## Advisory: Ministerial Advisory Committee (MAC) on Covid-19:

## Parental access to hospitalised children

### SUMMARY: KEY MESSAGES: PARENTAL ACCESS TO HOSPITALISED CHILDREN

1. **Avoid separation of mother/primary caregiver and child – explore all options and be innovative to avoid separation. Only separate in exceptional circumstances** e.g. adequate facilities do not exist to jointly accommodate parent/primary caregiver and newborn/young infant/child in hospital. **Both parents should be allowed access to hospitalized children**, under strict infection prevention and control (IPC) measures and non-pharmaceutical interventions (NPI) including hand sanitisation, face masks, and physical distancing.
2. **Newborns /young infants and their parents / primary caregivers have a reasonably high likelihood of having a similar COVID-19 status, and should be managed as a single dyad rather than as two separate individuals.** A positive SARS-CoV-2 result in either member of the dyad should prompt management of each as potentially infectious. Cohort dyads based on their COVID-19 status: COVID-19 negative dyad (both negative), COVID-19 positive dyad (either positive).
3. **Promote, support and encourage breastfeeding, or breastmilk feeding, and discuss skin-to-skin care of newborns with the mother/primary caregiver**. Ideally, promote breastfeeding and skin-skin contact, with infection prevention and control (IPC) measures and non-pharmaceutical interventions (NPI) (i.e. mother/primary caregiver dons a surgical mask and practices hourly hand hygiene and respiratory etiquette). Kangaroo mother care (KMC) units should continue only if cohorting is possible, IPC and NPI is maintained and the physical space facilitates isolation of infected dyads with distancing from uninfected dyads. With regards to the continued running of KMC units, Individual health facilities may tailor local decisions after consultation with district-level and paediatric experts, based on local availability of space, IPC and NPI. Individual health care providers may tailor skin-skin decisions for an individual dyad after counselling a mother/primary caregiver, based on choice, and ability to implement IPC and NPI.
4. **Provide surgical masks to all parent(s)/primary caregivers**, accompanying a child to hospital. These should be replaced daily throughout the hospital stay.
5. **Every hospital is mandated to provide lodger/boarder mother facilities for COVID-19 positive, COVID-19 negative and PUI mothers (separately)**. Stringent IPC measures and NPI should be implemented (see points 6-7 below). **If facilities are limited, prioritise breastfeeding mothers in the following order: (i) COVID-19 negative, (ii) PUI (iii) COVID-19 positive.**
6. **Implement administrative controls to reduce infection risk:**

- **Identify an infection control marshal (staff member) in each children's ward, during every shift**, to encourage and enforce IPC measures and NPI amongst staff, patients and parent(s).
- **Identify a mother / peer champion or staff member to orientate new lodger others and oversee compliance with IPC measures and NPI** including strict hand hygiene - hourly handwashing/sanitization with alcohol based hand rub; 12-hourly symptom screening, surgical face masks at all times except when bathing, eating or sleeping – these should be changed daily. Mothers should eat outside, weather permitting, or in a well ventilated area, away from other boarders (preferably 2 metres or at least 1 metre apart). Restrict movement to between the lodge and the child's ward.

7. **Reinforce engineering controls to reduce infection risk: Ensure at least 1 metre, and preferably 2 metre spacing between** mothers' beds and hospital beds/incubators/bassinet with sanitizer at the foot of every bed/incubator/bassinet.
8. **If parental separation is unavoidable, limit it to as short a period as possible, and implement innovative methods to facilitate contact** including daily phone calls, photographs and video/WhatsApp calls, and skin-skin interactions by a caregiver or staff member designated to care for the newborn/young infant/child. Assist with lactation/re-lactation after the acute illness.
9. **Engage with communities to explore the repurposing of homes/ community halls around the hospital to accommodate dyads.**
10. **Policies and practices (e.g. IPC measures/ NPI) around parental access to hospitalized children during COVID-19 could cause or exacerbate stress: Link parents to local community resources or facilitate access to grants**. Additionally, obtain feedback on hospital processes/systems/policies to optimize processes, systems and practices.

## DETAILED MAC ADVISORY:

**BACKGROUND:**

The Human Rights Commission lodged a complaint with the Ombud about lack of parental access to hospitals due to COVID-19-related policies or guidelines, prompting a MAC advisory.

