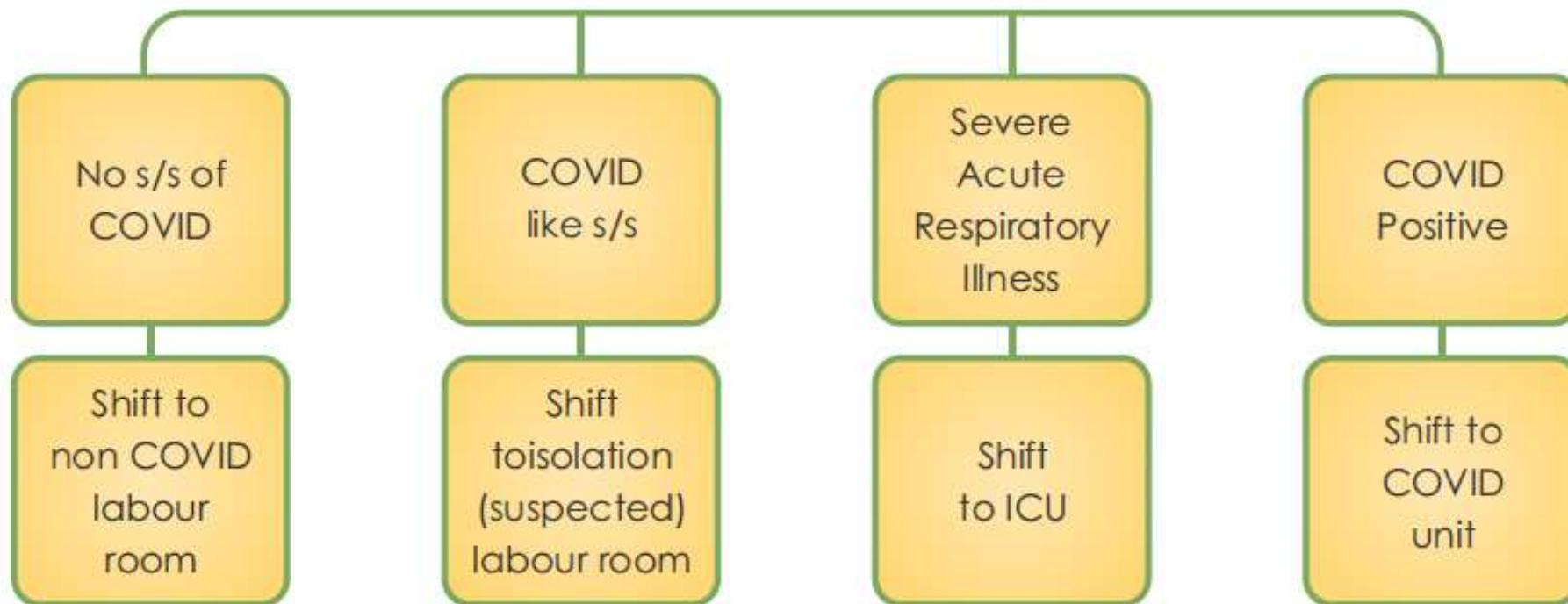
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## Triage: Rule out COVID symptoms, rule out SARI



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# Guidelines for management of all pregnant women in labour

- Generally, management of labor is not altered in women giving birth during the COVID-19 pandemic or in women with confirmed or suspected COVID-19 that is asymptomatic or mildly symptomatic<sup>3</sup>.
- Person-to-person contact and time in the labor unit and hospital should be limited, as safely feasible.
- Minimize number of people involved in any procedure including CPR.
- No CPR, crash intubation, peri-mortem cesarean sections or conducting a childbirth without protecting yourself first should be done.
- Adequate equipment and trained healthcare providers should be available for intra-partum monitoring and obstetric interventions.

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# Birth companion during labor and delivery

- A birth companion (Doula) is important to many laboring women and one support person can be permitted who must remain with the laboring woman (may not leave her room and then return).
- The support person should be screened for fever and other symptoms before entering the building and in accordance with hospital policies.
- Those with any symptoms consistent with COVID-19, exposure to a confirmed case within 14 days, or a positive test for COVID-19 within 14 days should not be allowed to attend the labor and birth.
- If screening is negative, we require that the support person wear a cloth face covering, at a minimum, consistent with CDC guidance<sup>4</sup>.

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# Induction of labour:

- There is no rationale to induce labour or deliver a woman early because of COVID-19 infection<sup>5</sup>.
- An individual assessment regarding the urgency of planned induction of labour should be done.
- If induction of labour cannot safely be delayed, the general advice for COVID 19 should be followed.

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## An aesthesia in COVID +/-COVID Suspect pregnant woman:

- Prefer regional instead of General Anesthesia unless respiratory compromise is present where General Anesthesia and subsequent ventilation will be needed.
- If general anesthesia is required, an acrylic safety box must be used at the time of intubation.
- If general anesthesia is to be administered, preoxygenate the pregnant woman with 100% oxygen for 5 minutes and provide rapid sequence induction(RSI)
- Minimum number of people required should stay in the OT during intubation and specially 15-20 minutes after extubation when risk of aerosol generation is maximum.
- Regional analgesia and anesthesia can be used in women with COVID-19 infection. Specialized techniques can be adopted for general anesthesia<sup>5</sup>

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## Once admitted in an isolation room with labour pains:

- Laboring woman must wear a mask.
- Full maternal and fetal assessment for the severity of COVID-19 symptoms & confirmation of the onset of labour which should follow a multidisciplinary team approach including an infectious diseases or medical specialist.
- SARS-CoV-2 has not been detected in vaginal secretions or amniotic fluid, so rupture of fetal membranes and internal fetal heart rate monitoring may be performed for usual indications, but data are limited<sup>6</sup>.

