



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

July 13, 2020

DEPARTMENT MEMORANDUM

No. 2020 - 0319

FOR : **DOH CENTERS FOR HEALTH DEVELOPMENT DIRECTORS, MINISTER OF HEALTH-BANGSAMORO AUTONOMOUS REGION FOR MUSLIM MINDANAO (BARMM), EXECUTIVE DIRECTORS, CHIEFS OF HOSPITALS, MEDICAL CENTERS, INSTITUTES, SANITARIA AND INFIRMARIES, AND OTHER CONCERNED BUREAUS, SERVICES, UNITS AND OFFICES**

SUBJECT : **Interim Guidelines on COVID-19 Management of Pregnant Women, Women About to Give Birth, and Newborns**

I. BACKGROUND

The World Health Organization (WHO) has declared coronavirus disease 2019 (COVID-19) as a pandemic. As such, the Philippines was declared under state of public health emergency. As part of the contingency plan against COVID-19, identified areas were placed under community quarantine, to halt the transmission of the virus.

Protocols and guidelines in the prevention, control, and treatment of infectious diseases during the prenatal period, childbirth, the immediate postpartum and postnatal periods, and the newborn's first 28 days of life are already in place and have incorporated the rights-based approach to health. The continuity of services to deliver quality maternal, newborn and child care for women, and their infants and children, are assured in various laws such as RA 10354 *Responsible Parenthood and Reproductive Health Law*, RA 11148 *Kalusugan at Nutrisyon ng Mag-Nanay Act*, RA 10028 *Expanded Promotion of Breastfeeding Act*, RA 10821 *Children's Emergency Relief and Protection Act*, and RA 11332 *Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act* to ensure that appropriate measures are implemented to protect the health of both the mother and her infant or child.

These interim guidelines further provide the recommendations from the WHO Clinical Management of COVID-19 – Interim Guidance (May 27, 2020) and the best available evidence deemed appropriate for the Philippines' health system and context. Likewise, the recommended COVID-19 algorithms for pregnant patients and care of newborns developed by the Philippine Society of Public Health Physicians are adopted as referenced in the sections that follow herein this document.

II. GENERAL GUIDELINES

- A. To prevent and control transmission of COVID-19 and manage suspect, probable and confirmed cases of women, newborns, infants and young children in health facilities, these interim guidelines include:
1. Infection Prevention and Control Strategies
 2. Screening and Early Recognition of Women About to Give Birth
 3. Management of Postpartum Women

4. Management of the Newborn after Delivery up to the First Six (6) Hours
 5. Care of the Newborn in the Neonatal Care Unit, Isolation Area, or Kangaroo Mother Care (KMC) Unit
 6. Managing Infant Feeding Concerns During COVID-19 pandemic
 7. Testing
- B. This also includes a system for assessing all patients at admission, allowing for early recognition of possible COVID-19 and immediate isolation of patients with suspected disease in an area separate from other patients. (**Figure 1D Boxes 1-13** discusses triage for all pregnant women with or without exposure, with or without symptoms, regardless of RT-PCR test results).
- C. In areas with no sustained COVID-19 transmission, health care workers must exercise increased caution and implement appropriate infection prevention and control strategies before proceeding with usual care.

III. SPECIFIC GUIDELINES

A. Infection Prevention and Control Strategies

1. Based on the WHO Interim Guidance on Infection Prevention and Control (IPC) during Health Care when COVID-19 is suspected, the following strategies to prevent or limit transmission in healthcare settings shall be observed:
 - a. Ensure triage, early recognition through adherence to risk assessment protocols or checklist, and source control (isolating suspect COVID-19 cases);
 - b. Apply standard precautions for all patients;
 - c. Implement empiric additional precautions (droplet, contact and whenever applicable, airborne precautions) for suspect, probable, and confirmed cases;
 - d. Implement administrative controls; and,
 - e. Use environmental and engineering controls.
2. Standard precautions should always be applied in all areas of healthcare facilities, including hand hygiene and the use of appropriate personal protective equipment (PPE) during direct and indirect contact with patients' blood, body fluids, secretions (including respiratory secretions), and non-intact skin. Further, these also include prevention of needle-stick or sharps injury, safe waste management, and cleaning and disinfection of equipment and healthcare settings.
3. In addition to standard precautions, health care workers (HCW) should do a point-of-care risk assessment for every patient contact to determine whether additional precautions (e.g. droplet, contact, or airborne) are necessary.
4. HCW should practice proper hand hygiene and be guided by DM 2020-0249 on the Use of the Infection Prevention and Control Checklist for Healthcare Workers Readiness and the WHO's "5 Moments for Hand Hygiene" approach, which recommends to perform hand hygiene before touching a patient, before any clean or aseptic procedure is performed, after exposure to body fluid, after touching a patient, and after touching a patient's surroundings. Hand hygiene includes either cleansing hands with soap and water or with an alcohol-based hand rub. Alcohol-based hand rubs are preferred if soap and water are not accessible.

