National Institute for Health and Care Excellence

Draft for consultation

Postnatal care

[F] Content of postnatal care contacts

NICE guideline tbc

Evidence reviews

October 2020

Draft for consultation

These evidence reviews were developed by the National Guideline Alliance, part of the Royal College of Obstetricians and Gynaecologists

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Contents

Content of postnatal care contacts

This evidence review supports recommendations 1.2.1, 1.2.2, 1.2.3, 1.2.4, 1.2.5, 1.2.6, 1.2.8, 1.2.9, 1.2.10, 1.2.11, 1.2.12, 1.3.1, 1.3.2, 1.3.3, 1.3.4, 1.3.5, 1.3.6, 1.3.7, 1.3.8 and 1.3.9.

Review question

What is the essential content of postnatal care contacts for women and babies?

Introduction

After giving birth women routinely see health professionals on several occasions. It is unclear what the optimum content of such contacts should be. During a period of considerable physiological and psychological change it is important for professionals not to miss significant problems. This review was intended to identify the essential elements of postnatal contacts.

Due to the scale and complexity of the topic it was agreed that reaching consensus by committee discussion alone would be challenging and therefore this question would be approached using a formal consensus technique. The nominal group technique (the details of which are described in supplementary material 1) was agreed to be an appropriate formal consensus method for producing these recommendations. The formal consensus approach was supplemented by a systematic review of published systematic reviews (see below). The recommendations would cover the areas that the committee agreed would be essential content of postnatal care contacts and which were listed a priori in the review protocol.

Summary of the protocol

Please see Table 1 for a summary of the population, study type, publication date, publication distribution and topic areas of this review.

Table 1: Summary of the protocol

Population	• Women during the postnatal period who gave birth to one, two or three healthy infants at term. • Healthy infants during the postnatal period who were born at term.
Study type	• High quality published guidelines on postnatal care content • Systematic reviews of RCTs and qualitative studies (where there are gaps left by the guidelines in terms of topic areas or subgroups)
Publication date	• Published since 2006
Publication distribution	• Guidelines and studies from high income countries, as defined by the World Bank
Topic areas	• Provision of advice and information for parents or immediate family • Assessment and care of baby • Assessment and care of mother (physical and mental health) • Assessment of the support available to the mother and baby from the partner or family • Assessing the risk of domestic abuse

RCT: randomised controlled trial

For further details see the review protocol in appendix A.

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual 2014. The formal consensus methods specific to this review question are described in the review protocol in appendix A, with further detail in supplementary material 1.

Declarations of interest were recorded according to NICE's 2014 conflicts of interest policy until March 2018. From April 2018 until June 2019, declarations of interest were recorded according to NICE's 2018 conflicts of interest policy. From July 2019 onwards, the declarations of interest were recorded according to NICE's 2019 conflicts of interest policy. Those interests declared before July 2019 were reclassified according to NICE's 2019 conflicts of interest policy (see Register of Interests).

Clinical evidence

Included studies

Guidelines

Eleven guidelines were identified for this review (American College of Obstetricians and Gynecologists 2018 [ACOG], Beyond Blue 2011, Centre of Perinatal Excellence [COPE] 2017, Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists [FSRH] 2017, Fleming 2015, National Institute for Health and Clinical Excellence [NICE] 2006, National Maternity Review 2016, Scottish Intercollegiate Guidelines Network [SIGN] 2012, United Nations Children's Fund [UNICEF] 2012, Wilkinson 2012, World Health Organization [WHO] 2013).

Seven guidelines reported recommendations relating to provision of advice (Beyond Blue 2011, FSRH 2017, NICE 2006, National Maternity Review 2016, UNICEF 2012, WHO 2013, Wilkinson 2013), 2 guidelines reported recommendations relating to the assessment and care of the baby (UNICEF 2012, WHO 2013), 3 guidelines reported recommendations relating to the assessment and care of the mother's physical health (ACOG 2018, NICE 2006, WHO 2013), 5 guidelines reported recommendations relating to the assessment and care of the mother's mental health or emotional well-being (Beyond Blue 2011, COPE 2017, NICE 2016, SIGN 2012, WHO 2013), 2 guidelines reported recommendations relating to the assessment of support available to the mother and baby (Beyond Blue 2011, WHO 2013), 1 guideline reported recommendations relating to assessing the risk of domestic violence (WHO 2013), and 2 guidelines made recommendations about general principles (NICE 2006, WHO 2013).

One guideline reported recommendations specific to adolescent mothers (Fleming 2015). No recommendations were made relating to other subgroups of interest.

Systematic reviews

Two systematic reviews were identified for this review (Turnbull 2012, Shaw 2006).

One review reported findings relating to the assessment and care of the baby (Shaw 2006) and 1 review reported findings relating to the assessment and care of the mother's mental health or emotional well-being (Shaw 2006).

One review reported findings specific to women with substance misuse problems (Turnbull 2012) and 1 review reported findings specific to women for whom safeguarding concerns have been identified (Shaw 2006).

The included guidelines and systematic reviews are summarised in Table 2.

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Guidelines and published systematic reviews not included in this review are listed, and reasons for their exclusions are provided in appendix K.

Summary of clinical studies included in the evidence review

Summaries of the studies that were included in this review are presented in Table 2.

Table 2: Summary of included guidelines and systematic reviews

Study	Guideline / review title	Topic areas of interest
ACOG 2018 Committee opinion US	'Committee Opinion' on optimizing postpartum care	• Assessment and care of the mother (physical)
Beyond Blue 2011 Clinical guideline Australia	Depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. A guideline for primary care health professionals	• Provision of advice • Assessment and care of the mother (mental health/emotional well-being) • Assessment of support available to the mother and baby
COPE 2017 Clinical guideline Australia	Mental health care in the perinatal period: Australian clinical practice guideline	• Assessment and care of the mother (mental health/emotional well-being)
Fleming 2015 Clinical guideline Canada	Adolescent pregnancy guidelines	• Subgroups (adolescent mothers)
FSRH 2017 Clinical guideline UK	CEU clinical guidance: Contraception after pregnancy	• Provision of advice
National Maternity Review Service guideline	Better Births: Improving outcomes of maternity services in England – A five year forward view for maternity care	• Provision of advice

Study	Guideline / review title	Topic areas of interest
England		
NICE 2006 Clinical guideline England	Postnatal care: Routine postnatal care of women and their babies	• Provision of advice • Assessment and care of the mother (physical) • Assessment and care of the mother (mental health/emotional well-being) • General principles
Shaw 2006 Systematic review Australia, Canada, Ireland, UK, USA	Systematic review of the literature on postpartum care: Effectiveness of postpartum support to improve maternal parenting, mental health, quality of life, and physical health	• Assessment and care of the baby • Assessment and care of the mother (mental health/emotional well-being) • Subgroups (women for whom safeguarding concerns have been identified)
SIGN 2012 Clinical guideline Scotland	Management of perinatal mood disorder	• Assessment and care of the mother (mental health/emotional well-being)
Turnbull 2012 Systematic review Australia, USA	Home visits during pregnancy and after birth for women with an alcohol or drug problem	• Subgroups (women with substance misuse problems)
UNICEF 2012 Clinical and service guideline UK	Baby friendly standards	• Provision of advice • Assessment and care of the baby
WHO 2013 Clinical guideline International	WHO recommendations on postnatal care of the mother and newborn	• Provision of advice • Assessment and care of the baby • Assessment and care of the mother (physical) • Assessment and care of the mother (mental health/emotional well-being) • Assessment of support available to the mother and baby • Assessing the risk of domestic violence
Wilkinson 2012 Clinical guideline US	Preventative Services for Children and Adolescents	• Provision of advice

ACOG: American College of Obstetricians and Gynecologists; CEU: Clinical Effectiveness Unit; COPE: Centre of Perinatal Excellence; FSRH: Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists; NICE: National Institute for Health and Clinical Excellence; SIGN: Scottish Intercollegiate Guidelines Network; UNICEF: United Nations Children's Fund; WHO: World Health Organization

See the full evidence tables in appendix D. Forest plots are not appropriate for formal consensus and no meta analysis was conducted on the basis of the systematic reviews (and so there are no forest plots in appendix E).