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# Mode of delivery

- In a pregnant woman with suspected or confirmed COVID-19 should be guided by her obstetric assessment and her physiological stability (cardio-respiratory status and oxygenation).
- COVID-19 itself is not an indication for induction of labor or cesarean section. No evidence to favor one over the other. Caesarean section should ideally be undertaken only when medically justified and dictated by usual obstetric practice.

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# 1<sup>ST</sup> Stage of Labour

- Continuous electronic fetal monitoring should be done during labor. If facilities for the continuous electronic fetal monitoring are not available, manual monitoring by frequent auscultation of fetal heart rate should be done during the labor as indicated for a high-risk delivery, but may be difficult with full PPE.
- Use designated stethoscope, BP apparatus, pulse ox meter, fetal doppler for such pregnant woman and do not share any items including mobile phones.
- Oxygenation status of women during labor should be monitored by a pulse ox meter hourly and oxygen therapy should be titrated to maintain oxygen saturation of more than 94%.
- Maternal monitoring including temperature, respiratory rate & oxygen saturations<sup>2</sup>.

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# 1<sup>ST</sup> Stage of Labour

- Intake and output of fluids should be carefully monitored in these women, and aggressive hydration should be avoided since it can lead to pulmonary edema and worsen maternal oxygenation that may already be compromised<sup>7</sup>.
- Repeated unnecessary vaginal examinations to be avoided to minimize risk of exposure to doctors.
- Strict maintenance of partograph in such pregnant woman. Unnecessary prolongation of labour is avoided and early decision for LSCS to be taken in case of suspected delay in progress of labour.

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# 1<sup>ST</sup> Stage of Labour

## MATERNAL PARAMETERS

Pulse	Respiratory rate
BP	Saturation
Intake/Output	
Uterine contractions	
PV when indicated	

## FETAL PARAMETERS

Foetal heart rate monitoring  
(Continuous / intermittent  
as indicated)

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## 2<sup>nd</sup> Stage of labour

- Active pushing during second stage of labour may increase exposure to the pregnant woman's respiratory secretions because of deep breathing and maternal expulsive efforts.
- Pregnant woman should be instructed to push with a closed mouth as maximum aerosol generation occurs at this stage.
- Barrier between chest and abdomen for women with known or suspected infection should be kept in order to prevent infection to accoucheur at foot end.
- Health care providers to maintain social distancing even when off duty / in the duty room while
- Avoid unnecessary episiotomy and instrumentation due to fear of extension and more operative intervention under anesthesia.

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## 3<sup>rd</sup> Stage of labour

- Double oxytocics for PPH prophylaxis has to be given to all pregnant woman

**It includes,**

- Inj.Oxytocin 10 IU IM
- Inj.Oxytocin 20 IU in 1 pint of RL
- Tb.misoprostol 800 mcg PR

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## 3<sup>rd</sup> Stage of labour

- Active management of third stage of labour should be routinely performed.
- Neonatal resuscitation corners located at 2 meter away from the delivery table.
- ACOG has stated that delayed umbilical cord clamping is highly unlikely to increase the risk of transmitting pathogens from an infected mother to the fetus.<sup>8</sup>
- Umbilical cord blood banking can be performed if planned; the risk of COVID-19 transmission by blood products has not been documented and is unclear at present.<sup>8</sup>

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## 3<sup>rd</sup> Stage of labour

- Though guidelines promote delayed cord clamping and skin to skin contact but in present scenario with limited evidence early cord clamping and avoidance of skin to skin contact is practiced.
- Mother-to-child transmission of corona virus during pregnancy is unlikely, but after birth, a newborn is susceptible to person-to-person spread and the virus has not been detected in amniotic fluid, breast milk , or other maternal samples<sup>9</sup>
- The World Health Organization has promoted skin to skin contact. The numerous benefits of skin to skin contact and breastfeeding substantially outweigh the potential risk of transmission and illness associated with COVID 19<sup>10</sup>. This practice of skin to skin contact has to be individualized.

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## SOP for Caesarean Section of COVID +/-COVID Suspect

- Caesarean section is reserved for those with obstetric indications.
- OT should have negative pressure facility.
- Take proper consent – inform that category one CAESAREAN SECTION cannot be performed, as the team needs time to put on PPE and prepare the entire team.
- Shift the pregnant woman in designated OT for COVID.

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## SOP for Caesarean Section of COVID +/-COVID Suspect

- Minimize the number of persons in the OT and minimize the movement of the team in and out of the OT during the procedure.
- Give preoperative antibiotic prophylaxis.
- Start blood transfusion only if indicated.
- Shift the pregnant woman back to her same allotted bed after Caesarean section

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## SOP for Caesarean Section of COVID +/-COVID Suspect

- One birth companion in level 1 protection will help pregnant woman in initiating breastfeeding.
- Proper biomedical waste management to be supervised by nursing staff after the delivery and caesarean section.
- Instruments to be sent to the CSSD for processing in double polythene bags
- Cleaning and fumigation as per hospital protocols after the procedure but wait for one hour if possible before reusing the OT.

