

# Flexible Frameworks for Safe and Quality Midwifery Care during COVID-19

## Recommendations for governments and health authorities

Version 1 - April 16, 2020

The Canadian Association of Midwives (CAM) and the National Aboriginal Council of Midwives (NACM) are the national organizations representing midwives and the profession of midwifery in Canada. As primary health care providers, midwives are experts in normal birth and community-based care. Midwives are health care professionals with the training and expertise to provide perinatal, including intrapartum care outside of hospitals. As we collectively confront the COVID-19 pandemic and the magnitude of its impact to our public health care system, CAM and NACM recommend that governments, public health authorities, and system policy and decision makers consider how childbirth occurs in the context of COVID-19 and ***put in place flexible frameworks for perinatal care provision to ensure the safety of birthing people, families, and health care providers during this pandemic.***

### KEY RECOMMENDATIONS DURING THE COVID-19 PANDEMIC

1. Prepare for temporary restructuring of perinatal care services.
2. Protect the health and safety of front-line care providers, including midwives.
3. Maintain equitable, safe, and quality care to pregnant people and their newborns.
4. Protect communities where access to health care is limited or non-existent.

### **Recommendation 1: Prepare for temporary restructuring of perinatal care services.**

Childbirth is the most common reason for hospital admissions.<sup>1</sup> As hospitals see a surge in COVID-19 in the coming weeks and months, midwives offer critical risk mitigation services by providing perinatal care outside of hospital settings.

To reduce the exposure of birthing people and their care providers to COVID-19, we recommend the following:

- 1.1. Immediately develop and plan for the implementation of birthing locations that are separate from acute care treating COVID-19 patients. Locations could include hospital birthing units that are physically segregated from COVID-19 patient care units, free standing birth centres, and temporary birthing facilities in hotels and other appropriate locations.
- 1.2. Maintain community-based services, including access to home birth, for as long as feasible to reduce the risk of COVID-19 transmission.<sup>2,3,4</sup> Where midwifery workforce is lower, consider a multidisciplinary team approach to facilitate community-based births.

<sup>1</sup> Canadian Institute for Health Information (2019) Inpatient Hospitalization, Surgery and Newborn Statistics, 2017-2018.

<https://www.cihi.ca/en/hospital-stays-in-canada>

<sup>2</sup> Hutton, EK; Reitsma, A; Simioni, J; Brunton, G; Kaufman, K. (2019) Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses. *EClinicalMedicine*, vol. 14, pp. 59-70.

<sup>3</sup> Nacoti, Mirco, et al. (2020) At the Epicenter of the Covid-19 Pandemic and Humanitarian Crisis in Italy: Changing Perspectives on Preparation and Mitigation. *NEJM Catalyst*.

<sup>4</sup> World Health Organization. COVID-19: Operational guidance for maintaining essential health services during an outbreak. Available at: <https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak> [Accessed 8 April 2020]

- 1.3. Adopt a phased approach to limit or increase community-based services as local conditions change.<sup>5</sup> - Refer to Appendix A for details.
- 1.4. Establish regular communication with ambulance transport services to ensure timely transport to referral hospitals and understanding of potential limitations of facilities.
- 1.5. Shift to virtual prenatal and postnatal care as much as possible by ensuring access to virtual tools.

## **Recommendation 2: Prioritize the health and safety of frontline care providers, including midwives**

Health care professionals are at high risk of COVID-19 infection due to repeated exposure and, in many contexts, have inadequate access to personal protective equipment (PPE). Reproductive health care professionals offer an essential service that must be preserved during this pandemic.

We recommend the following:

- 2.1. PPE must be available to all health care providers, including midwives.
- 2.2. Provincial/territorial/federal protocols on use of PPE should include evidence-based clinical guidance from the World Health Organization recommendations.<sup>6</sup> If jurisdictional recommendations differ due to PPE supply shortages, this should be explicitly communicated to health care providers.
- 2.3. Given limited evidence regarding pregnancy and COVID-19, we recommend redeploying pregnant health care providers to indirect care provision (for example, only virtual visits, operational support, etc.). Pregnant health care providers with co-morbidities and pregnant health care providers after 28 weeks gestation should not be providing direct client care to COVID-19 positive clients.<sup>7,8</sup>
- 2.4. Informed choice discussions with clients should include possible implications of having an asymptomatic support person in labour. The community's capacity to respond to the pandemic must be conveyed to the client in these extraordinary circumstances.
- 2.5. Perinatal health care workers must not be redeployed or crossover to other care units during the pandemic.
- 2.6. Provide mental health support and sufficient rest periods for all health care providers.

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<sup>5</sup> Royal College of Midwives and Royal College of Obstetricians and Gynaecologists (April 9, 2020) Guidance for provision of midwife-led settings and home birth in the evolving coronavirus (COVID-19) pandemic.

<sup>6</sup> Rational use of personal protective equipment (PPE) for coronavirus disease (COVID-19) and considerations during severe shortages. World Health Organization, Interim Guidance, April 6, 2020.