Quality assessment of clinical outcomes included in the evidence review

The 11 included guidelines were assessed using the AGREE II tool. See the results of the quality assessment in the AGREE II tables in appendix F. The 2 systematic reviews were assessed using the Risk of Bias in Systematic reviews (ROBIS) checklist. See the results of the quality assessment in the clinical evidence tables in appendix D.

Economic evidence

Included studies

A single economic search was undertaken for all topics included in the scope of this guideline and additional economic searches were conducted that used search terms specific to this review question combined with a search filter for economic evaluations but no economic studies were identified which were applicable to this review question. See the literature search strategy in appendix B and economic study selection flow chart in appendix G.

Excluded studies

No economic studies were reviewed at full text and excluded from this review.

Economic model

No economic modelling was conducted for this review question because the committee agreed that other topics were higher priorities for economic evaluation.

Evidence statements

Clinical evidence statements

Statements presented to the committee to rate (drafted from the included guidelines and systematic reviews) in round 1

Thirty-four statements were drafted using the 11 included guidelines and the 2 included systematic reviews. The drafted statements covered the following topic areas and subgroups: provision of advice (n=6), assessment and care of the mother's physical health (n=6), assessment and care of the mother's mental health or emotional well-being (n=8), the assessment and care of the baby (n=3), assessment of the support available to the mother and baby (n=2), assessment of the risk of domestic violence (n=1), adolescent mothers (n=2), women with substance misuse problems (n=1), primiparous women (n=1), women for whom safeguarding concerns have been identified (n=3) and general principles (n=1). No recommendations were identified, and therefore no statements were drafted, for women with

multiple births, physical or cognitive disabilities, or women who have difficulty accessing postnatal care services or are unsupported.

The committee were presented with 34 statements in round 1 of the formal consensus exercise. Twenty-one of these statements reached ≥80% agreement in round 1 and were included for the discussion with the committee. Three statements had <60% agreement and were discarded. Six statements had between 60% and 79% agreement and these were re-drafted for round 2. A further 4 statements that had <60% agreement demonstrated obvious and addressable issues (for example being made acceptable through small changes in wording or emphasis); these statements were re-drafted for assessment by the committee in round 2.

See appendix M for the questionnaire that the committee received and details of round 1 which are provided in Table 11.

Re-drafted statements presented to the committee to rate (re-drafted from round 1) in round 2

The 10 re-drafted statements were assessment by the committee in round 2. Six of these statements reached ≥80% agreement and were included for the discussion with the committee. The remaining 4 statements did not reach sufficient agreement and were discarded.

See

Table 12 in appendix M for details of round 2.

Final agreed statements

After the 2 rounds of formal consensus the committee reached consensus agreement on the following 27 statements, which were discussed by the committee in order to develop recommendations. The agreed statements were discussed as the basis for the recommendations but were not necessarily worded in the way the committee wanted, or lacked detail the committee thought was important. Therefore, the agreed statements were modified using the committee's experience and expertise to develop recommendations.

The provision of advice

- Give women advice on lifestyle issues (such as diet, sleep and hygiene) in the postnatal period.
- Give women relevant, clear information about their own and their babies' health and well-being so they can recognise and respond to concerns.
- Recommend and actively support breastfeeding.
- Recommend immunisation to parents, as per existing WHO guidelines.
- Tell women about the effectiveness of different contraceptive methods including any adverse effects.
- Tell women about the physiological process of recovery after birth.

The assessment and care of the mother (physical)

- In the first postpartum visit conduct a comprehensive assessment of the mother's physical well-being.
- At every postnatal contact, assess for urinary incontinence and bowel function.
- At every postnatal contact, assess the following: healing of any perineal wound, perineal pain and perineal hygiene.
- At each postnatal contact, enquire about any physical symptoms or concerns.
- At every postnatal contact, assess the following: breast pain, uterine tenderness and lochia.

The assessment and care of the mother (mental health/emotional well-being)

- In the first postpartum visit conduct a comprehensive assessment of the mother's social and psychological well-being.
- All women should be assessed for symptoms of depression and anxiety and offered appropriate support throughout the postnatal period.
- If major depression in the postnatal period is indicated by the EPDS, women should be referred for further assessment.
- Psycho-education for women should be a routine part of postnatal contacts and should include discussion of mental health and provision of educational material.
- Where appropriate involve partners in psycho-education for women and discussions about mental health.
- Women should be given the opportunity to talk about their birth experience in the first postnatal contact.

The assessment and care of the baby

- Throughout the postnatal period support parents with tools and techniques to encourage bonding and social interaction with their baby.
- Assess feeding progress at every postnatal contact.

Assessment of the support available to mother and baby from the partner and family

- Give women the opportunity to discuss relationship or family dynamics in a one to one environment.

Assessment of the risk of domestic violence

- At every postnatal care contact, observe women for any risks, signs and symptoms of domestic abuse.

Specific to subgroups (adolescent mothers)

- Provide postnatal care programmes tailored to adolescent parents to improve their knowledge of parenting and provide contraceptive counselling.
- Give targeted breastfeeding support to women who report breastfeeding concerns and base support on individual needs and circumstances. (NB. This revised statement was originally under the 'adolescent mothers' subgroup of statements although the wording was discussed and changed after round 1.)

Specific to subgroups (women for whom safeguarding concerns have been identified)

- Where there is a high risk of family dysfunction, provide women with case conferencing throughout the postnatal period.
- Where there is a high risk of family dysfunction, provide women with additional home visits throughout the postnatal period.
- Where there is a high risk of family dysfunction (for example, conflict, abuse or neglect), consider signposting women to appropriate community services, including peer support programmes where available.

General principles

- Provide postnatal care contact in accordance with the principles of person-centred care.

Economic evidence statements

No economic evidence was identified which was applicable to this review question.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

Even though the statements come from guidelines that aim to improve outcomes for women and babies, in the formal consensus methodology used in this review there are no outcomes that were considered formally by the committee; therefore the committee were not required to determine which outcomes were critical or important.

The quality of the evidence

The quality of guidelines was critically appraised by 2 reviewers using the AGREE II instrument. Seven of the 11 included guidelines were deemed as high quality, being given an

overall rating of ≥70%. The 4 guidelines which scored <70% contributed very little to the statements on which the committee voted, either because they contained very little relevant data or their data were similar to those extracted from more rigorously developed guidelines. The committee were therefore confident about the quality of the basis for the statements presented to them. Ultimately their voting was influenced by considerations about best practice and maximising positive outcomes for women and babies, informed by their own expertise and knowledge of the relevant evidence base.

In terms of the quality of individual AGREE II domains, the majority of included guidelines scored highly on 'scope and purpose'. Generally the overall objective of those guidelines and the health question were clearly defined and although the population was not always explicitly stated, it was usually possible to infer that guidelines referred to people being served by maternity services, in line with the scope of this review. The majority of included guidelines also scored highly on 'clarity of presentation', with recommendations presented clearly and concisely and organised under subheadings, either in the body of the document or in an appendix.

Almost half (n=5) of the guidelines scored highly on 'rigour of development' because they were informed by a systematic review of the literature, although search strategies were not always made available.

Overall, the majority of guidelines scored poorly (<70%) in the 'applicability' domain with limited discussion about how to implement the guidance and little consideration of potential barriers and facilitators including resource implications. The majority of guidelines also scored poorly on 'editorial independence' because they were not developed by appropriate stakeholders, or did not demonstrate that the views of intended users were represented.

The quality of the 2 systematic reviews, which informed first round statement in 2 areas (support for women with substance misuse problems and support for women where safeguarding concerns have been identified) was assessed using the ROBIS checklist. Overall both systematic reviews were judged to be at high risk of bias. Methodological limitations included a lack of clear reporting or an absence of reporting about eligibility criteria. Other concerns related to use of a limited range of databases, exclusion of grey literature, lack of critical appraisal of included papers, a lack of clarity about women or interventions in the included studies and an absence of testing the robustness of the review findings.