5. Recommendation for outpatient care during prenatal visits, postpartum and postnatal follow-up visits of women during their pregnancy and after delivery shall observe the following:
 - a. Essential preventive measures: physical distancing, hand hygiene and respiratory hygiene;
 - b. Strict hand hygiene, respiratory hygiene, and the use of surgical masks by patients, with or without respiratory symptoms;
 - c. Contact and droplet precautions for all suspect, probable, and confirmed cases;
 - d. Triage and early recognition, and prioritizing care of symptomatic patients;
 - e. Separate waiting room or area for symptomatic patients;
 - f. Educate patients and other household members on early recognition of symptoms, basic precautions and which health care facility to go to;
 - g. Consider modifications to standard protocols for antenatal visits and procedures, depending on levels of community quarantine including use of telehealth, reducing the number of clinic visits.
6. Maternal and Newborn Infection Prevention and Control
 - a. Face masks must be worn by or provided to the mother during consultation, delivery, postpartum, and during care of the baby;
 - b. DO NOT put on a face mask and/or face shield on the newborn;
 - c. In the context of newborn care and breastfeeding, cough etiquette should be into a tissue (instead of into the elbow) that is disposed immediately in proper bins, followed by hand hygiene practice;
 - d. Wash hands using soap and water immediately before and immediately after handling the baby or changing diapers;
 - e. Disinfect frequently handled surfaces (e.g. cell phones, knobs, switches);
 - f. On nipple care, as long as IPC measures above are observed, washing or cleaning the nipple before or after feeding is discouraged.

B. Screening and Early Recognition of COVID-19 Among Women about to Give Birth (Annex A)

Pregnant women who are contacts, suspect, probable, or confirmed COVID-19 should have access to a birthing facility (e.g. RHU birthing home, lying in clinic, infirmary, or a hospital) composed of a physician, midwife, nurse, other allied health professionals, and community-based health workers. In hospital settings, this encompasses obstetric, fetal medicine and neonatal care, as well as mental health and psychosocial support, lactation management and maternal nutrition counselling, with readiness to care for maternal or obstetric and neonatal complications.

1. Women in Active Labor or Imminent Delivery (Woman About to Give Birth)

a. No Exposure and Without Symptoms

- i. If the woman does not have any exposure and has no respiratory symptoms, proceed to usual care and anticipatory management;
- ii. If considering the possibility of asymptomatic transmission of COVID-19, implement infection prevention and control strategies;

- iii. Monitor progress of labor and delivery, as well as the fetal status and refer accordingly;
 - iv. Deliver the baby in accordance with essential intrapartum and newborn care (EINC) protocol (“*Unang Yakap*”);
 - v. Refer to section on Management of the Newborn after Delivery.
- b. Contact (with NO respiratory symptoms), Suspect, Probable, or Confirmed COVID-19 cases with MILD symptoms**
- i. Patients should contact the telehealth provider or the Barangay Health Emergency Response Team (BHERT) for proper coordination and referral into the facility.
 - ii. If the woman is a contact, suspect, probable or confirmed COVID-19 case, implement infection prevention and control strategies. Admit and direct patients in an isolation room. A team of healthcare workers should be designated to care exclusively for these types of patients to reduce transmission risk. Make arrangements for referral if the health facility is not capable.
 - iii. Discuss benefits and risks of non-separation versus 14 days of separation (or until return of concordant test results);
 - iv. Discuss benefits and risks of alternate caregivers. Should the mother prefer separation, alternate caregivers include all possible contacts (e.g. health workers, family) of the baby during the time of separation from the mother
 - (a) Discuss with the family who the available alternate caregiver/s will be, what their COVID-19 status are, what the transmission risks are, and which PPEs are needed;
 - (b) Alternate caregivers must also undergo assessment regarding symptoms, contact, and exposure via residence or travel;
 - v. Monitor maternal (including oxygen saturation) and fetal conditions, and progress of labor;
 - vi. If the mother prefers non-separation, deliver the baby in accordance with essential intrapartum and newborn care (EINC) protocol while strictly observing infection prevention and control measures. Otherwise, deliver the baby, dry immediately and thoroughly, do properly-timed cord clamping. Refer to section on Management of the Newborn after Delivery.
- c. Contacts (with NO respiratory symptoms), Suspect, Probable, or Confirmed COVID-19 cases with SEVERE symptoms and/or with Danger Signs**
- i. Patients should contact the telehealth provider or BHERT for proper coordination and referral into the facility.
 - ii. Require all transport personnel to wear appropriate PPEs, to be removed once patient has been transferred;
 - iii. Stabilize the patient prior to transport to higher-level COVID-19 facility. Give oxygen and the target pulse oximetry 92-95% at room air;
 - iv. Stabilize the patient with danger signs using interventions in accordance with the RA 10354 and its IRR for basic emergency obstetric and newborn care.