***Characteristics of childhood and hospitalisation during childhood:***

1. Childhood is a period of physical, psychological and social vulnerability.
2. Illness and admission to hospital are traumatic events with the potential for physical, emotional and social harm to young children.
3. The potential trauma of admission may be exaggerated by the need for social distancing, infection prevention and control (IPC) measures, and non-pharmaceutical interventions (NPI) including personal protective equipment (PPE).

***Benefits of parental presence / involvement during hospitalization:***

1. Studies report that the stress levels of parents are reduced by being more informed and involved in caring for their children while in hospital. [1] Furthermore, in a post-tonsillectomy unit, parent satisfaction was higher when they were involved in caring for their children. [2]
2. Systematic reviews have demonstrated that parents and health care providers recognize the value of parents being with their child during hospitalisation. [3]
3. With regards to newborns, a systematic review and meta-analysis of randomized controlled trials on the effect of kangaroo mother care (KMC) on hospital management indicators including length of stay. The KMC group performed significantly better on the following outcomes: overall length of hospital stay (significantly shorter), frequency of readmission and patient satisfaction. [4] Additionally, skin-skin contact in the first hours of life is associated with reduced postpartum hemorrhage risk, decreased rates of postpartum depression and anxiety, and increased odds of successful breastfeeding. [5]
4. In the context of COVID-19 data quantifying the risks and outcomes of newborn exposure to maternal COVID-19 continue to be assimilated, and new data emerge almost daily. While individual reports have raised the possibility of intrauterine SARS-CoV-2 transmission, breastmilk transmission has not been described. However the possibility of transmission through respiratory droplets intra- or post-delivery is real.
5. On the one hand cluster outbreaks of COVID-19 in mothers lodges or Kangaroo Mother Care Units, coupled with isolated adverse newborn outcomes despite negative SARS-CoV-2 test results [6] have led to cautious expert opinions and individualised management: pre-delivery counselling with temporary post-delivery separation of COVID-19 infected mothers from their infants and expressed breastmilk feeding collected while practicing strict infection control has been recommended.[6]
6. On the other hand, for global public health, the World Health Organisation recommends that mother-infant pairs should remain together while rooming-in throughout the day and night practicing skin-to-skin contact, including kangaroo mother care, especially immediately after birth and during establishment of breastfeeding, whether they or their infants have suspected or confirmed COVID-19. [7]
7. The European Paediatric Association also recommends that mothers and infants should be enabled to remain together, practice skin-skin contact and room-in throughout the day and night, whether or not the mother or child has suspected, probable, or confirmed COVID-19, especially straight after birth during establishment of breastfeeding. [8]

8. Separation of mother/primary caregiver-baby pairs could theoretically minimise the risk of SARS-CoV-2 transmission; however by March 2020, and at the time of writing this advisory there was no strong evidence highlighting the benefit of separation. [9]
9. Additionally, separation may not prevent infection as described in a case series from Wuhan – neither does it prevent infection post discharge. [9] It could also disrupt newborn physiology (higher heart and respiratory rates, and lower glucose levels in newborns). As noted by the Royal College of Midwives, Obstetricians and Gynecologists and Paediatricians in the UK, ''routine precautionary separation of a mother and a healthy baby should not be undertaken lightly, given the potential detrimental effects on feeding and bonding.''[10] Isolation is a significant stressor for newborn infants; for those infants already infected with SARS-CoV-2, isolation could worsen the disease course.
10. Separation also stresses mothers, increasing heart rate and salivary cortisol levels, and in the context of a pandemic this can cause significant additional suffering that could worsen the mother's disease course. [9]
11. Current evidence shows that risk of newborn infection is very low and most infected newborns do not have significant morbidity. [5] The benefit from KMC to both the infant/mother dyad outweighs the risks particularly in low and middle income countries. Consequently, the mother/primary caregiver should be empowered and given the option to do KMC with explanation of risks and benefits with emphasis on IPC and NPI to reduce the risk of transmission. Infant/mother dyads should remain together if possible and encouraged to KMC; these infants do not need to be nursed in an incubator if they remain with their mother in isolation – if not doing skin to skin they can be in a cot next to the mothers bedside.
12. Parental stress has been linked to poorer developmental outcomes in preterm infants. [11] Cessation of visitation all together during a pandemic, while not empirically studied, could undoubtedly add to the parental stress of NICU admission, with subsequent deleterious effects on the development of infants.
13. Lastly, separation could interfere with maternal milk production and supply, disrupting innate and specific immune protection. [9]

