New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

COVID-19 Alert Level 3 or 4
Information for Midwives: updated 27 August 2021

Guidance for community midwifery care and COVID-19 risk reduction

This information is subject to change according to Ministry of Health updates.

This advice is for community midwifery care at **Alert level 3 or 4**.

For advice on **Alert levels 1 or 2**: please see on the College website.

Contents

Key messages

- Face masks are mandatory for all midwives and anyone accessing midwifery care.
- This means women should wear face masks during care provision
- Screen all women prior to in-person contact. See information on symptoms and high index of suspicion (HIS) on the Ministry website.
- Women who have symptoms of Covid-19 or meet case definition criteria need to be tested.
    - If these women require a clinically necessary assessment, discuss with the DHB to determine the appropriate setting
- In-person visits for well women who do not meet HIS criteria should be conducted partially by phone or video. Limit in-person contact to 15 minutes or less where possible, for the physical assessment.
- See recommended schedule of visits for antenatal and postpartum care for decision support around midwifery contacts with women.
- All services operating at these alert levels are required to display the official NZ COVID Tracer QR code posters. Community midwives are recommended to set up a Tracer QR code for clients to scan during home visit. For information on obtaining a QR code see the Ministry of Health website.
- Midwives, women and whānau are recommended to download and use the Ministry of Health's Covid tracer app.
- Midwives may find it useful to download the Ministry of Health Āwhina app which provides notifications of updated Covid advice.
- The Ministry of Health has recognised the mental health impact of Covid-19 and has provided dedicated support for health workers. On the Covid-19 Mental health and wellbeing resources webpage there is information about counselling services that are available to support frontline health workers
- Covid-19 Advice for Māori has been produced by Te Rōpū Whakakaupapa Urutā | National Māori Pandemic Group.

Introduction

This advice is specific to COVID-19 Alert Level 3 or 4, which requires everyone, including pregnant women and their families, to stay at home – unless they require or provide an essential service or safe service/business. Accessing midwifery care in both the community and hospital are essential services during this period. This document includes guidance for when a face-to-face physical assessment of the woman is suggested to support her biophysical health, and when a telephone/video call assessment can be undertaken to assess wellbeing, provide advice, and support her psychosocial health and health education needs.

The decision points in the College of Midwives Handbook for Practice have been used as a framework, in order to ensure this guide is relevant and specific to the New Zealand context of midwifery.

Whilst it is reasonable to defer or delay some face-to-face consultations/contacts, women will still require a physical assessment at some stages, and some physical care needs are critically time sensitive

and cannot be deferred, for example assessment of fetal growth, screening, newborn assessment and weighing.

This guidance is provided to support midwives during the discrete period of the COVID-19 Alert Level 3 or 4.

In person contact should be deferred, if clinically appropriate, if a woman:

- has symptoms consistent with COVID-19
- meets High Index of Suspicion (HIS) criteria
- has been tested for COVID-19 and is awaiting results
- has confirmed COVID-19.

Alert level 3 and 4 information

Alert level 3

- People are instructed to stay home in their bubble other than for essential personal movement – including to go to work, school if they have to, or for local recreation.
- Physical distancing of 2m outside home (including on public transport), or 1m in controlled environments like schools and workplaces.
- To wear masks in public places and when visiting essential services.
- People must stay within their immediate household bubble, but can expand this to reconnect with close family/whanau, or bring in caregivers, or support isolated people. This extended bubble should remain exclusive.

Alert level 4

- People instructed to stay at home (in their bubble) other than for essential personal movement.
- Businesses closed except for essential services. Midwifery is an essential service.
- Physical distancing of 2m outside home (including on public transport).
- To wear masks in public places and when visiting essential services.

Midwifery care and health equity

It is important that women know they can continue to access midwifery and maternity care during alert levels 3 and 4.

Principles for midwifery care

1. Ensure each woman understands how and when to contact her midwife when needed. Reassure women that it is safe to have necessary midwifery visits at alert level 3 or 4 and that midwives and other health professionals have infection prevention and control measures in place Encourage them to seek and access additional health care for any concerns. Reiterate signs and symptoms that would require the woman to contact you and ensure prompt assessment and appropriate referral.