Benefits and harms

Assessment and care of the woman

Five of the final agreed statements related to the physical assessment and care of the mother and a further 6 statements related to the assessment and care of the mother's mental health and emotional wellbeing. The statements recommended a comprehsive assessment of the woman's physical wellbeing and also her social and psychological wellbeing in the first postpartum visit. Although they agreed there were benefits to this, the committee felt there would be an advantage in conducting these assessments during every postnatal care contact rather than just the first visit. They also felt it was unnecessarily formal and passive to recommend 'comprehensive assessments' at every contact (as in the agreed statements) so they phrased the recommendations in terms of assessment, discussions and information sharing. For ease of reference (in practice) the committee grouped a number of the statements into a single recommendation about discussing general health and wellbeing. Signposting to NICE guidelines on maternal and child nutrition; on weight management before, during and after pregnancy; and on smoking: stopping in pregnancy and after childbirth were also made. In this recommendations they also incorporated the statements on

safeguarding and domestic abuse, signposting to the NICE guideline on domestic violence and abuse.

Contraception was one of the issues mentioned as a topic for discussion with the woman in relation to general health and wellbeing. The committee noted that in recent months, there's been a change in practice to focus postnatal contraception service within the maternity services instead of the community health care providers. The committee noted that training is required for maternity services to be able to provide this.

The committee agreed that assessments of physical wellbeing of the woman are not in the remit of health visitors so they made a specific recommendation for midwives. For physical signs or symptoms that the committee agreed were potentially serious, they listed these on the basis of their own expertise, rather than on the basis of the statements, which lacked this level of detail. They agreed the greatest benefit would be in telling women about these symptoms or signs (such as chest pain and persistent or severe headaches) and that they should seek help without delay if they occur. They also emphasised the importance of appropriate referral when healthcare professionals have cause for concern about the woman's physical health. This is perhaps particularly relevant for health visitors because the women's physical health assessment is not in their remit.

One of the final agreed statements about mental health and emotional wellbeing stated that women should be given the opportunity to talk about their birth experience in the first postanatal contact. The committee agreed this could have important benefits for emotional health, although the need and the timing of this discussion should be according to the individual woman. There may a benefit particularly if the birth experience was difficult although they felt it was important for every women to have the opportunity – at every contact – not least because an apparently unproblematic experience from the health professionals' perspective may actually have been traumatic for the woman and she may be in need of support and further information.

Finally, aware of existing, relevant NICE guidelines on a number of important aspects of physical and mental wellbeing in the postnatal period, the committee signposted to these to avoid duplication. They made recommendations linking to NICE guidelines on antenatal and postnatal mental health, sepsis, hypertension in pregnancy, diabetes in pregnancy, venous thromboembolism and urinary incontinence and pelvic floor prolapse.

Assessment and care of the baby

Only 2 of the final statements from the formal consensus process related specifically to the assessment and care of the baby. The committee agreed to use these statements in an overarching recommendation to give parents information about issues including bonding and emotional attachment and feeding. The benefits of these had previously been established and discussed through other evidence reviews during the development of this guideline. However the committee felt parents would also benefit from additional information so on the basis of their own expertise they agreed to include other topics in this recommendation such as how to bathe the baby and vitamin D supplementation (for which they also signposted to the NICE guideline on vitamin D supplement use).

A further 2 final agreed statements related to the provision of immunisation advice and the provision of advice relating to the baby's health and wellbeing. The committee strongly agreed with the importance of these and included immunisation as a topic in the information giving recommendation, also signposting to Public Health England's routine childhood immunisations schedule, which they felt strengthened this aspect of the recommendation and emphasised the benefits. The committee were also aware of a NICE guideline being developed on vaccine uptake.

Based on the statement about provision of advice about the baby's health and wellbeing, the committee agreed to combine it with the statement about feeding progress to make a general recommendation to ask whether there are any concerns about the baby's general wellbeing, feeding or development. They agreed this conversation should take place at every postnatal contact, supported by observations and a review of the history.

They also agreed about the importance for the healthcare professionals engaging with the families in the immediate postnatal phase to be aware of the need for an urgent clinical assessment if the baby has not passed mecomium within 24 hours of birth as this may for example be a sign of bowel obstruction.

As well as using the statement about the baby's health and wellbeing to inform this general, opening recommendation, the committee also agreed it should be the basis of a more specific recommendation, which would achieve even greater benefit. They therefore recommended a complete examination of the baby within 72 hours and at 6 to 8 weeks, and they included a detailed list of physical aspects to be checked and these were based on the committee's expertise, including their knowledge of a similar recommendation in the NICE guideline on postnatal care published in 2006. Through discussions of these physical aspects the committee agreed that a separate recommendation about weight and head circumference measurement is needed. The committee discussed that in practice measurement of head circumference is sometimes overlooked compared with weight measurements. They also emphasised the importance of plotting these measurements into a growth chart. The recommendation is also supported by UK-WHO growth charts which also sets the standard for the timing of these measurements.

Finally, aware of existing, relevant NICE guidelines on a number of important aspects of the baby's physical health in the postnatal period, the committee signposted to these in a number of recommendations to avoid duplication. They made recommendations linking to NICE guidelines on jaundice for newborn babies under 28 days and faltering growth. They also agreed it was essential to signpost to the NHS screening programmes on newborn blood spot screening and newborn hearing screening.

Other statements

Not all of the statements included after the second round of voting were explicitly used to make recommendations about the content of postnatal care contacts. However, the points they conveyed were used to support other recommendations already drafted on the basis of evidence from other reviews. For example, there were statements about providing tailored postnatal care programmes to adolescent mothers and giving them targeted breastfeeding support. The committee did not feel the evidence for these was sufficiently strong or that younger mothers should be singled out as lacking in parenting knowledge. They did nevertheless make a more general reference in the recommendations about supporting breastfeeding. They agreed there was a benefit in making people aware that younger women and women from a low-income or disadvantaged background 'may' need extra support and encouragement and this was supported by the qualitative data in review S and quantitative review P.

One of the final included statements promoted the importance of providing postnatal care in accordance with the principles of person centred care. The committee were in strong agreement about the benefits of this but they felt the message was more effectively conveyed as an underlying principle, which influenced many of the recommendations. Examples include the section on communication with women which emphasised that others such as partners and families should be involved in postnatal care according to the woman's wishes. Also, that information should be tailored in terms of timing and content and should be

individualised and sensitive. The point was also made that the assessment and care of the woman should include asking her about her wellbeing as well as her health, taking a holistic approach, which would enable conversations and information sharing about issues that are important and relevant to each woman's wishes and circumstances.

Cost-effectiveness and resource use

No economic evidence is available for this review question. Determining the essential content of postnatal care contacts may have some resource implications (in terms of health professional time) but can greatly improve women's and babies' health through early detection of potential health problems. This is expected to lead to improved outcomes for the woman and the baby, and cost savings to the health service, because any health issues can be identified and treated appropriately at an early stage, before they become more severe and require a more resource intensive intervention.

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Appendices

Appendix A – Review protocols

Review protocol for review question: What is the essential content of postnatal care contacts for women and babies?