***Experiences within the South African context and abroad:***

1. Four months ago 9 mothers, 2 babies, 4 doctors, and a nurse tested positive for COVID-19 at the General Justice Gizenga Mpanza Hospital (previously Stanger hospital) in KwaZulu-Natal, despite IPC measures (https://ewn.co.za/2020/05/05/two-babies-14-adults-test-positive-for-covid-19-in-kzn-hospital): the source of infection was a lodger mother who did not disclose close contact with a COVID-19 case.
2. At Chris Hani Baragwanath Hospital (CHBH) before June 2020, mothers were allowed to visit daily and stay until 6pm. On 08 June 2020, a mother in the KMC ward was found to have symptoms during screening, and subsequently tested COVID-positive (personal communication, Prof Velaphi). She was sent home for self-isolation. Sixteen mothers who were with her in the KMC were tested, and 12 were positive; and 8 of their babies were positive. Two babies who were in KMC during this time period subsequently died, and both were COVID-19 positive and their lungs had features suggestive of COVID-19 on histopathology. Subsequent to this outbreak, a decision was taken to test all mothers before they could be admitted to KMC unit. These mothers were well and asymptomatic, visiting their babies in the neonatal unit on a daily basis when they were being tested. It was found that about 20% of these asymptomatic mothers were positive for COVID-19. Based on these findings a decision was taken to stop mothers visiting daily, testing all mothers whose babies were ready for KMC, admitting to KMC only the negative ones. When a new lodger facility was opened in August, only negative mothers were allowed to lodge. Mothers not in the KMC wards or lodger facility are

encouraged to express breast milk at home and ask relatives to bring milk on a daily basis. In addition a study on Group B Streptococcus at CHBH identified 4 COVID-19 positive asymptomatic mothers post-delivery.

3. By September 2020, the SARS-CoV-2 epidemic in South Africa was on a rapid decline and the probability of mothers being infected has become diminishingly low. Whilst this may change there is currently ample room to foster mother-baby interactions to ensure newborn and long-term health. At Baragwanath hospital testing amongst pregnant women has demonstrated a continued decline in positivity rates, which is now close to zero (see Figure 1 below).