2. Midwives continue to be clinically responsible for the co-ordination and provision of maternity care for the women in their caseload. Midwives continue to use their clinical judgement to determine the optimum midwifery contact for each woman within their care, as determined by each woman's individual needs.
3. Referrals to DHBs for specialist consultations continue as per the Referral Guidelines and each DHB's processes.
4. Women should continue to have access to midwifery care and regular contact, but midwives need to adapt their care provision to minimise physical contact with clients by using telephone and/or video calling where possible.
5. During telephone/video call contact, consider the woman's confidentiality by ensuring she is aware that she may be required to share personal information. She may want to consider being alone in a room during her consultation.
6. Turanga Kaupapa and tikanga continue to be supported during this time.
7. Ensure comprehensive documentation of all contacts with women and reasons for providing any care that differs from your standard practice. Document clinical decision-making, rationale, actions and advice for any contact including telephone/video calls and in person.
8. Midwives should document when a telephone/video call contact was attempted but failed and ensure follow-up with the woman.
9. It is important to ensure women know how to contact their midwife for any urgent concerns about their pregnancy or baby.
10. Maternity care requirements remain unchanged and midwives should offer screening, information and advice at the usual gestation. Service provision may be changed to support reduced face-to-face contact.
11. Practise continuity of carer throughout antenatal, birth, and postnatal midwifery care where possible to reduce risk of exposure for women and midwives.

Prioritising care

During lockdowns, health care services that continue to operate are modified to minimise in-person contact by undertaking, where possible, telephone or video contacts. Some women experience barriers to accessing clinically or socially indicated services due to the suspension or restriction of services by a number of health service providers. These changes have the potential to more significantly affect populations who already experience health inequity and outcome disparities.

In order to meet our Tiriti o Waitangi responsibilities, midwives continue to provide care and make relevant referrals to ensure existing health inequities are not further compounded by the reduction in the availability of some services.

12. Consider the impact of the COVID-19 pandemic response, including lockdown, on women and whānau who live with deprivation and women with co-morbidities, including any barriers to accessing health services.
13. Covid-19 Advice for Māori has been produced by Te Rōpū Whakakaupapa Urutā | National Māori Pandemic Group.
14. Continue to undertake booking health assessments in the first trimester by using phone or videocalling, in order to ensure health promotion, information sharing and referrals are completed in a timely manner. Encourage early registration.

15. Promote and refer for influenza vaccination at the woman's earliest convenience (during 'flu season) and pertussis vaccination to occur from 16 weeks of pregnancy. Reassure women it is safe to see their GP for these vaccinations.
16. Mental health may have been affected by a variety of stress responses relating to the effects of being in lockdown. Check in with women about their mood and mental wellbeing. Advise women to use the national mental health line by calling 1737 or refer to GP or support services.
17. Family violence increased during lockdown and may increase with additional stress on moving back up alert levels. Consider more frequent family violence screening and refer as necessary.
18. Refer to the Well Child Tamariki Ora (WCTO) provider of the woman's choice and the GP by 4 weeks postpartum. Add a notification on the referral if the woman or baby have increased needs so that WCTO can prioritise them. Advise women about the importance of childhood immunisations beginning at 6 weeks, according to the schedule.

Responsibility for care

- If a woman is symptomatic or meets HIS criteria or has confirmed COVID-19, the LMC midwife liaises with DHB maternity services for care that cannot be deferred. If a physical assessment is required, discuss the appropriate setting for the woman's care with the hospital team.
- The LMC midwife remains responsible for labour and birth care for their clients who do not have symptoms, HIS criteria or confirmed COVID-19.
- For women who either have symptoms (and test results not yet available), meet HIS criteria or have COVID-19 in labour, discuss with the DHB regarding transfer to the DHB for labour and birth care. For women with mild symptoms, who do not meet HIS criteria, and are awaiting COVID-19 test results, the LMC midwife may choose to provide labour care. This is discussed with the DHB on a case-by-case basis.
- If uncertain, discuss with DHB maternity team.

There is a clear definition of **symptoms** and **High Index of Suspicion criteria** for testing on the Ministry of Health website.

Practice management of contacts with women

Midwives who are not practising because they are in an at-risk group (see Occupational health guidance for vulnerable community-based self-employed midwives) or are in quarantine/self-isolation may support their colleagues through providing telephone/video call contact and COVID-19 screening.

If a woman has symptoms consistent with COVID-19 / has been tested for COVID-19 and is awaiting results / has confirmed COVID-19: contacts should only take place when they cannot be safely deferred until after the end of the quarantine/self-isolation period. If a face-to-face contact is required discuss with the DHB regarding the appropriate setting for the visit. It must not occur in your clinic. This will require PPE equipment according to the current PPE guidance and requesting the woman to wear a face mask during the contact.