C. Management of Postpartum Women

1. Implementation of infection prevention and control (IPC) strategies shall be applied to all postpartum women, cases of postpartum complications, miscarriage or still births, and late pregnancy fetal loss.
2. Communicate outcomes of birth and the condition of the newborn to both the mother and father, or other immediate relatives or caregivers, especially those newborns who were required to be transferred or admitted to the neonatal care unit.
3. Regardless of COVID-19 status, monitor all postpartum women for complications (e.g. hemorrhage, blood pressure elevation, difficulty of breathing, edema, and signs of infection unrelated to COVID-19).
4. Regardless of COVID-19 status, provide psychosocial/mental health support, lactation and maternal nutrition counselling, and practical infant feeding support, especially for those who may need to be separated from the newborn.
5. Regardless of COVID-19 status, provide counsel and services on family planning and reproductive health.

D. Management of the Newborn after Delivery to First Six (6) Hours

1. If the Mother has NO exposure and has NO symptoms (*See Annex B*)
 - a. Maintain IPC measures, both for the healthcare team and the mother.
 - b. Discuss the plan of EINC and corresponding precautions related to COVID-19.
 - c. Proceed with the implementation and sequence of the four core steps of the essential newborn care protocol with the early initiation of breastfeeding within at least 60 minutes after birth.
2. If Mother is a Contact, Suspect, Probable or Confirmed COVID-19 case (ANNEX A & B)
 - a. Mother has severe symptoms and/or with danger signs
 - i. Alert neonatal care unit staff to prepare a transport incubator and the COVID-19 isolation room or area for newborns;
 - ii. Deliver the baby following IPC and COVID-19-aligned EINC protocols with due consideration of informed choice and mother's preference.
 - b. Mother prefers non-separation after informed choice
 - i. Deliver baby in accordance with the EINC protocols while strictly observing infection prevention and control measures;
 - ii. Maintain non-separation of the mother-infant dyad if the newborn is clinically stable and if the mother is also not in respiratory distress;
 - iii. Proceed with rooming-in of both the mother and baby;
 - iv. Mother should be able to observe the baby in a crib that is at least one (1) meter or three (3) feet away from her bed and exercise full precautions.
 - c. Mother prefers separation after informed choice
 - i. Deliver the baby, dry immediately and thoroughly, do properly-timed cord clamping at least one (1) minute after birth, and implement separation;
 - ii. Advise alternate caregiver on IPC and infant feeding options;
 - iii. Separation can be discontinued as follows:

- (a) until RT-PCR swab test results for mother and baby are concordant OR
 - (b) until 14 days from resolution of symptoms of mother OR
 - (c) until 14 days from last significant exposure of mother
 - iv. Infant bassinets or cribs in the newborn isolation area should be at least one (1) meter or three (3) feet away from each other, exercising fall precautions. DO NOT put face masks and/or face shields on newborns;
 - d. For newborns in respiratory distress regardless of mother's COVID-19 status
 - i. Perform the newborn resuscitation protocol as indicated with health workers in full PPE, and if available, using aerosol boxes for intubation procedures;
 - ii. Coordinate referral and transport to a NICU. Whenever possible, transfer the newborn with the mother to the appropriate health facility.
 - 3. Administer components of routine newborn care after the newborn's first full breastfeeding. Monitor baby's vital signs, condition and watch out for respiratory distress syndrome, signs of neonatal sepsis or pneumonia. If RT-PCR swab testing is feasible, collect specimens from the upper respiratory tract for COVID-19 testing while observing strict IPC measures.
- E. Care of the Newborn in the Neonatal Care Unit, Isolation Area, or Kangaroo Mother Care (KMC) Unit**
- 1. There should be no promotion of breastmilk substitutes, breastmilk supplements, feeding bottles and teats, pacifiers or dummies in any part of the health facilities providing maternity and newborn services, or by any of the staff as stated in the Milk Code (Executive Order No. 51, s.1986) and its revised Implementing Rules and Regulation.
 - 2. For those awaiting the COVID-19 test results or completion of the 14-day isolation period, all newborns who are well, including preterm, small for gestational age, and low birth weight infants, and are able to be cup-fed, should be given preferably with their mother's own expressed breastmilk.
 - 3. Similarly, newborn who are sick, in respiratory distress or are unable to be cup-fed due to prematurity should be given their mother's own expressed breastmilk or pasteurized breastmilk once condition permits.
 - 4. Initiate and practice kangaroo mother care (KMC) at birth for clinically stable preterm, small for gestational age, or low birth weight infants and for those who are together in their own rooms in the ward or maternity unit, KMC ward or unit, or in COVID-19 isolation areas with strict observance of IPC measures.
 - 5. Father or caregiver of newborns who are confirmed COVID-19 should be allowed to visit and care for their newborn infant, provided that their COVID-19 status is known to the pediatrician, neonatologist and other health care staff attending to the newborn and subject to strict adherence to infection prevention and control measures, and wearing of proper PPE, as appropriate.
 - 6. Father or caregiver of newborns who test negative for COVID-19 should be encouraged to cup feed their newborns or also provide kangaroo care subject to strict adherence to infection prevention and control measures, and wearing of proper PPE, as appropriate.

F. Managing Infant Feeding Concerns During COVID-19

1. Advise the mother to maintain use of a surgical mask, cough into tissue and dispose (not into elbow), perform hand washing or hand hygiene practices immediately before and after handling newborn. DO NOT put a face mask or shield on a newborn.
2. For separated infants (i.e. mothers who are critically ill or those who opted for separation after informed choice), health workers or alternate caregivers who will prepare and provide infant feedings in the health facility and at home should be counselled on strict hand washing practice immediately before and immediately after preparing the breastmilk and cup feeding per demand, with strict observance of infection prevention and control measures and proper use of PPEs. The hierarchy of infant feeding options are as follows:
 - a. Direct breastfeeding with strict IPC
 - b. Expressed breast milk of infant's own mother with IPC
 - c. Donor breast milk, preferably pasteurized
 - d. Hygienically and properly prepared breastmilk substitutes, only after all of the above have been exhausted. Donations of formula milk are prohibited. Local government procurements are governed by the provisions of DOH DM 2020-0231 *Guidelines on the Standard Regulation of Donations, Related to EO 51 to health facilities and workers, local government units, NGOs and private groups and individuals in support to the Response to Emergencies, Disasters, and Situations Where Health and Nutrition of Mothers, Infants and Young Children are Affected.*
3. Establishment of exclusive breastfeeding
 - a. Early initiation of exclusive breastfeeding provides a physiologic mechanism in the transitioning of the newborn infant outside the uterine environment. Delays in breastfeeding initiation result in increased risk for infection-related deaths among newborns, and result in breastfeeding difficulties. Breastfeeding problems can undermine food security of a household with limited resources, as funds are funneled to prioritize infant milk formula.
 - b. Breastfeeding positioning and attachment should be properly assessed prior to discharge, especially in light of restrictions on mobility and the challenges of providing remote care. Establish a communication channel to monitor breastfeeding status and provide alternative mechanisms to support breastfeeding at home (e.g. community support groups).
 - c. If separation is necessary, caregivers who will prepare and provide expressed breastmilk at home should be counselled on storage, handling and cup feeding per demand. Ensure strict handwashing immediately before preparing the breast milk and before breast milk cup feeding.

G. Testing

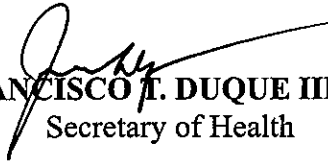
Guidelines in this policy ensure that sound and compassionate clinical judgement is facilitated considering limited testing capacity in primary care and low resource settings.