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# Management of Pregnant woman with COVID-19- Admitted to Critical Care:

Particular considerations for pregnant women are:

- Hourly observations, monitoring both the absolute values and the trends.
- Titrate oxygen to keep saturations >94%.
- Hourly respiratory rate looking for the rate and trends: Young fit women can compensate for deterioration in respiratory function and are able to maintain normal oxygen saturations before they suddenly decompensate.
- So, a rise in the respiratory rate, even if the saturations are normal, may indicate deterioration in respiratory function and should be managed by starting or increasing oxygen.

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## Evidence based principles of management include:

- Conservative Intravenous fluid strategies
- Empirical early antibiotic for possible bacterial pneumonia
- Invasive ventilation where required
- Periodic prone positioning during mechanical ventilation but as difficult to maintain this position in pregnant women they may be placed in the lateral position.

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## Postnatal Management

- She should be encouraged to maintain the good practices of hygiene related to the puerperium and hand hygiene
- She should consume a healthy, nutritious diet to recover from the infection and build immunity.
- In case of community spread, stable neonates exposed to COVID-19 from mothers should be roomed-in with their mothers and be exclusively breastfed with appropriate hand hygiene and proper use of mask if she is willing.
- For supporting lactation, nurses trained in essential newborn care and lactation management should be provided. A healthy asymptomatic willing family member who is not positive for COVID-19 and has not been in direct contact with suspected or confirmed COVID-19 person may be allowed to provide support for mother and neonate.

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# Postnatal Management

- If rooming-in is not possible because of the sickness in the neonate or the mother, the neonate should be fed expressed breast milk of the mother by a nurse or a trained healthy family member. Other option can be expressed breast milk with breast pump but due care of sanitization of breast pump
- If mother is critically ill or no healthy relative , baby may be isolated and formula feeds can be given.
- If safe, early discharge to home followed by telephonic follow-up or home visit by a designated healthcare worker may be considered.

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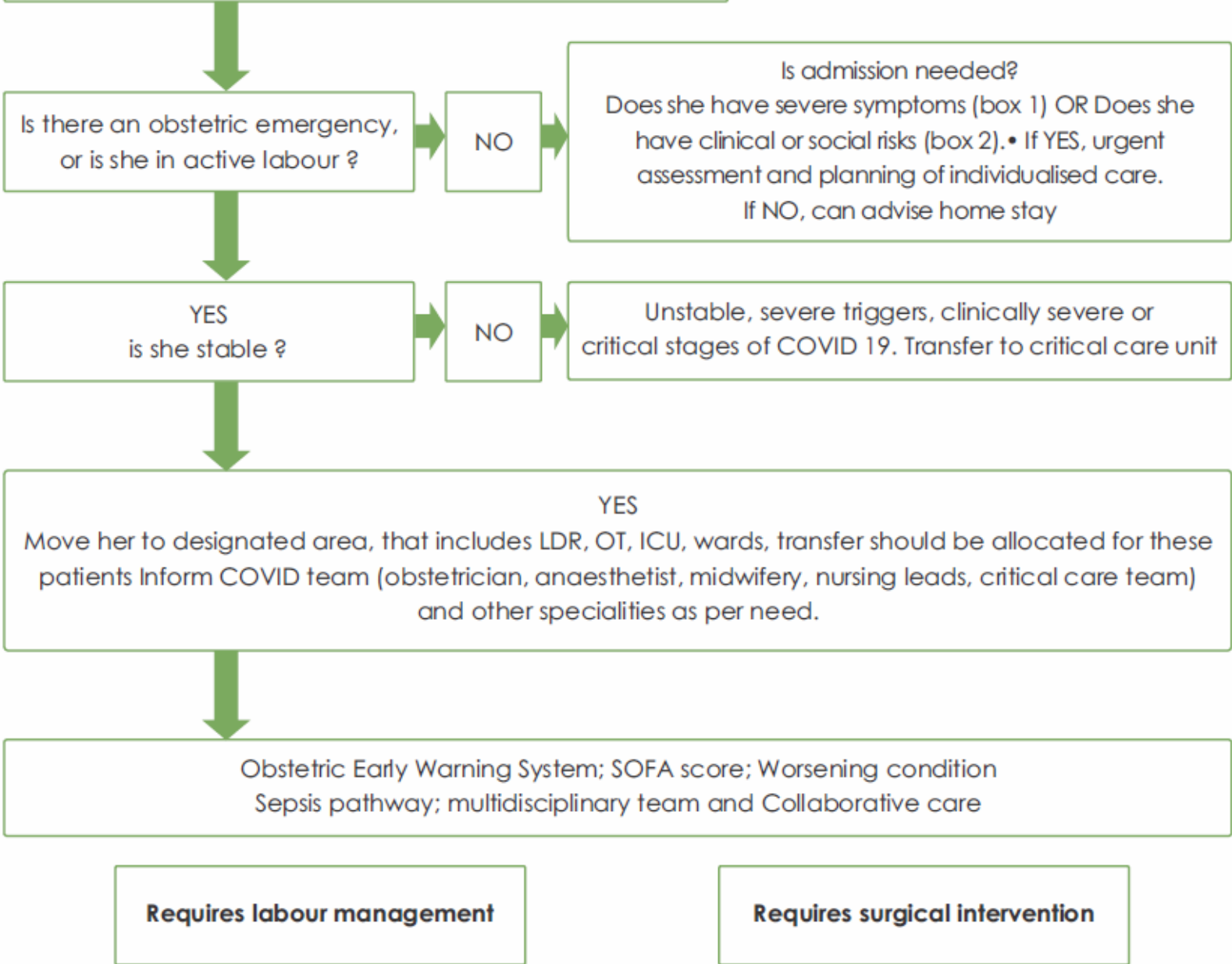
# FLOW CHART OF MANAGEMENT OF PREGNANT WOMEN WITH SUSPECTED OR CONFIRMED COVID 19 INFECTION WITH RESPIRATORY SYMPTOMS<sup>7</sup>