Undertaking a telephone/video call contact

Appointments may consist of a telephone/video call, in-person contact, or may be a combination of these. Detailed information on telephone/video assessments is available on the College website.

Offer in-person contact for necessary screening (BP, fetal growth) as per tables 2 & 3 and additional in-person contact as necessary if, during your telephone/video call contact, you identify a need for physical assessment. Identify any clinical issues that may require further investigation prior to an in-person assessment.

During the telephone/video call contact

- **Information sharing**: Share the usual information appropriate to the woman's gestation, including options for screening and recommended testing, ongoing pregnancy planning, information on what to expect in physical changes and fetal activity.
- **Assessment and screening**: Assess the woman's physical and psychosocial wellbeing and consider whether a physical assessment is required.
- **Decision making**: Identify referral needs e.g. ultrasound scans, blood tests, or need for prescriptions and document discussions and decisions.
- **Health information and education**: Discuss self-care and lifestyle, consider more frequent family violence screening (family violence increased in lockdown), reiterate signs and symptoms that would require the woman to contact you, e.g. reduced fetal movements, vaginal bleeding or leaking of fluid, abdominal pain, headaches, blurred vision or anything else that is causing concern.

Undertaking a face-to-face/physical assessment

It is important that midwives, women and families/whānau protect themselves from potential exposure to COVID-19. In the context of midwifery care, this involves following hygiene, physical distancing and PPE recommendations:

During all face-to-face midwifery care, practise:

- The midwife and woman both wear face coverings
- Frequent and meticulous hand hygiene: soap and water where possible, hand sanitiser (**min 70% alcohol**) if soap and water not available. Take your own towel and soap to visits.
    - Hand washing/sanitising after physical touch (hands-on assessment e.g. BP, palpation) and on leaving the home or when client leaves clinic)
    - Reiterate hygiene measures to women
- Physical distancing (2m or more, physical touch only as necessary)
- Cough and sneeze etiquette
- Keep the clinic visit short. Conduct your conversation aspect of the visit by phone first, then only do the physical assessment in person. Physical assessment should be no more than 15 minutes.

Personal Protective Equipment (PPE) recommendations are in the Ministry guideline for PPE use in maternity settings. The recommendation for wearing face masks has been updated and masks should be worn for in-person contact during alert level 3 or 4. When full PPE is needed it is important to be confident in the appropriate way to put on (don), take off (doff) and safely dispose of PPE: see PPE Poster

Where PPE is required, the DHB supplies this, as well as training on correct application and removal of PPE.

The Ministry of Health has advised the College that midwives are not expected to do any visit that requires PPE (according to the Ministry's advice) if they cannot access PPE from the DHB. If PPE is unobtainable, care may need to be provided in a DHB facility where PPE is available.

Prior to any face-to-face contact, in all cases:

- Contact women individually prior to face-to-face appointments to advise them of the changes to care provision at this time.
- Phone ahead to screen all women for COVID-19 risk before appointment – see questions below. If you can't contact the woman, ask the screening questions when she arrives and before she enters your clinic or before you enter her home.
- Screening calls may be a role for midwifery practice partners who are not able to provide face-to-face care.

COVID-19 screening questions

Screen the woman according to the case definition and testing guidance on the Ministry website.

If the woman answers yes to any of the questions: if it is clinically safe, defer any face-to-face contact until the woman's COVID-19 status is known or her self-quarantine/self-isolation period is finished. If a face-to-face assessment is required, discuss the woman's care needs with the DHB to determine the appropriate location.

See the current case definition for updated details.

Table 1. In-person contact in either the clinic or woman's home

In clinic environment	In the woman's home
Ask the woman to wait in her car until you are ready to see her in clinic and request that she comes in alone.	Request that the woman is alone in one room of the house for your appointment.
Maintain optimal hygiene practices, especially hand washing.	Carry your own soap and fresh towel to each home contact, to ensure optimal hygiene practices can be achieved in a home environment, especially hand washing.
• Midwife and woman to wear face coverings • Hand wash or sanitise (with 70% alcohol-based hand rub) before and after physical touch (hands-on assessment e.g. BP, palpation)	

- Reinforce hygiene education during your contact
- Keep appointments to the shortest time possible to complete clinically necessary care - preferably no longer than 15 minutes
- Maintain physical distancing during the appointment where possible (2 metre gap), except for when you need to be in direct physical contact with the woman
- Prior to and immediately following hands-on assessments – move back to physical distancing
- Arrange ongoing antenatal appointments and reiterate contact advice – this can be done by phone, if required, to minimise face-to-face contact time
- Wash your hands at the end of the appointment