<sup>7</sup> Royal College of Midwives and Royal College of Obstetricians and Gynaecologists (April 9, 2020) Guidance for provision of midwife-led settings and home birth in the evolving coronavirus (COVID-19) pandemic.

<sup>8</sup> Institut national de santé publique du Québec. (March 29, 2020) COVID-19 (SARS-CoV-2) : Recommandations intérimaires sur les mesures de prévention en milieux de travail pour les travailleuses enceintes ou qui allaitent. <https://www.inspq.qc.ca/sites/default/files/covid/2912-travailleuses-enceintes-allaitent.pdf>

### **Recommendation 3: Maintain equitable, safe, and quality care to pregnant people and their newborns.**

Perinatal care must continue to be evidence-based and decisions on provision of care must reflect evolving local realities regarding access to emergency services and capacities of referral sites. Pregnant people must remain the primary decision makers with regards to available choices in childbirth. In all circumstances, decisions around perinatal health care must apply a reproductive justice and harm-reduction approach.

We recommend the following evidence-based measures:

- 3.1. A sexual and reproductive health and justice approach must be centred during the COVID-19 response. People whose human rights are least protected are likely to experience compounding difficulties and carry heavier personal burden from the legacies of COVID-19. The way forward will be community driven. Taking a human rights lens to sexual and reproductive health, where intersecting injustices and power differentials are acknowledged, is foundational to equitable distribution of resources and collaborative solutions.
- 3.2. High quality, safe, evidence-based, and respectful obstetric care must be provided in all birth settings. Unnecessary interventions in birth must be reduced.
- 3.3. The birthing parent and their newborn must not be separated at birth unless absolutely necessary.
- 3.4. Breastfeeding should be promoted and supported for all clients.<sup>9</sup>
- 3.5. Support people should not accompany clients during in-person prenatal and postnatal visits to decrease risk of family exposure to the virus and to preserve critical PPE.
- 3.6. Pregnant people and their families should follow strict isolation protocols, except for medical appointments, starting at 36 weeks of pregnancy and into the postpartum period to decrease exposure to COVID-19 for themselves and their newborn and for the safety of their health care providers.
- 3.7. The support person at birth should be someone from the isolated family unit. Considerations must be taken with regards to the support person for people who are evacuated from their home communities to give birth.

### **Recommendation 4: Protect communities where access to health care is limited or non-existent.**

In Canada, many rural, remote, and Indigenous communities have limited access to health care and are particularly vulnerable to catastrophic outcomes of the COVID-19 pandemic.

We recommend the following:

- 4.1. Prioritize testing for COVID-19 for pregnant clients. In addition, prioritize testing for birthing people and their support person prior to their release from hospital facilities with priority given to people returning to remote communities.

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<sup>9</sup> Narvey, Michael (April 6, 2020) Breastfeeding when mothers have suspected or proven COVID-19. Canadian Paediatric Society, Practice Point. <https://www.cps.ca/en/documents/position/breastfeeding-when-mothers-have-suspected-or-proven-covid-19>

- 4.2. Conduct a review of current evacuation protocols and procedures so that clients evacuated from their remote community to give birth are redirected to out-of-hospital sites or hospital units that do not provide acute care to COVID-19 patients.
- 4.3. People who have been evacuated from their communities and who have given birth must be adequately funded and supported to undertake strict isolation practices before and after returning to their community.
- 4.4. Rural, remote, and Indigenous communities should be supported through funding, education, and availability of health care providers to follow, where possible, the recommendations outlined in this document.

**For more information on the recommendations in this document and for media requests, please contact Eby Heller at [eheller@canadianmidwives.org](mailto:eheller@canadianmidwives.org).**

## **APPENDIX A**

This example of a phased approach is adapted for a Canadian context from the document *Guidance for provision of midwife-led settings and home birth in the evolving coronavirus (COVID-19) pandemic*, published by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists as a tool for evaluating local conditions to determine if changes in the provision and location of birth services must be made. Daily monitoring is recommended, as shifts between phases (both increasing and decreasing) may be very rapid.

**Phase 1:** Maintain routine services but with heightened attention to infection control practices, increased use of PPE. Prepare for Phases 2 and 3. Inform the public that the provision of care may need to change. Plan for alternate birth service locations and human resources that are separate from acute COVID-19 centres.

**Phase 2:** Introduce as staffing shortages reach 20- 30% and EMS experiences minor delays. Offer homebirth only to low risk multiparous clients to reduce the likelihood of EMS transfers. Encourage use of birth centres or alternate birth service locations for all low risk, asymptomatic clients. Use dedicated private taxi for non-emergency transfer. Monitor daily to determine if/when Phase 3 should be triggered.

**Phase 3:** Introduce as staffing shortages reach greater than 30% and EMS experiences severe delays. Discontinue home birth except where client chooses against midwife's advice (so as to prevent unattended home birth). Move birth services out of hospital where there is a surge of COVID-19 cases in hospital, either to another nearby hospital or to a hotel converted to a birthing centre. Monitor daily to determine when de-escalation to Phase 2 should be triggered.