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1. Give her a mask to put on, and should not be removed
2. Reassure her that we will take care
3. Health care team to be in PPE, as recommended)





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## Disinfection of surfaces in the childbirth/neonatal care areas according to guidelines

- **Minimal composition of PPE for the management of suspected or confirmed cases of COVID-19 to be followed according to guidelines**
- **Biomedical waste disposal to be followed as per guidelines**
- Follow routine biomedical waste disposal handling, segregation, transport and final disposal guidelines as prescribed by the Government of India.

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## Discharge policy

- For asymptomatic woman mother can be discharged on day 7.
- For mild/very mild/pre-symptomatic cases
  - Pregnant woman can be discharged after 10 days of symptom onset and no fever for 3 days.
  - No need for testing prior to discharge
- Pregnant woman will be advised to follow home isolation for a further 7 days after discharge.

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# Discharge policy

- **For moderate cases**

- Pregnant woman can be discharged
  - (a) if asymptomatic for 3 days
  - (b) after 10 days of symptom onset.
- No need for testing prior to discharge.
- Pregnant woman will be advised to follow home isolation for a further 7 days after discharge.

- **For severe cases**

- Discharge after clinical recovery and pregnant woman tested negative once by RT-PCR (after resolution of symptoms).

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## SURAKSHA MODULE – 2

# POSTPARTUM AND NEWBORN CARE

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# POSTPARTUM AND NEWBORN CARE

“ You can do everything you can to try to stop bad things from happening to you, but eventually things will happen, so the best prevention is positive attitude” – Marie Osmond.

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# POSTPARTUM AND NEWBORN CARE

The mother and the newborn need utmost care for prevention and transmission of corona virus infection (COVID-19) around the time of parturition, so maternity care providers carry highest responsibility to take appropriate precautions.

## **This includes:**

- Appropriate space and staff to isolate pregnant patients with suspected or confirmed COVID-19,
- Training for all healthcare personnel for correct adherence to infection control practices,
- Use and handling of personal protective equipment (PPE); and
- Processes to protect newborns from the risk of COVID-19.<sup>1</sup>

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# During hospitalization

- All healthcare facilities providing obstetric care must ensure that healthcare personnel are trained and capable of implementing the recommended infection control interventions.<sup>1</sup>
- Healthcare facilities providing inpatient obstetrical care should limit visitors to pregnant women with suspected or confirmed COVID-19.<sup>1</sup>
- Depending on the extent of community-transmission, hospitals may consider limiting visitors to only one essential support person and the same person should be present throughout hospitalization.<sup>1</sup>
- Visitors should be instructed about the use of masks and should not be allowed to go to other locations within the hospital premises, including the newborn unit.<sup>1</sup>

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## Mother/Newborn contact

- Mother/newborn skin-to-skin contact has various benefits including mother/newborn bonding, increased likelihood of breastfeeding, stabilization of glucose levels, and maintaining the newborns body temperature.
- Transmission of COVID-19 after birth through contact with an infected individual is a major concern. Determination of whether or not to separate a mother with suspected or confirmed COVID-19 from her new born should be made on case-by-case basis.<sup>1</sup>

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## Mother/Newborn contact

Considerations in this decision include:

- The clinical condition of the mother and of the infant.
- SARS-CoV-2 testing results of mother (confirmed vs. suspected) and infant (a positive infant test would negate the need to separate)
- Desire to feed at the breast

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## Mother/Newborn contact

- Facility capacity to accommodate separation or co-location.
- The ability to maintain separation upon discharge.
- Other risks and benefits of temporary separation of a mother with known or suspected COVID-19 and her infant.
  
- A newborn to a woman with suspected or confirmed COVID-19 requires 14 days of quarantine and infection prevention and control precautions.<sup>2</sup>

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## Measures to be taken to reduce the risk of transmission from mother to newborn in case of no separation include:

- ✓ Use physical barriers like a curtain between the mother and newborn and keep the newborn  $\geq 6$  feet away from the mother.<sup>1</sup>
- ✓ Mother with suspected or confirmed COVID-19 should put a face mask and practice hand hygiene prior to every feeding or other close contact with newborn.<sup>1</sup>
- ✓ The facemask should not be removed during contact with newborn.<sup>1</sup>
- ✓ All practices should be continued while the mother is on transmission-based precautions.<sup>1</sup>

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## Measures to be taken to reduce the risk of transmission from mother to newborn in case of no separation include:

If the decision is made to temporarily put the mother with known or suspected COVID-19 and her infant to reduce the risk of transmission in separate rooms, the following should be considered:

- Infants with suspected COVID-19 should be isolated from other healthy infants
- If another healthy family or staff member is present to provide care such as diapering, bathing and feeding for the newborn, they should use appropriate PPE with its disposal. For healthy family members, appropriate PPE includes gown, gloves, face mask, and eye protection.
- For healthcare personnel, recommendations for appropriate PPE are outlined.