Allow time between the end of a clinic appointment and the beginning of the next one for cleaning of all surfaces and equipment	Set up your car hatch or boot with cleaning/sanitising equipment so that you can clean your equipment before driving away

Cleaning of equipment and environment

Remove toys, magazines from clinics
After each in-person contact, ensure the following (depending on whether in the clinic or the home)

- Carry out a thorough clean of the clinic room
- Clean all 'high-touch' surfaces (e.g. desks, including phones, keyboards) with antiseptic wipes or disinfectant, including bleach solutions
- Clean midwifery equipment between uses
- Always wear disposable gloves when cleaning
- Wash your hands immediately after cleaning
- Ensure PPE is disposed of safely and appropriately as per your local DHB instructions.

Special circumstances

English as a second language

Providing care for women who have limited or no English (or not a language spoken by the midwife)

As per usual practice, it is recommended that an interpreting service is used for discussions with women and families who do not speak English, if the midwife does not speak the woman's language herself. COVID-19 presents unique challenges with relation to conducting telephone consultations in these circumstances.

All College members are able to register to access a telephone interpreting service called EziSpeak via the MMPO. EziSpeak states it provides 24/7 access to interpreters for more than 180 languages. Interpreters are usually available within 2 minutes when a call is made to the service. Three-way

telephone conversations can be conducted between the midwife, the woman and an interpreter, but videoconferencing and teleconferencing are not available as yet.

Instructions on setting up a three-way telephone conversation from an Android or iPhone:

1. Phone EziSpeak as per the instructions you received from MMPO.
2. Ask for an interpreter in the language you require.
3. Once the interpreter answers the call, explain that you will put them on hold while you call the woman.
4. On your smartphone screen, tap 'add call'. This will put the interpreter on hold once you select or dial the woman's number.
5. When the woman answers, tap 'merge calls'.
6. You can end the call for either participant to return to a normal two-way call, or end the call completely with both at the same time.

It is important to familiarise yourself with guidelines on using interpreting services, particularly for phone calls. Guidelines for health professionals working with remote interpreters can be found at eCALD.

Rurality/contact issues

Where women do not have access to online or phone contact, or it is unreliable, you will need to discuss how you can achieve contact with the woman. Think about how you have maintained contact in the past. If the woman requires financial support to maintain voice contact (not just text) then discuss this with the DHB social work team in the first instance. If longer in-person contacts are unavoidable, ensure that physical distancing is maintained at all times except when direct physical contact is required. Request that only the woman is in the room with you if undertaking home visits.

Frequency of midwifery contacts

Tables 2 and 3 are a guide to support midwifery practice during COVID-19 Alert Levels 3 and 4. The midwife uses her clinical judgement and discussion with the woman to determine what is required for each woman in her individual circumstances. There is a wide breadth of health information and education that midwives share and discuss with women. It is important that midwives have these discussions at the appropriate time for each woman and this can be facilitated by phone or video appointments.

Service linkage – Referral to Well Child services

Referral for Well Child/Tamariki Ora Services should continue in the usual way. Where midwives have concerns for a baby e.g. recent discharge from NNU/SCBU, weight gain/feeding issues, the midwife can alert the provider to the specific clinical concern on her referral form and ask that they be contacted to discuss their concerns. This will help the Well Child/Tamariki Ora service prioritise these babies.

Claiming for midwifery care: Covid-19 special circumstances

The Ministry of Health will continue to pay midwifery claims for labour and birth care when a handover to the DHB has been required due to COVID-19, or when usual antenatal/postnatal care has not been

possible due to COVID-19. Follow instructions on the MOH Primary Maternity Services Notice website under the heading: Claiming for COVID-19 related transfers of care.

ANTENATAL CONTACTS

Table 2 is a guide for suggested antenatal contacts to provide care for women during their pregnancy.

If a woman has confirmed COVID-19 OR symptoms consistent with COVID-19 OR is in self-isolation as a contact: contacts should only take place when they cannot be safely deferred until after the end of the quarantine/self-isolation period. However, essential and urgent midwifery care for these women and their babies should continue. This includes, but is not limited to: necessary antenatal assessments in late pregnancy, and assessment for any obstetric concerns at any stage of pregnancy (e.g. bleeding, pre-eclampsia, decreased fetal movements). The most appropriate place for the urgent assessment to take place might be your local DHB or the woman's home, depending on the full clinical picture.