Table 3: Review protocol

Field (based on PRISMA-P)	Content
Review question	What is the essential content of postnatal care contacts for women and babies?
Type of review question	Formal consensus
Objective of the review	The focus of this review question is on the content of postnatal care contacts for women and babies and is deliberately broad. Standard methods for guideline development, based on a systematic review of published evidence, were judged, during scoping, not to be appropriate. This is due to several potential difficulties. Firstly, such a broad area is likely to return large quantities of papers when the literature search is conducted. Secondly, the evidence that is identified is likely to be varied, complex, and therefore challenging to meaningfully synthesise. Due to these factors, it was agreed that rather than a standard systematic review, formal consensus methods would be used to inform the drafting of recommendations in this area. To be transparent and use a robust process the proposal is to use a specific methodology, 'nominal group consensus', which is described in VIII below.
Eligibility criteria – population/disease/condition/issue/domain	**Population** • Women during the postnatal period who gave birth to one, two or three healthy infants at term. • Healthy infants during the postnatal period who were born at term. **Issue** The content of postnatal care contacts (involving the birth team, GP, community midwifery and community health visitor teams), which may include but not be limited to: • Provision of advice and information for parents or immediate family

Field (based on PRISMA-P)	Content
	• Assessment and care of baby • Assessment and care of mother (physical and mental health) • Assessment of the support available to the mother and baby from the partner or family • Assessing the risk of domestic abuse
Eligibility criteria – intervention(s)/exposure(s)/prognostic factor(s)	• Published guidelines on postnatal care content. • A focused search of recent systematic reviews on the topic of postnatal care content will also be conducted (see developer comment in row IX below).
Eligibility criteria – comparator(s)/control or reference (gold) standard	Not applicable
Outcomes and prioritisation	Not applicable
Eligibility criteria – study design	Formal consensus methods The modified nominal group technique (Bernstein 1992) was selected due to its appropriateness for use within the guideline development process. This method, which is the most commonly used in healthcare is an effective and efficient means of obtaining consensus from a range of participants and is transparent, making it possible to trace how a group came to a decision and formed recommendations (Murphy 1998). • The NGA technical team will extract the relevant recommendations from each guideline or systematic review, and derive a set of statements pertaining to the content of postnatal care contacts. • Statements will be checked for clinical content by the NGA Clinical Advisor and committee chair • In round 1, the committee will be presented with a consensus questionnaire with statements to be rated. They will be asked to rate their agreement based on their personal opinion of what constitutes best practice, taking into account their expertise, rather than describing current practice. Ratings should be based on agreement with the overall focus of the statement, rather than specific wording.

Field (based on PRISMA-P)	Content
	• Agreement with the statements can be rated on a 9-point Likert scale where 1 represented strongly disagree, 5 represented neither agree nor disagree and nine represented strongly agree. • Participants also have the option of indicating that they have insufficient knowledge in a given area to provide a rating. These ratings will then be grouped into 3 categories: 1–3 (disagree), 4–6 (neither agree nor disagree), or 7–9 (agree). • Participants will also be able to provide a written comment regarding their reason for any disagreement and how the statement could be modified. • The NGA technical team will provide committee members with the overall percentage agreement, distribution of responses to each statement, and additional comments. • Statements with greater than or equal to 80% agreement will be used to inform drafting of recommendations (taking into account comments from the committee members). • Statements where there is 60 to 80% agreement will either be used to inform recommendations if the comments from committee members are consistent, and are easy to address with minor amendments, or alternatively the statements will be re-drafted based on the committees' comments, discussed at the committee meeting, and re-rated following the same procedure as round 1. Following the second round of rating, statements will either be used to inform recommendations, or disregarded based on percentage agreement • Statements with less than 60% agreement in round 1 will be generally disregarded unless there are obvious and addressable issues identified from the comments.
Other inclusion exclusion criteria	**For guidelines** Country: Guidelines from low- and middle-income countries, as defined by the World Bank, will be excluded, as the configuration of antenatal and postnatal services in these countries might not be representative of that in the UK. Date: Include guidelines published since 2006 (since this was the publication date of the relevant NICE recommendations) **For systematic reviews**

Field (based on PRISMA-P)	Content
	Study design: Systematic reviews of RCTs Systematic reviews of qualitative studies. Country: Studies from low- and middle-income countries, as defined by the World Bank, will be excluded, as the configuration of antenatal and postnatal services in these countries might not be representative of that in the UK. Date: The cut-off date for systematic reviews will be aligned with the cut-off date applied to guidelines. Systematic review findings will be used to plug gaps left by the guideline in terms of the elements of postnatal care content, as set out in section IV of this protocol.
Proposed sensitivity/sub-group analysis, or meta-regression	**Separate statements will be drafted for the following population groups:** • singletons versus multiples • multiparous, primiparous • young women (19 years or under) • women with physical and cognitive disabilities • women who have difficulty accessing postnatal care services and women who are unsupported • women and babies for whom safe guarding concerns have been identified (e.g. domestic violence, substance misuse)
Selection process – duplicate screening/selection/analysis	**For guidelines** Each identified guideline will be assessed by the technical team using the AGREE II instrument. The senior systematic reviewer will provide quality assurance of this process. Details about AGREE II can be found here: http://www.agreetrust.org/wp-content/uploads/2013/10/AGREE-II-Users-Manual-and-23-item-Instrument_2009_UPDATE_2013.pdf **For systematic reviews**

Field (based on PRISMA-P)	Content
	Study selection (inclusion/exclusion) and data extraction for the formulation of statements will be undertaken by individual reviewers from the NGA technical team. Each included systematic review will be assessed for risk of bias using the ROBIS tool http://www.bristol.ac.uk/media-library/sites/social-community-medicine/robis/robisguidancedocument.pdf Internal (NGA) quality assurance processes will include consideration of the outcomes of weeding, study selection, data extraction and critical appraisal.
Data management (software)	Statements will be generated in excel/word
Information sources – databases and dates	The following databases will be searched: • CDSR • DARE • Embase • EMCare • HTA Database • MEDLINE and MEDLINE IN-PROCESS Searches will be restricted by: • Date limitations: 2005 to 26th October 2018 (updates the NICE CG37 'models of care' search, dated August 2005). • English language • Guidelines • Systematic reviews Other searches: • Inclusion lists of systematic reviews For full details see appendix B.

Field (based on PRISMA-P)	Content
Identify if an update	This guideline will update the NICE guideline on postnatal care up to 8 weeks after birth (CG37). All reviews are being conducted afresh. Ten recommendations on this topic were included in CG37 (2006).
Author contacts	Developer: The National Guideline Alliance https://www.nice.org.uk/guidance/indevelopment/gid-ng10035.
Highlight if amendment to previous protocol	For details please see section 4.5 of Developing NICE guidelines: the manual 2014.
Search strategy – for one database	NA
Data collection process – forms/duplicate	A standardised evidence table format will be used, and published as appendix D (clinical evidence tables)
Data items – define all variables to be collected	For details please see evidence tables in appendix D (clinical evidence tables)
Methods for assessing bias at outcome/study level	Not applicable
Criteria for quantitative synthesis (where suitable)	Nor applicable
Methods for analysis – combining	For details of the methods please see Supplement 1: Methods.

Field (based on PRISMA-P)	Content
studies and exploring (in)consistency	
Meta-bias assessment – publication bias, selective reporting bias	Not applicable
Assessment of confidence in cumulative evidence	Not applicable
Rationale/context – Current management	For details please see the introduction to the evidence review.
Describe contributions of authors and guarantor	A multidisciplinary committee developed the guideline. The committee was convened by the National Guideline Alliance (NGA) and chaired by Dr David Jewell in line with section 3 of Developing NICE guidelines: the manual 2014. Staff from the NGA undertook systematic literature searches, appraised the evidence, conducted meta-analysis and cost-effectiveness analysis where appropriate, and drafted the guideline in collaboration with the committee. For details of the methods please see Supplement 1: Methods.
Sources of funding/support	The National Guideline Alliance is funded by NICE and hosted by The Royal College of Obstetricians and Gynaecologists
Name of sponsor	The National Guideline Alliance is funded by NICE and hosted by The Royal College of Obstetricians and Gynaecologists
Roles of sponsor	NICE funds the National Guideline Alliance to develop guidelines for those working in the NHS, public health, and social care in England
PROSPERO registration number	This review is not registered with PROSPERO

AGREE: Appraisal of Guidelines for Research and Evaluation; DARE: Database of Abstracts of Reviews of Effects; HTA: Health Technology Assessment; NGA: National Guideline Alliance; NHS: National health service; NICE: National Institute for Health and Care Excellence; PROSPERO: International prospective register of systematic reviews; RCT: randomised controlled trial; ROBIS: Risk of Bias in Systematic Reviews

Appendix B – Literature search strategies

Literature search strategies for review question: What is the essential content postnatal care contacts for women and babies?