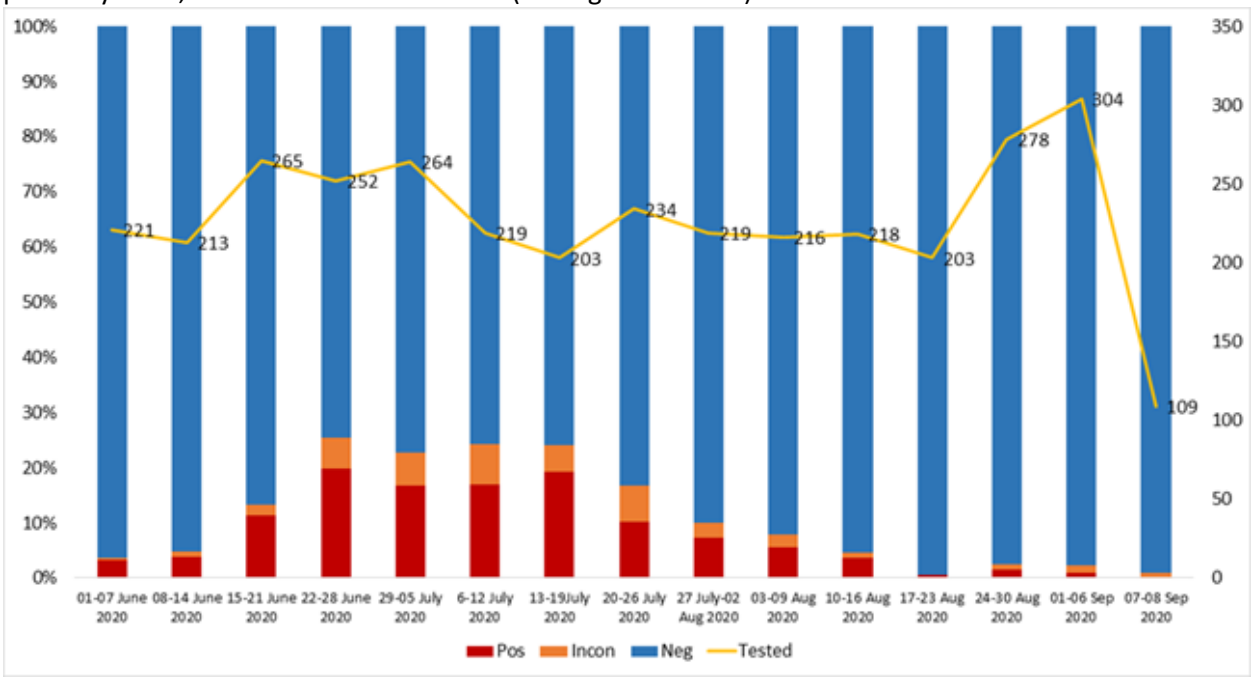


Figure 1: SARS-CoV-2 testing and results amongst pregnant women at CHBH, 1 June-8 September 2020. Source: Shabir Madhi

4. A paper published in the Lancet Child and Adolescent Health reporting data from a New York hospital during March-May 2020, demonstrated that of the 120 babies born to 116 COVID-positive mothers, none had acquired COVID-19 by 1 month of age. [12] All neonates who roomed in with their mothers were kept in a closed Giraffe isolette (General Electric Healthcare, Chicago, IL), initiated skin-skin in the delivery room with appropriate infection control and were held by mothers for feeding after appropriate hand hygiene, breast cleansing, and use of a (maternal) surgical mask. Only mothers were allowed in the postpartum unit for the duration of the neonate's stay. All mothers were allowed to breastfeed. Mothers of neonates admitted to the neonatal intensive care unit (NICU) were allowed to visit 14 days after they tested positive if they had been afebrile for at least 72 hours.

***Ethics around parental visitation rights:***

1. Hospital policies that limit visitor, and by extension, limit mobility, are rooted in consequentialist ideals. [13] This means such limitations must have a positive impact on the greater constituency.
2. One could argue that restricting parental access to hospitalized children is entrenched within utilitarianism i.e. maximizing the good for the highest number, and libertarianism, which states that the "the only purpose for which power can be rightfully exercised over any member of a civilized community against his will, is to prevent harm to another."[14] The current pandemic would constitute justification of limited liberties under the basis of utilitarianism and libertarianism,

justifying the draconian limitation of parents at the bedside if there are no less intrusive measures of preventing the spread of SARS-CoV-2.

3. In 1984 the Siracusa Principles, outlined by the United Nations, coalesced the conditions necessary to legitimize restrictive public health measures in the setting of a pandemic. [15] Importantly, these principles stipulate that the least restrictive measures of interference and disruption should be used to achieve the public health goal.
4. In the context of COVID-19 the proper application of PPE, can contain and reduce spread. [16, 17] However, the prospect of allowing asymptomatic carriers, who could be contagious, into the NICU is daunting. This anxiety comes from other staff members and mothers coming into contact with a mother who is COVID-19 positive; even with PPE a zero risk to others cannot be guaranteed and therefore health services cannot guarantee first do no harm for all. However the risk from mothers to their own babies is low; consequently, it is completely reasonable to keep infants with their mothers even if the mother is COVID-19 positive provided she is well enough to care for her baby and follows strict infection control measures.
5. Lastly the ethics of having contrasting hospital policies (whereby some hospitals allow parental access whilst others do not) is disingenuous because the guiding principle is not based on facts particular to the case or the community, but instead on hospital protocol. [14]

**PROPOSED WAY FORWARD:**

**AVOID SEPARATING PARENTS AND HOSPITALIZED CHILDREN**

- **Newborns /young infants / children and their parents / primary caregivers have a reasonably high likelihood of having a similar COVID-19 status.**
- Newborn/young infant and parent should therefore be considered and managed as a single dyad rather than as two separate individuals. COVID-19 positive mothers may spread SARS-CoV-2 to other mothers or to hospital staff. A positive SARS-CoV-2 result in either member of the dyad should prompt management of each as potentially infectious.
- Children should have access to both parents during their hospitalization (see section on fathers below).