If an in-person contact is required, discuss with the DHB regarding the appropriate setting for the visit. It must not occur in your clinic. This will require PPE equipment according to the current PPE guidance and requesting the woman to wear a face mask during the contact.

Table 2. Guide to frequency of contacts in pregnancy during COVID-19 Alert Levels 3 and 4

The midwife uses her clinical judgement and discussion with the woman to determine the frequency and type of contact required for each woman in her individual circumstances, including the need for in-person assessment for acute concerns.		
Gestational age	**Type of contact**	**Rationale for in-person contact**
First trimester before 12 weeks or at initial booking if occurs after first trimester	**Booking** – most information can be gained and shared by telephone/video calling prior to actual contact where the physical care can be provided **In-person contact** for physical assessment	A baseline blood pressure (BP) is necessary so that pregnancy induced hypertension can be identified later in pregnancy. Urinalysis is recommended to identify any underlying infection. BMI is calculated in early pregnancy to enable risk assessment and provision of health advice. If blood pressure and initial antenatal blood results are available through the GP then an in-person contact may not be needed.
Between 12 and 20 weeks gestation	Telephone/video call contact between 12 and 16 wks gestation	If any concerns, consider in-person assessment
	Telephone/video call contact between 16 and 20 wks gestation	Woman may have anatomy scan, which can provide reassurance of fetal health
Between 20 and 24 weeks gestation	**Consider in-person contact** Information gained and shared by telephone/video call prior to contact	Undertake BP, palpation, FH auscultation, urinalysis, family violence screening If the woman has declined having an anatomy scan, an assessment of fetal growth by palpation is important. A physical assessment enables assessment of fetal growth and maternal physical health.

Between 24 and 30 weeks gestation	Telephone/video call contact	If any concerns, consider in-person assessment
	In-person contact (closer to 28 weeks) Information gained and shared by telephone/video call prior to contact	Undertake BP, palpation, fundal-symphysis height (FSH), FH auscultation, urinalysis, consider family violence screening A physical assessment is required to assess fetal growth and maternal physical health. Subsequent antenatal blood testing options
Between 30 and 32 weeks gestation	Telephone/video call contact	If any concerns, consider in-person assessment
Between 32 and 36weeks gestation	**In-person contact** Information gained and shared by telephone/video call prior to contact	Need to undertake BP, palpation, FSH, FH auscultation and urinalysis A physical assessment enables assessment of fetal growth and maternal physical health (eg. to exclude pre-eclampsia)
	Telephone/video call contact	If any concerns, consider in-person assessment
Between 37 and 40 weeks gestation	Weekly contacts with **at least 2** being **in person** For nulliparous women or known health issues or risk factors**, consider weekly in-person contacts**	Undertake BP, urinalysis, palpation, FSH, FH auscultation. Blood tests and repeat GBS swab if indicated Physical assessments enable assessment of fetal growth and maternal physical health
Between 40 and 42 weeks gestation	At least weekly **in-person** contacts	Undertake BP, urinalysis, palpation, FSH, FH auscultation. A physical assessment enables assessment of fetal growth and maternal physical health

POSTNATAL CONTACTS

Table 3 is a guide for suggested postnatal contacts to provide care for women and their babies following the birth.

If a woman has confirmed COVID-19 OR symptoms consistent with COVID-19 OR is in self-isolation as a contact: contacts should only take place when they cannot be safely deferred until after the end of the quarantine/self-isolation period. However, essential and urgent midwifery care for these women and their babies should continue. This includes, but is not limited to: necessary postnatal assessment including breastfeeding support, perineal/caesarean wound healing examination, newborn metabolic screen and full newborn examination and weight within the first week, and any urgent postpartum concerns (e.g. signs of infection, pre-eclampsia and others). The most appropriate place for the urgent assessment to take place might be your local DHB or the woman's home, depending on the full clinical picture.

If an in-person contact is required discuss with the DHB regarding the appropriate setting for the visit. This will require PPE equipment according to the current PPE guidance and requesting the woman to wear a face mask during the contact.