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## Breastfeeding

- Breast milk is the best source of nutrition for most infants. We do not know whether mothers with COVID-19 can transmit the virus via breast milk, but the limited data available suggest this is not likely to be a source of transmission. The viral DNA has not been detected in breast milk to date.<sup>2</sup>
- Whether and how to start or continue breastfeeding should be determined by the mother in coordination with her family and healthcare providers.
- Mothers with COVID-19 who intend to breastfeed should be encouraged to express their breast milk to establish and maintain milk supply. A dedicated breast pump should be provided to the patient.<sup>1</sup>

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# Breastfeeding

- Hand hygiene prior to feeding and the entire pump should be disinfected after use to reduce the risk of infection to the newborn.<sup>1</sup>
- If direct breastfeeding is intended, the mother should put on a face mask and practice hand hygiene before each feeding.<sup>1</sup>
- Currently , there is a lack of evidence to support precautions such as cleansing the breast prior to feeding or milk expression, but mothers may consider additional care to minimize theoretic potential routes of exposure.

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# Newborn COVID-19 testing

- Routine testing is not recommended for asymptomatic newborn to mother with suspected or confirmed COVID-19.<sup>2</sup>
- Tests are recommended in symptomatic newborn in case of contact with a COVID-19 positive caregiver or when transmission is suspected due to environmental setting.<sup>2</sup>
- Tests should be done 12-24 hours after birth.<sup>2</sup>

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# Newborn care

1. Newborns with suspected COVID-19 should be isolated from other healthy newborns.<sup>1</sup>
2. In case of temporary separation of the mother and newborn, family or staff member appointed to provide care and feed the newborn should use appropriate PPE. Family member should use appropriate PPE like gown, gloves, face mask, and eye protection.<sup>1</sup>
3. The number of visitors and the duration of visits to the newborn units should be restricted.<sup>2</sup>
4. Usual criteria should be considered for discharge.<sup>2</sup>
5. Healthcare providers should prioritize newborn care and vaccination of infants and young children when possible.<sup>3</sup>

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## Newborn care

Well term baby and well mother

Baby is well (term or near-term gestation) and mother is well

- o Co-locate with mother in a single room OR
- o Discharge home
- o PPE: Droplet and contact precautions

Baby requiring neonatal unit admission without respiratory support

- o Single room
- o Closed incubator/cot
- o PPE: Droplet and contact precautions

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# Newborn care

- **Baby requiring neonatal unit admission with respiratory support (or critically unwell and likely to require respiratory support)**
  - Negative pressure room (if available)
  - Closed incubator/cot
  - PPE: Airborne and contact precautions
- **Baby with confirmed COVID-19**
  - Babies are known to be significant shedders of respiratory viruses
  - A confirmed COVID-19 positive baby may or may not require care within neonatal unit
  - Follow PPE precautions appropriate to clinical situation as above

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## Initial care (baby of suspected or confirmed COVID-19 mother)

- Assign a dedicated neonatal team member to attend the birth according to usual clinical indications (i.e. not required for reason of suspected or confirmed COVID-19 mother alone)
- To minimise healthcare provider exposure
  - Consider if neonatal stabilization/resuscitation in a room outside of the birthing room/theatre is appropriate
  - Experienced/senior clinician to attend in the first instance
- If intubation not anticipated, droplet and contact precautions recommended
- If intubation Anticipated, use airborne and contact precautions

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# Initial care (baby of suspected or confirmed COVID-19 mother)

## Resuscitation

- Minimise equipment on resuscitation cot to essential items
  - Place extra equipment anticipated to be required in sealed plastic bags
- Follow standard neonatal resuscitation recommendations

## Admission to neonatal unit

- COVID-19 positive mother (i.e. no other neonatal criteria), is not itself an indication for admission to a neonatal unit
- Perform clinical assessment after birth as per usual assessment protocols
- Assess if required care can safely be provided during co-location with mother
- Follow usual clinical criteria, processes and protocols relevant to admission

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# Discharge

- Consider usual criteria for readiness for discharge (e.g. wellness, laboratory test results)
  - An appropriate caregiver has been identified and counseled.
  - For discharge home, a negative test is not required prior to release from isolation
- Discharge prior to 14 days  
Continue clinical monitoring and appropriate precautions until 14 days complete.
- Consider local capacity when determining how clinical monitoring is to be undertaken after discharge (e.g. telehealth services, home visiting, GP,ASHA and anganwadee workers)

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## Post discharge

- Provide post discharge advice about indications for readmission and possible course of disease.
- Most commonly reported are respiratory symptoms requiring readmission one to three weeks after discharge.
- Delay routine follow-up as required (e.g. hearing screen)

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## SURAKSHA MODULE – 2

# BREAST FEEDING IN COVID-19 SUSPECTS AND POSITIVE CASES

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# Introduction

- With the rapidly spreading pandemic of COVID-19 infection, pregnant women with suspected or confirmed COVID-19 and their new born infants form a special vulnerable group needing special care and attention. Perinatal period poses unique challenges for mother and baby. Breast feeding is one such aspect that requires taking a decision, the risks and benefits of breastfeeding, including the risk of holding the newborn in close proximity to the mother should be properly discussed.(1)
- Breast milk is the only nutrition support for majority of neonates and infants. Breast milk is essential as it not only is the source of nutrition but also acts as a natural immunity booster for neonates and infants(2). As of now very limited studies have been conducted to know whether mothers with COVID-19 can transmit the virus via breast milk, but the chances are least likely for a mother to child transmission of COVID-19 via breast milk(3).