1. Aligned with the latest guidelines on Expanded Testing, prioritize COVID-19 testing of suspect or symptomatic pregnant women to enable access to specialized care, preferably done at the end referral facility.
2. If COVID-19 RT-PCR swab testing is feasible, collect specimens from the upper respiratory tract (URT: nasopharyngeal or oropharyngeal). If URT specimens are negative and clinical suspicion remains, collect lower respiratory tract specimen (LRT: expectorated sputum [for adults], endotracheal aspirate, bronchoalveolar lavage) for RT-PCR testing and microbiologic stains/cultures.

IV. REPEALING CLAUSE

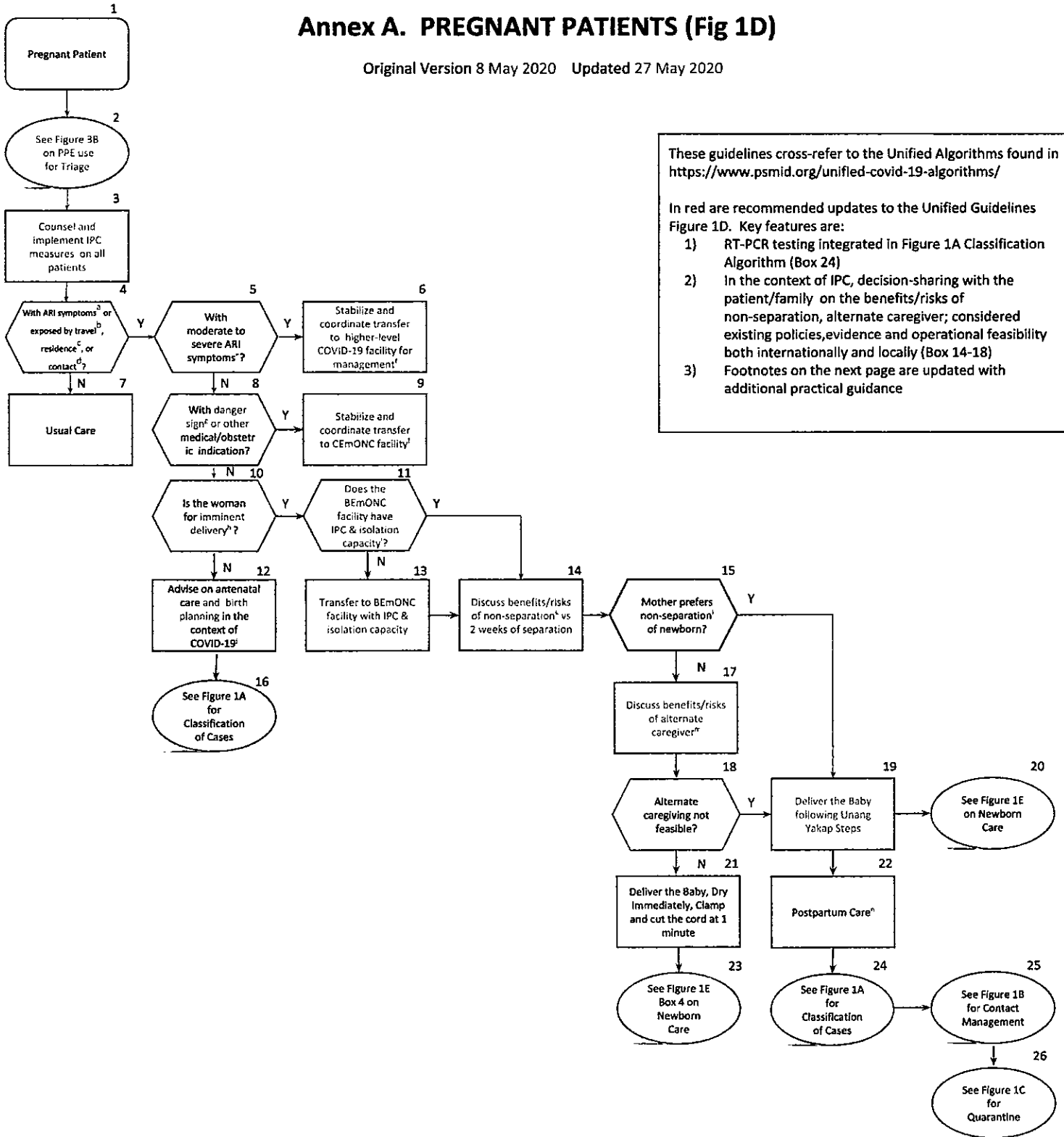
Department Memorandum 2020-0146 *Adoption of POGS, PPS, PIDSOG, PSMFM, PSNBM and PIDSP Clinical Approach to the Management of COVID-19 during Pregnancy and the Newborn* and other related issuances inconsistent or contrary to the provisions of this Memorandum are hereby repealed.