Table 3. Guide to frequency of contacts postpartum during COVID-19 Alert Levels 3 and 4

The midwife uses her clinical judgement and discussion with the woman to determine the frequency and type of contact required for each woman in her individual circumstances, including the need for in-person assessment for acute concerns.		
Postpartum days	**Type of Contact**	**Rationale for in-person contact**
Days 1, 2, 3 (daily contact depending on whether mother/baby are inpatients or at home, and local DHB guidance)	**In-person contact** (undertake non-physical aspect of appointment by phone or video call prior to entering the woman's home)	Undertake a full physical assessment of maternal and neonatal health: neonatal (Well Child Tamariki Ora) assessment including red eye reflex, metabolic screening, hip examination. Breastfeeding assessment and support, safe sleep space. If the woman is an inpatient, the DHB service may provide these assessments
Within 24 hours of discharge from maternity facility	**In-person contact** (undertake non-physical aspect of appointment by phone or video call prior to entering the woman's home)	To identify care needs and undertake a physical assessment of maternal and neonatal health
Day 4	Telephone/video call contact	
Day 5 to 7	**In-person contact** (undertake non-physical aspect of appointment by phone or video call prior to entering the woman's home)	Undertake a full physical assessment of woman and baby. Maternal physical and psychosocial wellbeing. Neonatal (Well Child Tamariki Ora) assessment including weight. Breastfeeding observation.
Day 9	Telephone/video call contact	
Day 10-14	**In-person contact** (undertake non-physical aspect of appointment by phone or video call prior to entering the woman's home)	Undertake a full physical assessment of woman and baby. Maternal physical and psychosocial wellbeing. Neonatal assessment including weight. Breastfeeding observation
Day 21	Telephone/video call contact	

Day 28 – 42 days	**In-person contact** (undertake non-physical aspect of appointment by phone or video call prior to entering the woman's home)	Undertake a full physical assessment of maternal health and neonatal health prior to midwifery discharge.
Refer to GP/Well Child services by 4 weeks	Referrals to Well Child/ Tamariki Ora and GP services should continue as usual.	

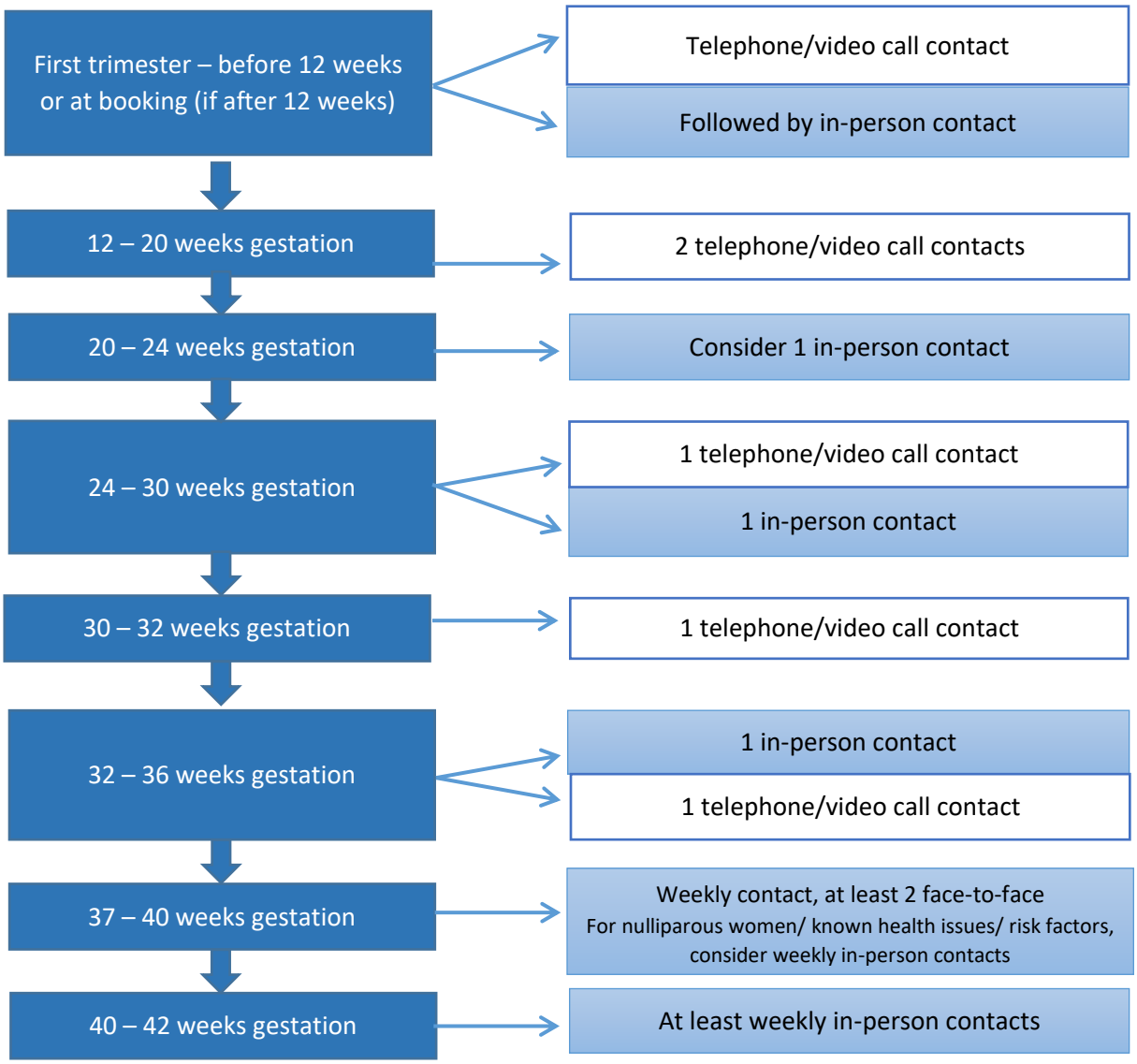
Appendix I. COVID-19 Alert Levels 3 and 4 flow chart guidance for antenatal care contact