Clinical search

The search for this topic was last run on 26th October 2018.

Database: Emcare, Embase, Medline, Medline Ahead of Print and In-Process & Other Non-Indexed Citations – OVID [Multifile]

#	Search
1	perinatal period/ or exp postnatal care/
2	1 use emczd, emcr
3	postpartum period/ or peripartum period/ or postnatal care/
4	3 use ppez
5	(((first time or new) adj mother*) or nullipara* or peri natal* or perinatal* or postbirth or post birth or postdelivery or post delivery or postnatal* or post natal* or postpartum* or post partum* or primipara* or puerpera* or puerperium* or ((after or follow*) adj2 birth*)).ti,ab.
6	or/2,4-5
7	exp infant/ use emczd, emcr, ppez
8	(babies or baby or infant* or newborn* or new born*).ti,ab.
9	or/7-8
10	or/6,9
11	ambulatory care/ or exp community care/ or community health nursing/ or general practice/ or health visitor/ or home care/ or exp primary health care/ or traditional birth attendant/ or midwif*.hw.
12	11 use emczd, emcr
13	ambulatory care/ or community health nursing/ or community health planning/ or community health services/ or general practitioners/ or general practice/ or exp home care services/ or midwifery/ or nurses, community health/ or patient care team/ or physicians, family/ or physicians, primary care/ or physicians, women/
14	13 use ppez
15	((birth adj (attendan* or team*)) or ((blanket or community or family or home or public) adj nurs*) or ((blanket or community or family or home or public or public) adj2 health adj2 (nurs* or practitioner*)) or clinician* or counsel?or* or family physician* or general practi* or gp or gps or (health adj (visit* or worker*)) or midwif* or personnel or phn or phns or physician* or professional* or scphn*).ti,ab.
16	or/12,14-15
17	communication/ or computer communication networks/ or consumer health information/ or health education/ or health promotion/ or information dissemination/ or information seeking behaviour/ or internet/ or pamphlets/ or exp patient education as topic/ or posters as topic/ or publications/ or government publications as topic/
18	17 use ppez
19	access to information/ or consumer health information/ or health education/ or health promotion/ or information dissemination/ or information seeking/ or information service/ or internet/ or medical

	information/ or patient education/ or patient information/ or information/ or publication/
20	19 use emczd, emcr
21	patient education handout.pt.
22	((advice or communicat* or educat* or information or (app* or booklet* or brochure* or dvd or handout* or hand out* or ict or internet* or leaflet* or manual* or media or online* or pamphlet* or phone or publication* or telephone or website* or web site* or web page* or webpage* or web based or written or video*)).ti,ab.
23	or/18,20-22
24	exp family/ use emczd, emcr, ppez or (brother* or father* or famil* or filiation or mother* or parent* or partner* or relative* or sister* or spouse*).ti,ab,hw.
25	23 and 24
26	assault/ or battering/ or exp domestic violence/ or physical violence/ or verbal hostility/ or violence/
27	26 use emczd, emcr
28	exp domestic violence/ or physical abuse/ or violence/
29	28 use ppez
30	(abus* or assault* or batter* or violen*).ti,ab,hw.
31	or/27,29-30
32	exp family/ use emczd, emcr, ppez or (brother* or father* or famil* or filiation or mother* or parent* or partner* or relative* or sister* or spouse*).ti,ab,hw.
33	*group processes/ or *peer group/ or *self help/ or *social network/ or *social support/ or *support group/
34	33 use emczd, emcr
35	group processes/ or hotlines/ or peer group/ or self-help groups/ or social support/
36	35 use ppez
37	((brother* or father* or famil* or filiation or mother* or parent* or partner* or relative* or sister* or spouse*) adj7 (advis* or advis* or assist* or counsel* or discus* or educat* or exchang* or interact* or intervention* or meeting* or phone* or program* or telephon* or therap* or service* or skill* or supervis* or support*)).ti,ab.
38	((brother* or father* or famil* or filiation or mother* or parent* or partner* or relative* or sister* or spouse*) and (advis* or advis* or assist* or counsel* or discus* or educat* or exchang* or interact* or intervention* or meeting* or phone* or program* or telephon* or therap* or service* or skill* or supervis* or support*) and (baby or babies or infant* or neonat* or mother* or parent*)).ti,ab.
39	(((assess* or evaluat*) and support* or (baby or babies or infant* or neonat* or mother* or parent*)) or ((assess* or evaluat*) adj10 (baby or babies or infant* or neonat* or mother* or parent*)))ti,ab,hw.
40	32 and (or/34,36)) or or/37-39
41	((assess* or care or evaluat*) adj5 (baby or babies or infant* or neonat* or mother* or parent*)).ti,ab,hw.
42	(10 and 16) and or/25,31,40-41
43	meta-analysis/
44	meta-analysis as topic/
45	systematic review/

46	meta-analysis/
47	(meta analy* or metanaly* or metaanaly*).ti,ab. or (metasynthes* or meta-synthes* or metasummar* or meta-summar* or metastud* or meta-stud* or metathem* or meta-them* or (qualitative adj2 (overview* or review*))).tw.
48	((systematic or evidence) adj2 (review* or overview*)).ti,ab.
49	((systematic* or evidence*) adj2 (review* or overview*)).ti,ab.
50	(reference list* or bibliograph* or hand search* or manual search* or relevant journals).ab.
51	(search strategy or search criteria or systematic search or study selection or data extraction).ab.
52	(search* adj4 literature).ab.
53	(medline or pubmed or cochrane or embase or psychlit or psyclit or psychinfo or psycinfo or cinahl or science citation index or bids or cancerlit).ab.
54	cochrane.jw.
55	((pool* or combined) adj2 (data or trials or studies or results)).ab.
56	(or/43-44,47,49-54) use ppez
57	(or/45-48,50-55) use emczd, emcr
58	or/56-57
59	exp clinical pathway/ or exp clinical protocol/ or exp consensus/ or exp consensus development/ or clinical pathway/ or exp practice guideline/
60	59 use emczd, emcr
61	critical pathways/ or clinical protocol/ or consensus/ or exp consensus development conference/ or exp consensus development conferences as topic/ or critical pathways/ or exp guideline/ or guidelines as topic/ or practice guidelines as topic/ or health planning guidelines/
62	(guideline or practice guideline or consensus development conference or consensus development conference, nih).pt.
63	or/61-62 use ppez
64	(position statement* or policy statement* or practice parameter* or best practice*).ti,ab,kw.
65	(standards or guideline or guidelines).ti,kw.
66	((practice or treatment* or clinical) adj guideline*).ab.
67	(cpg or cpgs).ti.
68	consensus*.ti,kw.
69	consensus*.ab. /freq=2
70	((critical or clinical or practice) adj2 (path or paths or pathway or pathways or protocol*)).ti,ab,kw.
71	recommendat*.ti,kw.
72	(care adj2 (standard or path or paths or pathway or pathways or map or maps or plan or plans)).ti,ab,kw.
73	(algorithm* adj2 (screening or examination or test or tested or testing or assessment* or diagnosis or diagnoses or diagnosed or diagnosing)).ti,ab,kw.
74	(algorithm* adj2 (therap* or treatment* or intervention*)).ti,ab,kw.
75	or/60,63-74
76	42 and or/58*,75*
77	limit 76 to yr="2005 -current"
78	limit 77 to english language

Database: CDSR [Wiley]