For strict compliance of all concerned.


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Secretary of Health

Annex A. PREGNANT PATIENTS (Fig 1D)

Original Version 8 May 2020 Updated 27 May 2020



These guidelines cross-refer to the Unified Algorithms found in <https://www.psmid.org/unified-covid-19-algorithms/>

In red are recommended updates to the Unified Guidelines Figure 1D. Key features are:

- 1) RT-PCR testing integrated in Figure 1A Classification Algorithm (Box 24)
- 2) In the context of IPC, decision-sharing with the patient/family on the benefits/risks of non-separation, alternate caregiver; considered existing policies, evidence and operational feasibility both internationally and locally (Box 14-18)
- 3) Footnotes on the next page are updated with additional practical guidance

Annex A. PREGNANT PATIENTS (Fig 1D)

Original Version 8 May 2020 Updated 27 May 2020

FOOTNOTES

^aAcute Respiratory Illness (ARI)

Flu-like symptoms (cough, colds, sore throat, body malaise; fatigue, fever)

^bExposure by travel

Travel from a country/area where there is sustained community level transmission to an area with no sustained community transmission

^cExposure by residence

Stays in a locality where there is sustained community level transmission

^dExposure by contact/occupation

1. Providing direct care to suspect, probable, or confirmed COVID-19 patients without using proper PPE (i.e. healthcare workers);
2. Face-to-face contact with a probable or confirmed case within 1 meter and for more than 15 minutes;
3. Direct physical contact with a probable or confirmed case; OR
4. Other situations as indicated by local risk assessments

^eSevere ARI symptoms for adults and adolescents,

Any of the following:

- altered mental state
- shortness of breath
- SpO₂ ≤93% at room air, RR >30/min
- systolic blood pressure of <90mmHg
- other signs of shock or complications

^fTransporting a patient

- Stabilize patient prior to transport: Give oxygen; Target pulse oximetry 92-95% at room air
- Require all transport personnel to wear appropriate PPE, to be removed once patient has been transferred
- Stabilize patient using corresponding interventions as per BEmONC guidelines

^gExamples of danger signs (DOH MNCHN MOP, 2011)

1. Swelling of legs, hands, and/or face
2. Severe headache, dizziness, blurring of vision
3. Convulsion
4. Vaginal bleeding, pale skin
5. Fever and Chills
6. Absence or decrease in baby's movement inside the womb,
7. Severe abdominal pain
8. Vaginal bleeding, foul smelling/watery vaginal discharge
9. Painful urination
10. Too weak to get out of bed

^hImminent Delivery

- Bulging, thin perineum during contractions, visible fetal head (for both term and preterm deliveries; WHO IMPAC 2006)
- At risk of preterm delivery within next 7 days (Rec. 1.10; WHO recommendations on interventions to improve preterm birth outcomes, 2015)
- Admit to a designated isolation area
- Require all personnel in attendance to wear the appropriate PPE

ⁱMaternal Infection Prevention and Control(IPC)

- A minimum of a face mask must be worn by or provided to the mother during delivery, postpartum, and during care of the baby
- In the context of newborn care and breastfeeding, cough etiquette should be into a tissue that is disposed immediately in proper bins, followed by hand hygiene practice
- Wash hands using soap and water before and after handling baby
- On nipple care, as long as IPC measures above are observed washing/cleaning the nipple before/after feeding is discouraged

^jAntenatal care

- Phone consultations recommended to minimize exposure risk
- Prenatal care under the current situation remains the same as standard of care, provided that physical distancing and IPC measures are still followed for in-person meetings
- Emphasis on obstetric danger signs must be made during all consults, including the need to escalate care from remote healthcare to the need to transfer to health care facilities
- Antenatal discussions should also include the formulation of modified birth plans during the pandemic

^kExamples of benefits of non-separation

Non-separation keeps babies warm, prevents exposure to diseases in the immediate environment, and helps establish breastfeeding. Delays in breastfeeding increases risk for infection-related deaths among newborns, and result in breastfeeding difficulties. Breastfeeding problems can undermine food security of a household with limited resources, as funds are funneled to prioritize infant formula. New evidence suggests that COVID-19 antibodies are found in the breastmilk of infected mothers.