This advice is specific to the COVID 19 Alert Levels 3 and 4 which requires everyone, including pregnant women and their families, to stay at home – unless they require an essential service (level 4) or access to a safe business (level 3). Accessing midwifery care in both the community and hospital are essential services.

Midwives should continue to use their clinical judgement to determine the optimum number of midwifery contacts for each woman within their care. Some women may require additional in-person contact to undertake physical assessment.

Flow chart guidance for Antenatal Care contact

For in-person contact, undertake non-physical aspect of appointment by phone or video call prior to clinic or home visit.



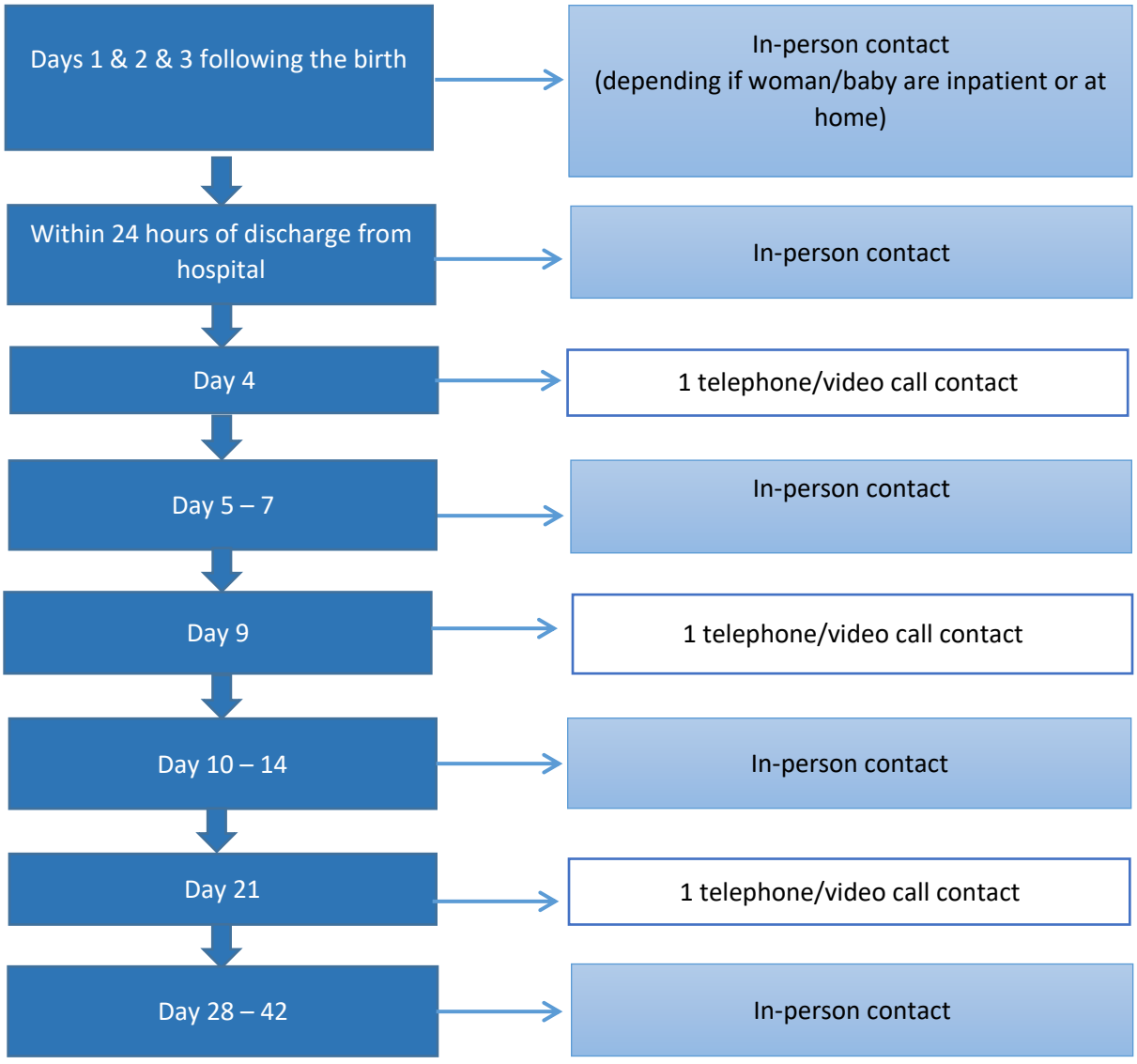
Appendix II. COVID-19 Alert levels 3 and 4 flow chart for postnatal care contact