#	Search
#1	mesh descriptor: [postpartum period] this term only
#2	mesh descriptor: [peripartum period] this term only
#3	mesh descriptor: [postnatal care] this term only
#4	((((“first time” or new) near/1 mother*) or nullipara* or “peri natal*” or perinatal* or postbirth or “post birth” or postdelivery or “post delivery” or postnatal* or “post natal*” or postpartum* or “post partum*” or primipara* or puerpera* or puerperium* or ((after or follow*) near/2 birth*))):ti,ab,kw
#5	#1 or #2 or #3 or #4
#6	mesh descriptor: [infant] explode all trees
#7	((babies or baby or infant* or newborn* or “new born*”)):ti,ab,kw
#8	#6 or #7
#9	#5 or #8
#10	mesh descriptor: [ambulatory care] this term only
#11	mesh descriptor: [community health nursing] this term only
#12	mesh descriptor: [community health planning] this term only
#13	mesh descriptor: [community health services] this term only
#14	mesh descriptor: [general practitioners] this term only
#15	mesh descriptor: [general practice] this term only
#16	mesh descriptor: [home care services] explode all trees
#17	mesh descriptor: [midwifery] this term only
#18	mesh descriptor: [nurses, community health] this term only
#19	mesh descriptor: [patient care team] this term only
#20	mesh descriptor: [physicians, family] this term only
#21	mesh descriptor: [physicians, primary care] this term only
#22	mesh descriptor: [physicians, family] this term only
#23	(((birth near/1 (attendan* or team*)) or ((blanket or community or family or home or public) near/1 nurs*) or ((blanket or community or family or home or public or public) near/2 health near/2 (nurs* or practitioner*)) or clinician* or counselor* or counsellor* or “family physician*” or “general practi*” or gp or gps or (health near/1 (visit* or worker*)) or midwif* or personnel or phn or phns or physician* or professional* or scphn*)):ti,ab,kw
#24	#10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23
#25	#9 and #24 with cochrane library publication date between jan 2005 and jan 2018

Database: DARE, HTA [CRD Web]

#	Search
#1	mesh descriptor postpartum period in dare, hta
#2	mesh descriptor peripartum period in dare, hta
#3	mesh descriptor postnatal care in dare, hta
#4	((((“first time” or new) near1 mother*) or nullipara* or “peri natal*” or perinatal* or postbirth or “post birth” or postdelivery or “post delivery” or postnatal* or “post natal*” or postpartum* or “post partum*” or primipara* or puerpera* or puerperium* or ((after or follow*) near2 birth*))) in dare, hta

#5	#1 or #2 or #3 or #4
#6	mesh descriptor infant explode 1
#7	((babies or baby or infant* or newborn* or “new born*”)) in dare, hta
#8	#6 or #7
#9	#5 or #8
#10	mesh descriptor ambulatory care in dare, hta
#11	mesh descriptor community health nursing in dare, hta
#12	mesh descriptor community health planning in dare, hta
#13	mesh descriptor community health services in dare, hta
#14	mesh descriptor general practitioners in dare, hta
#15	mesh descriptor general practice in dare, hta
#16	mesh descriptor home care services explode 1
#17	mesh descriptor midwifery in in dare, hta
#18	mesh descriptor nurses, community health in dare, hta
#19	mesh descriptor patient care team in dare, hta
#20	mesh descriptor physicians, family in dare, hta
#21	mesh descriptor physicians, primary care in dare, hta
#22	mesh descriptor physicians, family in dare, hta
#23	(((birth near1 (attendan* or team*)) or ((blanket or community or family or home or public) near1 nurs*) or ((blanket or community or family or home or public or public) near2 health near2 (nurs* or practitioner*)) or clinician* or counselor* or counsellor* or “family physician*” or “general practi*” or gp or gps or (health near1 (visit* or worker*)) or midwif* or personnel or phn or phns or physician* or professional* or scphn*)) in dare, hta
#24	#10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23
#25	#9 and #24 from 2005 to 2018

1 **Database:** DARE, HTA (global) [CRD Web]

#	Search
1	mesh descriptor postpartum period in dare,hta
2	mesh descriptor peripartum period in dare,hta
3	mesh descriptor postnatal care in dare,hta
4	(nullipara* or peri natal* or perinatal* or postbirth or post birth or postdelivery or post delivery or postnatal* or post natal* or postpartum* or post partum* or primipara* or puerpera* or puerperium* or ((after or follow*) near2 birth*)) in dare, hta
5	#1 or #2 or #3 or #4
6	mesh descriptor breast feeding explode all trees in dare,hta
7	mesh descriptor lactation in dare,hta
8	(breastfeed* or breast feed* or breastfed* or breastfeed* or breast fed or breastmilk or breast milk or expressed milk* or lactat* or (nursing next (baby or infant* or mother* or neonate* or newborn*))) in dare, hta
9	#6 or #7 or #8
10	mesh descriptor bottle feeding in dare,hta

11	mesh descriptor infant formula in dare,hta
12	(((bottle or formula or synthetic) near2 (artificial or fed or feed* or infant* or milk*)) or (artificial next (formula or milk)) or bottlefed or bottlefeed or cup feeding or (milk near2 (substitut* or supplement*)) or ((infant or milk or water or glucose or dextrose or formula) next supplement) or formula supplement* or supplement feed or milk feed or ((baby or babies or infant* or neonate* or newborn*) next (formula* or milk)) or formulafeed or formulated or (milk near2 powder*) or hydrolyzed formula* or (((feeding or baby or infant) next bottle*) or infant feeding or bottle nipple* or milk pump*)) in dare, hta
13	#10 or #11 or #12
14	#5 or #9 or #13

Health economic search

The search for this topic was last run on 5th December 2019.

Database: Emcare, Embase, Medline, Medline Ahead of Print and In-Process & Other Non-Indexed Citations – OVID [Multifile]

#	Search
1	perinatal period/ or exp postnatal care/
2	1 use emczd, emcr
3	postpartum period/ or peripartum period/ or postnatal care/
4	3 use ppez
5	(((first time or new) adj mother*) or nullipara* or peri natal* or perinatal* or postbirth or post birth or postdelivery or post delivery or postnatal* or post natal* or postpartum* or post partum* or primipara* or puerpera* or puerperium* or ((after or follow*) adj2 birth*)).ti,ab.
6	or/2,4-5
7	exp infant/ use emczd, emcr, ppez
8	(babies or baby or infant* or newborn* or new born*).ti,ab.
9	or/7-8
10	or/6,9
11	ambulatory care/ or exp community care/ or community health nursing/ or general practice/ or health visitor/ or home care/ or exp primary health care/ or traditional birth attendant/ or midwif*.hw.
12	11 use emczd, emcr
13	ambulatory care/ or community health nursing/ or community health planning/ or community health services/ or general practitioners/ or general practice/ or exp home care services/ or midwifery/ or nurses, community health/ or patient care team/ or physicians, family/ or physicians, primary care/ or physicians, women/
14	13 use ppez
15	((birth adj (attendan* or team*)) or ((blanket or community or family or home or public) adj nurs*) or ((blanket or community or family or home or public or public) adj2 health adj2 (nurs* or practitioner*)) or clinician* or counsel?or* or family physician* or general practi* or gp or gps or (health adj (visit* or worker*)) or midwif* or personnel or phn or phns or physician* or professional* or scphn*).ti,ab.
16	or/12,14-15