**BE GUIDED BY FOUR PRINCIPLES:**

- **First do no physical, emotional or social harm:** the best interest (nutrition, health, development and well-being) of every child should be prioritized – children should not be harmed nor should the decision cause harm to other children, caregivers or staff.
- **Maximise the good for the highest number,** whilst causing no harm.
- **Apply the least restrictive measures of interference and disruption to achieve the public health goal.**
- **Consider the feasibility** of implementing recommended protocols in different social, cultural and geographic contexts, including settings with limited resources.

**TEN RECOMMENDATIONS**

1. **Avoid separation: Separation of parent/primary caregiver and newborn/young infant / child should only occur under exceptional circumstances.** e.g. adequate facilities do not exist to jointly accommodate parent/primary caregiver and newborn/young infant/child in hospital.

- To minimize the possibility of physical, emotional and social harm to young children, every child requiring admission to hospital should be accompanied by a parent/their primary caregiver, based on child's maturity and need.
- As far as possible every newborn/child needing hospitalisation should ***be admitted*** with his/her parent /primary caregiver.
- Both parents should be allowed access to hospitalized children, under strict infection prevention and control (IPC) measures and non-pharmaceutical interventions (NPI) including hand sanitisation, face masks, and physical distancing.
- Parental counselling should include counselling for mothers and fathers. One-one counselling should include what is expected from parents, if the dyad is positive, negative or unknown (see classifications below), infection prevention and control (IPC) measures and non-pharmaceutical interventions (NPI) including hand sanitisation, wearing masks and physical distancing.
- The parent(s)/family must identify the primary person who will stay with the child with the understanding that this primary person should remain with the child for the full duration of their admission. If exceptional circumstances exist and the primary person is unable to stay for the full duration, a pass-out may be allowed, and parents may swop around. Strict IPC and NPI measures should be followed to prevent SARS-CoV-2 infection or limit spread.
- Current evidence shows that risk of newborn infection is very low and most infected newborns do not have significant morbidity. The benefit from KMC to both the infant/mother dyad outweighs the risks particularly in low and middle income countries. Consequently, the mother/primary caregiver should be empowered and in the case of newborns, given the option to do KMC with explanation of risks and benefits with emphasis on IPC and NPI to reduce the risk of transmission. Mother-newborn dyads should remain together if possible and encouraged to KMC; these infants do not need to be nursed in an incubator if they remain with their mother in isolation – if not doing skin to skin they can be in a cot next to the mothers bedside.

2. **Newborns/young infants / children and their parents / primary caregivers are likely to have a similar COVID-19 status and should be managed as a single dyad rather than as two separate individuals**. Primary caregiver and child should be tested for COVID-19 for cohorting:
   - COVID-19 negative dyad: both child AND primary caregiver have negative COVID-19 tests.
   - PUI dyad: unknown COVID-19 status of child and/or primary caregiver.
   - COVID-19 positive dyad: either child OR primary caregiver has a positive COVID-19 tests.

   Members of each category of dyad should be accommodated together and every hospital needs to assess where to accommodate each category:
   - COVID-19 negative dyads should be accommodated in the COVID negative unit[1] (this is the preferred option - a lounger chair should be provided) or the mother may be accommodated in the COVID-19 negative mother's lodge/cubicle/ward.
   - PUI dyads – should be accommodated in a designated ward (this is the preferred option) or the mother may be accommodated in the COVID-negative mother's lodge/cubicle/ward.
   - COVID-19 positive dyads should be accommodated in the COVID-19 unit[1] (this is the preferred option - a lounger chair should be provided) or the mother may be accommodated in a COVID-19 positive boarder facility or in an isolation field facility (transport will need to be provided if the isolation facility is far away).
   - If facilities exist, rooming in is the best option.

[1] unit refers to a ward, a cubicle or a section of a ward

- Large lodges can be split into sections if there are multiple ablutions and social spaces: (i) COVID-19 negative (ii) COVID-PUI (iii) COVID-19 positive.
- If space is limited then based on utilitarianism, libertarianism, the Siracusa principle and the four principle above, the breastfeeding mothers should be prioritized, in order of preference who are (i) COVID-19 negative (ii) PUI (iii) COVID-19 positive.