^lWhen the option to separate is preferred after discussion of scenarios, implement separation until the following:

1. RT-PCR test results for mother and baby return concordant or
2. Until 14 days from resolution of symptoms of mother or
3. Until 14 days from last significant exposure of mother who is a contact *Infant cribs in the newborn isolation area should be at least one (1) meter or three (3) feet away from each other, exercising full precautions. DO NOT put face masks or shields on newborns.*

^mAlternate caregivers

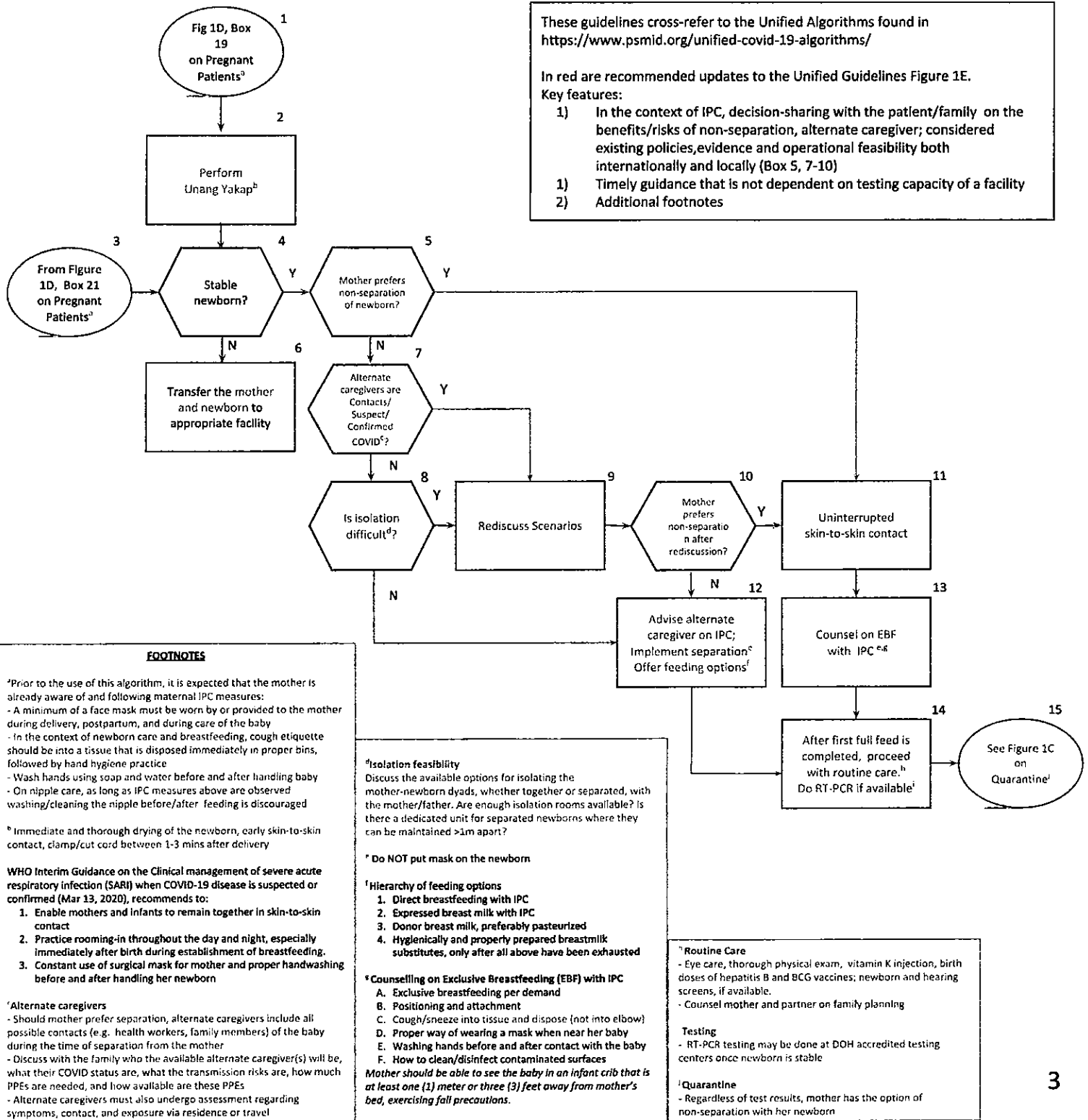
- Should mother prefer separation, alternate caregivers include all possible contacts (e.g. health workers, family members) of the baby during the time of separation from the mother
- Discuss with the family who the available alternate caregiver(s) will be, what their COVID status are, what the transmission risks are, how much PPEs are needed, and how available are these PPEs
- Alternate caregivers must also undergo assessment regarding symptoms, contact, and exposure via residence or travel