17	communication/ or computer communication networks/ or consumer health information/ or health education/ or health promotion/ or information dissemination/ or information seeking behaviour/ or internet/ or pamphlets/ or exp patient education as topic/ or posters as topic/ or publications/ or government publications as topic/
18	17 use ppez
19	access to information/ or consumer health information/ or health education/ or health promotion/ or information dissemination/ or information seeking/ or information service/ or internet/ or medical information/ or patient education/ or patient information/ or information/ or publication/
20	19 use emczd, emcr
21	patient education handout.pt.
22	((advice or communicat* or educat* or information or (app* or booklet* or brochure* or dvd or handout* or hand out* or ict or internet* or leaflet* or manual* or media or online* or pamphlet* or phone or publication* or telephone or website* or web site* or web page* or webpage* or web based or written or video*)).ti,ab.
23	or/18,20-22
24	exp family/ use emczd, emcr, ppez or (brother* or father* or famil* or filiation or mother* or parent* or partner* or relative* or sister* or spouse*).ti,ab,hw.
25	23 and 24
26	assault/ or battering/ or exp domestic violence/ or physical violence/ or verbal hostility/ or violence/
27	26 use emczd, emcr
28	exp domestic violence/ or physical abuse/ or violence/
29	28 use ppez
30	(abus* or assault* or batter* or violen*).ti,ab,hw.
31	or/27,29-30
32	exp family/ use emczd, emcr, ppez or (brother* or father* or famil* or filiation or mother* or parent* or partner* or relative* or sister* or spouse*).ti,ab,hw.
33	*group processes/ or *peer group/ or *self help/ or *social network/ or *social support/ or *support group/
34	33 use emczd, emcr
35	group processes/ or hotlines/ or peer group/ or self-help groups/ or social support/
36	35 use ppez
37	((brother* or father* or famil* or filiation or mother* or parent* or partner* or relative* or sister* or spouse*) adj7 (advis* or advis* or assist* or counsel* or discus* or educat* or exchang* or interact* or intervention* or meeting* or phone* or program* or telephon* or therap* or service* or skill* or supervis* or support*)).ti,ab.
38	((brother* or father* or famil* or filiation or mother* or parent* or partner* or relative* or sister* or spouse*) and (advis* or advis* or assist* or counsel* or discus* or educat* or exchang* or interact* or intervention* or meeting* or phone* or program* or telephon* or therap* or service* or skill* or supervis* or support*) and (baby or babies or infant* or neonat* or mother* or parent*)).ti,ab.

39	(((assess* or evaluat*) and support* or (baby or babies or infant* or neonat* or mother* or parent*)) or ((assess* or evaluat*) adj10 (baby or babies or infant* or neonat* or mother* or parent*)))ti,ab,hw.
40	32 and (or/34,36)) or or/37-39
41	((assess* or care or evaluat*) adj5 (baby or babies or infant* or neonat* or mother* or parent*)).ti,ab,hw.
42	(10 and 16) and or/25,31,40-41
43	budget/ or exp economic evaluation/ or exp fee/ or funding/ or exp health care cost/ or health economics/
44	43 use emczd, emcr
45	exp budgets/ or exp "costs and cost analysis"/ or economics/ or exp economics, hospital/ or exp economics, medical/ or economics, nursing/ or economics, pharmaceutical/ or exp "fees and charges"/ or value of life/
46	45 use ppez
47	budget*.ti,ab. or cost*.ti. or (economic* or pharmaco?economic*).ti. or (price* or pricing*).ti,ab. or (cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab. or (financ* or fee or fees).ti,ab. or (value adj2 (money or monetary)).ti,ab.
48	or/44,46-47
49	economic model/ or quality adjusted life year/ or "quality of life index"/
50	(cost-benefit analysis.sh. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.)
51	((quality of life or qol).tw. and cost benefit analysis.sh.)
52	or/49-51 use emczd, emcr
53	models, economic/ or quality-adjusted life years/
54	(cost-benefit analysis.sh. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.)
55	((quality of life or qol).tw. and cost-benefit analysis.sh.)
56	or/53-55 use ppez
57	(eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or euroqual 5d* or euro qual 5d* or euro qol* or euroqol*or euro quol* or euroquol* or euro quol5d* or euroquol5d* or eur qol* or eurqol* or eur qol5d* or eurqol5d* or eur?qul* or eur?qul5d* or euro* quality of life or european qol).tw.
58	(euro* adj3 (5 d* or 5d* or 5 dimension* or 5dimension* or 5 domain* or 5domain*)).tw.
59	(hui or hui2 or hui3).tw.
60	(illness state* or health state*).tw.
61	(multiattibute* or multi attribute*).tw.
62	(qaly* or qal or qald* or qale* or qtime* or qwb* or daly).tw.
63	(quality adjusted or quality adjusted life year*).tw.
64	(sf36 or sf 36 or sf thirty six or sf thirtysix).tw.
65	sickness impact profile.sh.
66	(time trade off*1 or time tradeoff*1 or tto or timetradeoff*1).tw.
67	(utilit* adj3 (score*1 or valu* or health* or cost* or measur* or disease* or mean or gain or gains or index*)).tw.
68	utilities.tw.
69	((qol or hrqol or quality of life).tw. or *quality of life/) and ((qol or hrqol* or quality of life) adj2 (change*1 or declin* or decreas* or deteriorat* or

	effect or effects or high* or impact*1 or impacted or improve* or increas* or low* or reduc* or score or scores or worse)).ab.
70	quality of life.sh. and ((health-related quality of life or (health adj3 status) or ((quality of life or qol) adj3 (chang* or improv*)) or ((quality of life or qol) adj (measure*1 or score*1))).tw. or (quality of life or qol).ti. or ec.fs.)
71	or/52,56-70
72	or/48,71
73	42 and 72
74	limit 73 to english language

1 **Database:** HTA, NHS EED [CRD Web]

#	Search
#1	mesh descriptor postpartum period in hta, nhs eed
#2	mesh descriptor peripartum period in hta, nhs eed
#3	mesh descriptor postnatal care in hta, nhs eed
#4	((((“first time” or new) near1 mother*) or nullipara* or “peri natal*” or perinatal* or postbirth or “post birth” or postdelivery or “post delivery” or postnatal* or “post natal*” or postpartum* or “post partum*” or primipara* or puerpera* or puerperium* or ((after or follow*) near2 birth*))) in hta, nhs eed
#5	#1 or #2 or #3 or #4
#6	mesh descriptor infant explode 1
#7	((babies or baby or infant* or newborn* or “new born*”)) in hta, nhs eed
#8	#6 or #7
#9	#5 or #8
#10	mesh descriptor ambulatory care in hta, nhs eed
#11	mesh descriptor community health nursing in hta, nhs eed
#12	mesh descriptor community health planning in hta, nhs eed
#13	mesh descriptor community health services in hta, nhs eed
#14	mesh descriptor general practitioners in hta, nhs eed
#15	mesh descriptor general practice in hta, nhs eed
#16	mesh descriptor home care services explode 1
#17	mesh descriptor midwifery in hta, nhs eed
#18	mesh descriptor nurses, community health in hta, nhs eed
#19	mesh descriptor patient care team in hta, nhs eed
#20	mesh descriptor physicians, family in hta, nhs eed
#21	mesh descriptor physicians, primary care in hta, nhs eed
#22	mesh descriptor physicians, family in hta, nhs eed
#23	(((birth near1 (attendan* or team*)) or ((blanket or community or family or home or public) near1 nurs*) or ((blanket or community or family or home or public or public) near2 health near2 (nurs* or practitioner*)) or clinician* or counselor* or counsellor* or “family physician*” or “general practi*” or gp or gps or (health near1 (visit* or worker*)) or midwif* or personnel or phn or phns or physician* or professional* or scphn*)) in hta, nhs eed
#24	#10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23
#25	#9 and #24 from 2005 to 2018

2 **Database:** Emcare, Embase, Medline, Medline Ahead of Print and In-Process & Other Non-
3 Indexed Citations (global) – OVID [Multifile]