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# Introduction

- There is a lot of concern regarding Breast feeding if a woman turns out to be positive for COVID-19. So, it is recommended that all confirmed or suspected COVID-19 cases and mothers with any symptoms who are breastfeeding or practicing skin-to-skin contact should take all due precautions.
- Whether and how to start or continue breastfeeding should be determined by the mother in coordination with her family and healthcare providers. A mother with confirmed COVID-19 should be counselled to take all possible precautions to avoid spreading the virus to her infant, including hand hygiene and wearing a cloth face covering

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## Actions for breastfeeding mothers who are suspects or confirmed cases of COVID-19

- A mother with suspected or confirmed COVID-19 should be counselled to take all possible precautions to avoid the transmission of the virus to the new born(3).
- A newborn who is being breastfed by a mother with suspected or confirmed COVID-19 should also be considered as having suspected COVID-19 (2).
- For the purpose of infection control and prevention, the newborn should be kept under the mother's recommended period of home isolation and 14 days following it (2).

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# Actions for breastfeeding mothers who are suspects or confirmed cases of COVID-19

- She should practice respiratory hygiene, including during feeding. If there are respiratory symptoms such as being short of breath, use a medical mask is recommended when near to the child(Image1)
- Thorough handwash/proper hand hygiene is highly recommended with soap or sanitizer before and after contact with infant.
- Routine cleaning and disinfection of any surfaces is recommended wherever that patient comes in contact with.



Women with COVID-19 can **breastfeed** if they wish to do so. They should:



Practice respiratory hygiene and wear a mask



Wash hands before and after touching the baby



Routinely clean and disinfect surfaces



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## Breastfeeding when the mother with COVID-19 and the newborn is temporarily separated:

- If patient is severely ill with COVID-19 or suffers from other complications that prevents her from caring for infant or continuing direct breastfeeding, advice expressed milk to safely provide breastmilk to your infant(3).
- The mother should be provided with a dedicated breast pump.
- She should follow proper hand hygiene before touching the pump or bottle parts and even before expressing breast milk. She should also practice respiratory hygiene by wearing a face mask.
- The mother should be trained to clean and sanitize the breast pumps after each use.
- It is important that all the parts that come in contact with the breast milk are cleaned

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# Breastfeeding when the mother with COVID-19 and the newborn is temporarily separated

- A healthy caregiver who is not at a high-risk of illnesses from COVID-19 should be allowed to feed the expressed breast milk to the newborn.
- The healthcare provider should follow the recommended infection prevention and control measures, including the use of appropriate personal protective equipment while feeding the newborn.
- If the mother with COVID-19 or it's complication is too unwell to breastfeed the newborn, she can be supported to safely provide breast milk to the newborn in a way possible to her.

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## The storage guidelines for breast milk if patient have COVID-19:

- The Academy of breast feeding medicine and International Lactation Consultant association(4)state that although it is still unknown whether mothers with COVID-19 can transmit the virus via breast milk, limited studies on breastfeeding women with COVID-19 and other coronavirus infections have not detected the virus in breast milk.
- From that perspective, one can follow the regular breast milk storage guidelines.

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## The storage guidelines for breast milk if patient have COVID-19:

Storage place	Room temperature 16 °C to 25 °C (60 °F to 77 °F)	Refrigerator 4 °C (39 °F) or colder	Freezer -18 °C (0 °F ) or colder	Previously frozen breast milk thawed in the refrigerator
Safe storage time	Up to four hours is best Up to six hours for milk expressed under very clean conditions*	Up to three days is best Up to five days for milk expressed under very clean conditions*	Up to six months is best Up to nine months for milk expressed under very clean conditions*	Up to two hours at room temperature Up to 24 hours in the refrigerator Do not refreeze

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## The storage guidelines for breast milk if patient have COVID-19:

- If mother has expressed breast milk cleanly and safely, she can store it at room temperature, in the fridge, or in the freezer, depending on how soon she want to use it.
- Mother should follow all the guidelines regarding cleaning and sanitising her breast pump These guidelines for storing and defrosting breast milk are a recommendation. They can contact their lactation consultant or breastfeeding specialist for further information.
- If mother is refrigerating or freezing expressed milk, she should always label the bottles or bags with the amount and the date it was pumped, so she can track and manage her stored milk.

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## What is the recommendation for use of breast pump if a mother is hospitalised due to Coronavirus disease?

- According to the Academy of Breastfeeding Medicine, mothers who intend to breastfeed / continue breastfeeding should be encouraged to express their breast milk to initiate and build / maintain milk supply. If possible, a dedicated breast pump should be provided by the hospital.
- Prior to expressing breast milk, before touching any pump or bottle parts, mothers should wash their hands appropriately and take the necessary precautions such as wearing a face mask for at least 5-7 days until cough and respiratory secretions are dramatically improved.

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## What is the recommendation for use of breast pump if a mother is hospitalised due to Coronavirus disease?

- After each pumping session, all parts that come into contact with breast milk should be thoroughly washed following hospital recommendations for proper pump kit cleaning and the exterior of the entire pump should be properly disinfected using 70% ethanol or another alcohol-based disinfectant that is active against SARS-CoV-2.

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## How long is Coronavirus stable on surfaces such as pumps/kits/accessories?