ⁿPostpartum Care

- Monitor postpartum patient in the same isolation area by the same delivery team
- Discharge early once stable, if mild case
- Coordinate with RESU for monitoring and surveillance
- Require all transport personnel to wear appropriate PPE (see Figure 3)

Annex B. Care of the NEWBORN whose Mother has NO/MILD SYMPTOMS (Fig 1E)

Original Version 8 May 2020 Updated 27 May 2020



These guidelines cross-refer to the Unified Algorithms found in <https://www.psmid.org/unified-covid-19-algorithms/>

In red are recommended updates to the Unified Guidelines Figure 1E.

Key features:

- 1) In the context of IPC, decision-sharing with the patient/family on the benefits/risks of non-separation, alternate caregiver; considered existing policies, evidence and operational feasibility both internationally and locally (Box 5, 7-10)
- 1) Timely guidance that is not dependent on testing capacity of a facility
- 2) Additional footnotes

FOOTNOTES

^aPrior to the use of this algorithm, it is expected that the mother is already aware of and following maternal IPC measures:

- A minimum of a face mask must be worn by or provided to the mother during delivery, postpartum, and during care of the baby
- In the context of newborn care and breastfeeding, cough etiquette should be into a tissue that is disposed immediately in proper bins, followed by hand hygiene practice
- Wash hands using soap and water before and after handling baby
- On nipple care, as long as IPC measures above are observed washing/cleaning the nipple before/after feeding is discouraged

^b Immediate and thorough drying of the newborn, early skin-to-skin contact, clamp/cut cord between 1-3 mins after delivery

WHO Interim Guidance on the Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected or confirmed (Mar 13, 2020), recommends to:

1. Enable mothers and infants to remain together in skin-to-skin contact
2. Practice rooming-in throughout the day and night, especially immediately after birth during establishment of breastfeeding.
3. Constant use of surgical mask for mother and proper handwashing before and after handling her newborn

^cAlternate caregivers

- Should mother prefer separation, alternate caregivers include all possible contacts (e.g. health workers, family members) of the baby during the time of separation from the mother
- Discuss with the family who the available alternate caregiver(s) will be, what their COVID status are, what the transmission risks are, how much PPEs are needed, and how available are these PPEs
- Alternate caregivers must also undergo assessment regarding symptoms, contact, and exposure via residence or travel

^dIsolation feasibility

Discuss the available options for isolating the mother-newborn dyads, whether together or separated, with the mother/father. Are enough isolation rooms available? Is there a dedicated unit for separated newborns where they can be maintained >1m apart?

^e DO NOT put mask on the newborn

^fHierarchy of feeding options

1. Direct breastfeeding with IPC
2. Expressed breast milk with IPC
3. Donor breast milk, preferably pasteurized
4. Hygienically and properly prepared breastmilk substitutes, only after all above have been exhausted

^gCounseling on Exclusive Breastfeeding (EBF) with IPC

- A. Exclusive breastfeeding per demand
- B. Positioning and attachment
- C. Cough/sneeze into tissue and dispose (not into elbow)
- D. Proper way of wearing a mask when near her baby
- E. Washing hands before and after contact with the baby
- F. How to clean/disinfect contaminated surfaces

Mother should be able to see the baby in an infant crib that is at least one (1) meter or three (3) feet away from mother's bed, exercising full precautions.

^h Routine Care

- Eye care, thorough physical exam, vitamin K injection, birth doses of hepatitis B and BCG vaccines; newborn and hearing screens, if available.
- Counsel mother and partner on family planning

Testing

- RT-PCR testing may be done at DOH accredited testing centers once newborn is stable

ⁱ Quarantine

- Regardless of test results, mother has the option of non-separation with her newborn

Recommended COVID-19 Algorithms for PREGNANT PATIENTS and Care of NEWBORNS

Version 8 May 2020 Updated 27 May 2020



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