This advice is specific to the COVID 19 Alert levels 3 and 4 which requires everyone, including pregnant women and their families to stay at home – unless they require an essential service (level 4) or access to a safe business (level 3). Accessing midwifery care in both the community and hospital are essential services.

Midwives should continue to use their clinical judgement to determine the optimum number of midwifery contacts for each woman within their care. Some women and babies may require additional in-person contact to undertake physical assessment.

Flow chart for postnatal care contact

For in-person contact, undertake non-physical aspect of appointment by phone or video call prior to entering the woman's home.



Appendix III. Minimising the risk of exposure to COVID-19 when in-person assessments are clinically necessary

For current PPE guidance, see the Ministry of Health website. Face coverings are recommended at all visits.

Before seeing women who are in quarantine/self-isolation, discuss with your DHB.

Table 4. Infection prevention and control measures for in-person contact

Appointment location	Well woman, no symptoms/HIS criteria	Woman has symptoms or meets HIS criteria	Woman with confirmed COVID-19
Clinic visit	**For clinically necessary visits:** • Remove toys, magazines • Clean equipment between uses (see below) • Clean clinic surfaces between clients (see above) • No waiting in waiting area: woman to remain in car and midwife texts/phones to ask her in	**No clinic visits**: Having symptoms or meeting HIS criteria means the woman must stay at home. See quarantine/self-isolation guidelines on the Ministry of Health website.	
Home visit	**For clinically necessary visits:** • Clean equipment between uses (see above)	**For clinically necessary visits:** • Discuss with DHB regarding where visit should take place • See the woman (and baby) on her own • Limit time for in-person contact to the physical assessment. Max 15 minutes and as much as possible stay 2 metres away • Conduct most of the conversation by phone • Follow MoH PPE in maternity settings guidance and provide the woman with a surgical face mask to wear for the whole visit	**If woman is hospitalised:** • Care is led by the DHB in accordance with pandemic plan and MOH guidance. **For clinically necessary home visits:** • Notify the DHB maternity service and seek individualised support • Visit takes place in the woman's home as the last visit of the day • See the woman (and baby) on her own • Limit time for in-person contact to the physical assessment. Max 15 minutes and as much as possible stay 2 metres away • Conduct most of the conversation by phone • Follow MOH PPE in maternity settings guidance and provide the woman with a surgical face mask to wear for the whole visit.

Appendix IV. Place of Birth

Public health measures take priority over women's birthing preferences in this exceptional circumstance. The choice of planned place of birth for women in quarantine/self-isolation for exposure to a confirmed or probable case of COVID-19 may be affected.

Advice on place of birth options and use of PPE has been produced by the Ministry of Health.

Table 5. COVID-19 place of birth options

Options to offer women for planned place of birth	**Well women, not in quarantine/self-isolation**	**Woman has symptoms or meets HIS criteria**	**Woman with confirmed or probable COVID-19**
Home	Yes	Discuss circumstances with woman and DHB to inform a decision	No
Primary birthing unit	Yes	No	No
Hospital (sec/tertiary)	Yes	Yes	Yes