- According to a new study from National Institutes of Health, CDC, UCLA and Princeton University scientists in [The New England Journal of Medicine](#)(5) the authors found that severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was detectable as follows

<b>In aerosols</b>	<b>On copper</b>	<b>On Cardboard</b>	<b>On Plastic</b>	<b>On Stainless Steel</b>
Up to <b>3 hours</b>	Up to <b>4 hours</b>	Up to <b>24 hours</b>	Up to <b>48 to 72 hours</b>	Up to <b>48 to 72 hours</b>

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## How should one clean her pumping equipment if positive for COVID-19?

- When using a breast pump to express breast milk, she should wash hands before touching any pump or bottle parts and follow the [CDC](#) recommendations for proper pump kit cleaning after each use.
- Recommendations encourage that someone who is not sick feed the expressed breast milk to the infant.

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## SURAKSHA MODULE – 2

# BEST PRACTICES FOR PREGNANT WOMEN DURING COVID 19

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# Introduction

- COVID 19 is an unique situation where risk and benefit of every health care needs to be evaluated and modified to decrease the risk without affecting benefits.
- Pregnancy is also an unique condition which is time bound as far as need for health care is required, deals with two healthy lives, and is state of altered physiology like hyper- coaguable state, immunosuppression, vertical transmission making pregnant mother more vulnerable for complications of COVID infection even though risk of catching infection is not increased as compared to non pregnant state.

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## Aim of this article is to summarize practices to be followed by maternity care providers to

- Minimize risk of catching COVID infection by otherwise healthy pregnant mother attending health facility for antenatal care
- Minimize risk of catching infection by health care providers
- To avoid risk of transmission because of travel involved in routine visits
- To be able to identify at risk mothers for COVID infection and trying to prevent complications by providing care by experts to them
- To achieve aim of antenatal care i.e. healthy baby and mother despite of restricted resources, less number of visits and ultrasound examination

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## Principles of changed face of antenatal care

- Reduce in person visits
- Combine examination, vaccination, investigations and if required ultrasound in same visits
- Optimize use of ultrasound to avoid risk to both, patient and care giver
- Use telemedicine for review of reports, prescribing for minor elements
- Train patient for home monitoring of blood pressure, weight and fetal movements and identifying danger signals
- Use appropriate precautions during in person visit, ultrasound and any other procedure

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## Plan for in person visits

- We used to insist that woman should report to doctor as soon as she misses the period. Now keeping the principle of social distancing in mind, we will encourage them to confirm pregnancy by urine pregnancy test at home and then consult the doctor for necessary investigations and medicines if possible on phone unless she desires MTP.
- Reports of investigations can be reviewed via telemedicine. To rule out ectopic pregnancy careful history needs to be taken. In high risk patients, one visit in first trimester is advised. Need of first trimester scan should be optimised and may be done around **12 to 13** weeks along with double marker.

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## Plan for in person visits:

- Asymptomatic patient can visit the health care facility around **18- 20** weeks, where systemic, obstetric examination, tetanus toxoid injection, investigations if any and anomaly scan can be done in one visit along with prescribing.
- Woman should be educated for home monitoring of blood pressure, weight and fetal movements. She should be made aware of danger signals for which she may need to consult doctor.
- Every visit should also be by appointment of all concerned wherever possible.

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## Plan for in person visits:

- If home monitoring is satisfactory for both, patient and doctor, then next visit is around **28** weeks to check interval growth of fetus clinically, vaccination and any change in treatment like increasing dose of Iron.
- If course of pregnancy is uneventful, then next visit is around **36** weeks for risk assessment of mother and fetus and discussing preliminary delivery plan, need for elective section.
- Final visit will be around **39** weeks for deciding delivery plan, testing for Corona, procedure to be followed for admission.

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## Plan for in person visits:

- While staying at home, pregnant woman should avoid unnecessary travel, should wash hands frequently, avoid touching face, nose, eyes with unwashed hands, cover mouth and nose with cloth while coughing/ sneezing, avoid close contact with other members in family or outsiders.
- Proactive efforts should be done during phone calls to relieve mental stress if any because of unique situation
- In case she develops any untoward symptom like pain in abdomen, bleeding or leaking per vaginum, raised blood pressure, decreased fetal movements, emergency visit should be arranged.

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# Some Tips About Telemedicine

Telemedicine has been permitted by the Medical Council of India at the present time . Below are some pointers towards safe telemedicine practice. ·

- The same ethical and professional standards should be practiced as per usual practice.
- Various forms of communication can be used as per the choice of both parties. This may be in the form of video (specialized telemedicine platforms or general platforms such as WhatsApp, Zoom, FacebookLive, Skype, etc.), audio (telephone or any other voice-over-Internet-protocol) or written communication (email, messages on various applications). · First consultations should preferably be via a video format to build rapport.

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# Some Tips About Telemedicine

- Emergency consultations should be limited to directing the patient or care giver to the appropriate site for physical care and advice about first aid until reaching such a site in case of respiratory symptoms.
- Interventions by the doctor could be health education, counselling or prescription of medications.
- Prescriptions should be provided in a standard format.
- Medications are grouped as per the mode of consultation, feasibility and safety of telemedicine. List O includes drugs which are available over the counter such as paracetamol, oral rehydration solutions, etc.