3. **Promote, support and encourage breastfeeding, or breastmilk feeding, and discuss skin-to-skin care of newborns with the mother/primary caregiver.** Ideally, promote breastfeeding and skin-skin contact, with infection prevention and control (IPC) measures and non-pharmaceutical interventions (NPI) (i.e. mother/primary caregiver dons a surgical mask and practices hourly hand hygiene and respiratory etiquette). Kangaroo mother care (KMC) units should continue only if cohorting is possible, IPC and NPI is maintained and the physical space facilitates isolation of infected dyads with distancing from uninfected dyads. Individual health facilities may tailor local decisions after consultation with district-level and paediatric experts, based on local availability of space, IPC and NPI. Individual health care providers may tailor skin-skin decisions for an individual dyad after counselling a mother/primary caregiver, based on their choice, and ability to implement IPC and NPI.

4. **Provide surgical masks to all parent(s)/primary caregivers**, accompanying a child to hospital. These should be replaced daily throughout the hospital stay.

5. **Every hospital is mandated to provide lodger/boarder facilities for mothers**, with stringent IPC monitoring, surgical masks for all mothers and twice daily COVID-19 screening. The lodger facility should be well ventilated and there should not be over-crowding. Wearing masks, physical distancing and regular hand-washing should occur.

6. **Reinforce administrative controls to reduce risk:**
   - Stagger meal times of lodger mothers.
   - Ring a bell hourly during waking hours to remind everyone about hand washing / sanitizing in the ward/lodger facility.
   - Identify an infection control marshal in each unit[1] to:
     - ensure physical distancing (at least 1 metre and preferably 2 metres, with a mask on) in the lodger facility/ KMC unit/ neonatal unit/ paediatric medical and surgical ward.
     - ensure adequate ventilation whilst keeping mothers/caregivers/babies warm and
     - monitor/prevent close contact between staff and mothers/primary caregivers during mealtimes.
   - Identify a champion to orientate new lodgers and oversee implementation of and compliance with IPC measures and NPIs:
     - Enforce strict hand hygiene – hourly handwashing or use of alcohol based hand rub (ABHR) during waking hours.
     - Enforce the wearing of face masks by all lodgers at all times except when bathing, eating or sleeping.
     - Eat outside, weather permitting, or in a well ventilated area, away from other lodgers (preferably 2 metres apart, and at least 1 metre apart).
     - Implement 12 hourly symptom screening of all lodgers – in or outside the mother's lodge;
     - Restrict lodgers' movement to walking between their accommodation and their child's ward.
   - Provide surgical masks to all parent(s)/primary caregivers on entrance to the hospital. These should be replaced daily throughout the hospital stay.
   - Inform each parent(s)/caregiver about the risk of COVID-19 during their hospital stay.

7. **Reinforce engineering controls to reduce risk:**
    - Space beds in the mother's lodge at least 1 metre, but preferably 2 metres apart.
    - Space hospital beds/incubators/bassinets at least 1 metre apart but preferably 2 metres apart.
    - Provide sanitizer at the foot of every bed/incubator/bassinet.

8. **If parental separation is unavoidable, limit it to as short a period as possible, and implement innovative methods to facilitate contact** including daily phone calls, photographs and video/WhatsApp calls, and skin-skin interactions by a caregiver or staff member designated to care for the newborn/young infant/child. This skin-skin should occur only if caregiver/staff member is wearing a clean surgical masks, and has sanitized her hands and observes cough etiquette. Assist with lactation/re-lactation after the acute illness.

9. Engage with communities to explore the repurposing of homes/ community halls around the hospital to accommodate dyads.

10. **Policies and practices (e.g. IPC measures/ NPI) around parental access to hospitalized children during COVID-19 could cause or exacerbate stress: Link parents to local community resources or facilitate access to grants**. Additionally, obtain feedback on hospital processes/systems/policies to optimize processes, systems and practices.

**ADDITIONAL CONSIDERATIONS IF MOTHER IS COVID-19 POSITIVE:**

**Scenario 1: Mother and newborn/young infant/child are well:**

- Do not hospitalize. Discharge newborn/young infant / child to isolate at home with mother.
- Promote and support breastfeeding.
- Encourage skin to skin in newborns if mother is able to wear a clean surgical mask just before commencing skin-skin contact, and has sanitized her hands and observes cough etiquette.
- Both to isolate for 10-days (or as per latest NICD recommendations).
- Parents to follow advice to prevent SARS-CoV-2 transmission to the newborn/young infant/child including hand hygiene, cough etiquette, mask use, cleaning breasts before breastfeeding.
- Emphasise importance of continued breastfeeding and routine care during and after isolation.