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## Some Tips About Telemedicine

- They may be advised by any mode of consultation. List A includes drugs that can be prescribed only after video consultation such as eye drops for conjunctivitis. List B comprises of drugs that are prescribed for the same condition as add-ons (Eg: ondansetron for severe nausea in pregnancy which is not relieved by first line agents like doxylamine). Certain medications (psychotropic agents, narcotics and schedule X drugs) cannot be prescribed in telemedicine consultations. ·
- Consent is implied when the patient initiates a consultation with the doctor. However, if the doctor has initiated the consultation (on the request of the patient's caregiver, for example), an explicit consent should be taken. This can be done by recording the patient saying a simple statement such as “I consent to avail consultation via telemedicine.” · At present, doctors do not need any special training to do telemedicine
- Documentation and maintenance of records may be in physical or electronic form about all consultations for particular patient
- Telemedicine may be a chargeable service.

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## Care to be taken during in person visit-

- Screening of patients on phone before appointment or at entry of clinic using checklist and thermal check for risk of Corona infection
- Suspect cases to be directed to Corona care clinics and authorities to be informed accordingly
- If appointment is taken, follow timing and avoid unnecessary waiting in clinic
- Only one attendant should accompany if she is not able to come alone
- Foot gears,(chappals and shoes) to be removed outside clinic, arrangements to be made to keep them individually and avoid mixing
- Hand hygiene with help of hand sanitizer kept in reception area for patient
- Social distancing and wearing of mask is must for patient and attendant

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## Care to be taken during in person visit-

- Doctors and paramedical staff should wear appropriate personal protection equipment i.e. Work uniform, disposable surgical cap and mask, disposable gloves ( level I protection).
- The person at entry of clinic doing COVID screening should use level II protection, i.e. disposable surgical cap, medical protective mask (N95), work uniform plus disposable medical protective uniform, latex gloves, goggles
- After dealing with every patient washing of hands or cleaning with sanitizer should be done
- Appropriate care to be taken while examination
- Routine chemo prophylaxis is not advocated for care givers not dealing with suspect or positive cases

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# Care to be taken in consulting room-

- Avoid air conditioning.
- An exhaust fan should be switched on or the window should be opened.
- The fan may be a ceiling fan or a standing/table fan blowing air in a direction away from the doctor. .
- The consulting room should be kept free from clutter and have the minimum amount of furniture necessary.
- The furniture should be hard surfaced to facilitate cleaning

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# Care to be taken in consulting room-

- The patient examination table can have disposable covers where possible. ·
- The number of fomites (mobile phones, electronic devices, pens, measuring tapes, stethoscopes and BP apparatus) should be kept to a minimum and frequently sanitized.
- Minimize handling paper, files and reports that the patient brings. It can be seen with the patient holding them or by photographs.
- The consulting room should be cleaned regularly.
- At the end of the clinic, the examination table should be disinfected. The room may be fumigated at the end of the day.

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# Care to be taken during ultrasound examination

Ultrasound examination rooms are usually small, less ventilated, air conditioned. In addition there are multiple surfaces where virus can remain for 4 to 5 days. Adequate distancing is not possible for sonologist. All these facts make ultrasound examination potential source of transmission unless at most precaution is taken. Doctor and patient both are at risk.

## ***Following points to be noted along with reducing number of examinations:***

- Scheduled appointment to avoid waiting time and exposure.
- After each examination, the highly touched surfaces of the ultrasound machine should be thoroughly cleaned.
- Replace the fabric cover chair with a hard surface chair so that cleaning becomes easy. If possible replace all washable linen, such as towels, pillow covers, and sheets with disposable

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# Care to be taken during ultrasound examination

- Clean ultrasound transducers and cables after every scan.
- Make use of disinfectant to wipe the patient's bed or couch before replacing it with the disposable paper cover.
- At the end of the day dispose of soiled linen in an appropriate container by using pairs of gloves.
- Clean the room and the equipment with disinfectant and wash hands for 20 seconds thereafter.
- The factors affecting the success of this changed strategy are, understanding of responsibility by patients and relatives at every stage right from giving correct answers for questions in checklist.

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# Care to be taken during ultrasound examination

- There is risk that patient may hide the information about contact, respiratory symptoms in fear of referral to COVID OPD. Effectiveness of communication while using telemedicine from both sides, up to date information about changing policies to reach to every level of maternity care provider from obstetricians to AYUSH practitioners to midwives, availability of resources to abide by given guidelines during in person visits and ultrasound examination.
- This situation is also going to increase economical, physical, psychological burden on health care facilities and patients

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# Care to be taken during ultrasound examination

- Reduction in number of visits and ultrasound examinations seems like arms of clock are moving anti clock wise.
- Before eighties, there was reluctance in society for early registration and regular antenatal visits.
- Ultrasound was not available everywhere, so clinical diagnosis was carrying importance. The only difference was patient were having strong faith on doctor. We need to be more careful.

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# Summary

- There are three things we must focus on:
- Patient education for- Home monitoring of blood pressure, weight, fetal movements, awareness of risk factors requiring urgent consultation, timely compliance to doctor's advise ,Simple exercises to keep them active while staying at home so that risk of thromboembolism is reduced
- Ensuring skill of caregivers and faith on their own clinical acumen so that dependability on ultrasound will decrease, mainly for fetal growth, amount of amniotic fluid, mal presentation, incomplete/ complete abortion.
- Improving doctor patient relationship and rebuilding faith on doctor's diagnosis along with support of law considering this special situation. One detrimental thing to this relationship is reassuring touch of doctor will not be so easy while following norms of social distancing.

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