**Scenario 2: Mother needs hospitalisation:**

- **Scenario 2A: Hospital facilities exist - breastfeeding newborns /young infants who are not mobile (crawling/walking) may remain with mother in isolation**
    - Mother to wear surgical mask and to observe all IPC measures and NPI outlined above.
    - Promote and support breastfeeding.
    - Mother should provide skin-skin contact for newborns if she is able to wear a clean surgical masks, and has sanitized her hands and observes cough etiquette. Mother should interact with the newborn/ infant (touch, sound) regularly.
    - Discharge as soon as possible.
    - Both to isolate for 10-days (or as per latest NICD guidelines)
    - Provide advice to prevent SARS-CoV-2 transmission to the **newborn/young infant** including importance of hand hygiene, cough etiquette, mask use, cleaning breasts before breastfeeding.
    - Emphasise importance of continued breastfeeding and routine care during and after isolation.

- **Scenario 2B: There are no or limited facilities or IPC cannot be maintained: separation is unavoidable – newborn/young infant / child will be discharged into the care of father/caregiver:**
    - Mother to remain in hospital only until absolutely necessary and to be discharged as soon as possible.
    - Promote and support breastfeeding - encourage breastmilk feeding at home: Mother should express milk and father / caregiver should collect milk and take it home, observing strict IPC and handwashing/ breast and container sanitization measures. Alternatively hospital may assist with obtaining donor breastmilk.
    - Whilst the dyad is separated, father / caregiver should provide skin-skin contact to newborns, and should interact with the newborn/infant/child (touch, sound) regularly. Skin-skin should occur only if father/caregiver is wearing a clean surgical masks, and has sanitized her hands and observes cough etiquette.
    - Both to isolate for 10 days (or as per latest follow-national guidelines)
    - Use innovative methods to keep mother in contact with newborn/young infant / child. Send mother photographs or videos or call mother using WhatsApp video to keep mother-baby in touch with each other during this difficult time.
    - Counsel on importance of breastfeeding and routine care once the 10-day period has been completed.
    - Support mother to re-lactate / resume breastfeeding when reunited with baby/infant.

**<u>Scenario 3: Newborn baby/ young infant / child needs hospitalisation:</u>**

- **Scenario 3A: Hospital isolation facilities exist - mother can remain with newborn baby/young infant / child**
    - ***Follow guidance as per Scenario 2A above.***

- **Scenario 3B: There are no lodger/boarder facilities or IPC cannot be maintained - separation is unavoidable:**
    - Newborn / young infant/ child to remain in hospital only until absolutely necessary and to be discharged as soon as possible.
    - Promote and support breastfeeding - encourage breastmilk feeding: Mother should express milk and father / caregiver should deliver milk, observing strict IPC and handwashing/ breast and container sanitization measures. Alternatively hospital may assist with obtaining donor breastmilk.
    - Whilst the dyad is separated, hospital staff should provide skin-skin contact, and should interact with the baby (touch, sound) regularly. Skin-skin should occur only if staff member is wearing a clean surgical masks, and has sanitized her/his hands and observes cough etiquette.
    - Mother and newborn/young infant / child to isolate for 10 days (or as per latest follow-national guidelines).
    - Use innovative methods to keep mother in contact with newborn/young infant / child. Send mother photographs or videos or call mother using WhatsApp video to keep mother-baby in touch with each other during this difficult time.
    - Counsel on importance of breastfeeding and routine care once the 10-day period has been completed.
    - Support mother to re-lactate / resume breastfeeding when reunited with baby/infant.

**SPECIFIC CONSIDERATIONS FOR FATHERS:**

Fathers must be allowed to visit their hospitalised child/children, with the following provisos:

1. IPC measures and NPIs should be used at all times, including hand sanitisation, face mask and distancing from staff / other caregivers.
2. A surgical mask must be provided to the father before he enters the unit.
2. Fathers should have unrestricted access to their children.
3. When a child is critically ill, during end-of-life care and when parents require counselling that is best undertaken with both parents together, fathers should be allowed access as and when needed.

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