#	Search
1	puerperium/ or perinatal period/ or postnatal care/
2	1 use emczd, emcr
3	postpartum period/ or peripartum period/ or postnatal care/
4	3 use ppez
5	(nullipara* or peri natal* or perinatal* or postbirth or post birth or postdelivery or post delivery or postnatal* or post natal* or postpartum* or post partum* or primipara* or puerpera* or puerperium* or ((after or follow*) adj2 birth*)).ti,ab.
6	or/2,4-5
7	breast feeding/ or breast feeding education/ or lactation/
8	7 use emczd, emcr
9	exp breast feeding/ or lactation/
10	9 use ppez
11	(breastfeed* or breast feed* or breastfed* or breastfeed* or breast fed or breastmilk or breast milk or expressed milk* or lactat* or (nursing adj (baby or infant* or mother* or neonate* or newborn*))).ti,ab.
12	or/8,10-11
13	artificial food/ or bottle feeding/ or infant feeding/
14	13 use emczd, emcr
15	bottle feeding/ or infant formula/
16	15 use ppez
17	(((bottle or formula or synthetic) adj2 (artificial or fed or feed* or infant* or milk*)) or (artificial adj (formula or milk)) or bottlefed or bottlefeed or cup feeding or (milk adj2 (substitut* or supplement*)) or ((infant or milk or water or glucose or dextrose or formula) adj supplement) or formula supplement* or supplement feed or milk feed or ((baby or babies or infant* or neonate* or newborn*) adj (formula* or milk)) or formulafeed or formulated or (milk adj2 powder*) or hydrolyzed formula* or (((feeding or baby or infant) adj bottle*) or infant feeding or bottle nipple* or milk pump*)).ti,ab.
18	or/14,16-17
19	or/6,12,18
20	budget/ or exp economic evaluation/ or exp fee/ or funding/ or exp health care cost/ or health economics/
21	20 use emczd, emcr
22	exp budgets/ or exp "costs and cost analysis"/ or economics/ or exp economics, hospital/ or exp economics, medical/ or economics, nursing/ or economics, pharmaceutical/ or exp "fees and charges"/ or value of life/
23	22 use ppez
24	budget*.ti,ab. or cost*.ti. or (economic* or pharmaco?economic*).ti. or (price* or pricing*).ti,ab. or (cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab. or (financ* or fee or fees).ti,ab. or (value adj2 (money or monetary)).ti,ab.
25	or/21,23-24
26	economic model/ or quality adjusted life year/ or "quality of life index"/
27	(cost-benefit analysis.sh. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.)
28	((quality of life or qol).tw. and cost benefit analysis.sh.)
29	or/26-28 use emczd, emcr
30	models, economic/ or quality-adjusted life years/

#	Search
31	(cost-benefit analysis.sh. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.)
32	((quality of life or qol).tw. and cost-benefit analysis.sh.)
33	or/30-32 use ppez
34	(eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or euroqual 5d* or euro qual 5d* or euro qol* or euroqol*or euro quol* or euroquol* or euro quol5d* or euroquol5d* or eur qol* or eurqol* or eur qol5d* or eurqol5d* or eur?qul* or eur?qul5d* or euro* quality of life or european qol).tw.
35	(euro* adj3 (5 d* or 5d* or 5 dimension* or 5dimension* or 5 domain* or 5domain*)).tw.
36	(hui or hui2 or hui3).tw.
37	(illness state* or health state*).tw.
38	(multiattibute* or multi attribute*).tw.
39	(qaly* or qal or qald* or qale* or qtime* or qwb* or daly).tw.
40	(quality adjusted or quality adjusted life year*).tw.
41	(sf36 or sf 36 or sf thirty six or sf thirtysix).tw.
42	sickness impact profile.sh.
43	(time trade off*1 or time tradeoff*1 or tto or timetradeoff*1).tw.
44	(utilit* adj3 (score*1 or valu* or health* or cost* or measur* or disease* or mean or gain or gains or index*)).tw.
45	utilities.tw.
46	((qol or hrqol or quality of life).tw. or *quality of life/) and ((qol or hrqol* or quality of life) adj2 (change*1 or declin* or decreas* or deteriorat* or effect or effects or high* or impact*1 or impacted or improve* or increas* or low* or reduc* or score or scores or worse)).ab.
47	quality of life.sh. and ((health-related quality of life or (health adj3 status) or ((quality of life or qol) adj3 (chang* or improv*)) or ((quality of life or qol) adj (measure*1 or score*1))).tw. or (quality of life or qol).ti. or ec.fs.)
48	or/29,33-47
49	or/25,48
50	19 and 50
51	limit 50 to english language
52	(animals/ not humans/) or exp animals, laboratory/ or exp animal experimentation/ or exp models, animal/ or exp rodentia/
53	52 use ppez
54	(animal/ not human/) or nonhuman/ or exp animal experiment/ or exp experimental animal/ or animal model/ or exp rodent/
55	54 use emczd, emcr
56	(rat or rats or mouse or mice).ti.
57	or/53,55-56
58	51 not 57

1 **Database:** HTA, NHS EED (global) [CRD Web]

#	Search
1	mesh descriptor postpartum period in hta, nhs eed
2	mesh descriptor peripartum period in hta, nhs eed
3	mesh descriptor postnatal care in hta, nhs eed

#	Search
4	(nullipara* or peri natal* or perinatal* or postbirth or post birth or postdelivery or post delivery or postnatal* or post natal* or postpartum* or post partum* or primipara* or puerpera* or puerperium* or ((after or follow*) near2 birth*)) in hta, nhs eed
5	#1 or #2 or #3 or #4
6	mesh descriptor breast feeding explode all trees in hta, nhs eed
7	mesh descriptor lactation in hta, nhs eed
8	(breastfeed* or breast feed* or breastfed* or breastfeed* or breast fed or breastmilk or breast milk or expressed milk* or lactat* or (nursing next (baby or infant* or mother* or neonate* or newborn*))) in hta, nhs eed
9	#6 or #7 or #8
10	mesh descriptor bottle feeding in hta, nhs eed
11	mesh descriptor infant formula in hta, nhs eed
12	(((bottle or formula or synthetic) near2 (artificial or fed or feed* or infant* or milk*)) or (artificial next (formula or milk)) or bottlefed or bottlefeed or cup feeding or (milk near2 (substitut* or supplement*)) or ((infant or milk or water or glucose or dextrose or formula) next supplement) or formula supplement* or supplement feed or milk feed or ((baby or babies or infant* or neonate* or newborn*) next (formula* or milk)) or formula feed or formulated or (milk near2 powder*) or hydrolyzed formula* or (((feeding or baby or infant) next bottle*) or infant feeding or bottle nipple* or milk pump*)) in hta, nhs eed
13	#10 or #11 or #12
14	#5 or #9 or #13

1

Appendix C – Clinical evidence study selection

Clinical study selection for: What is the essential content of postnatal care contacts for women and babies?

Figure 1: Study selection flow chart – guidelines

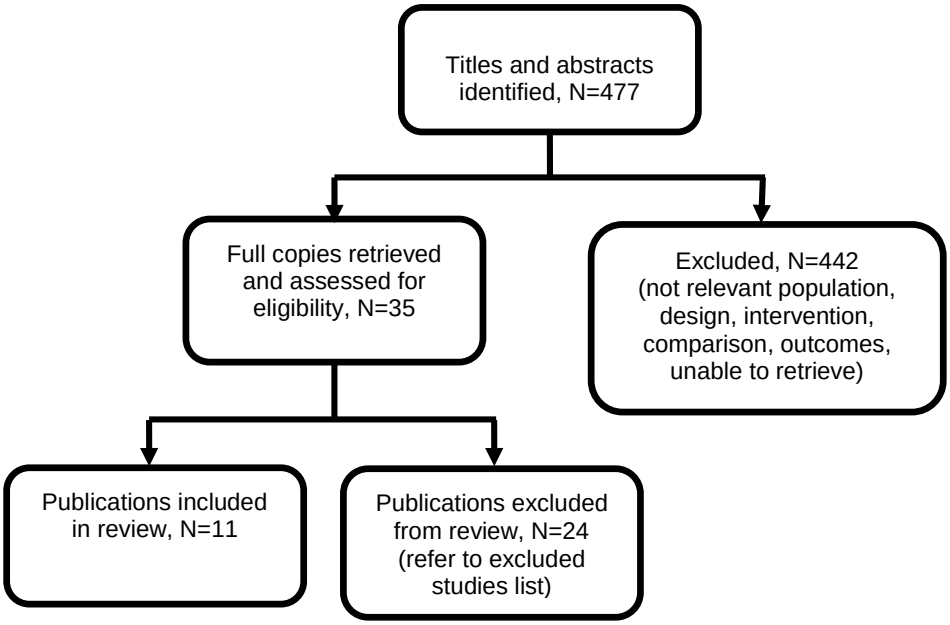
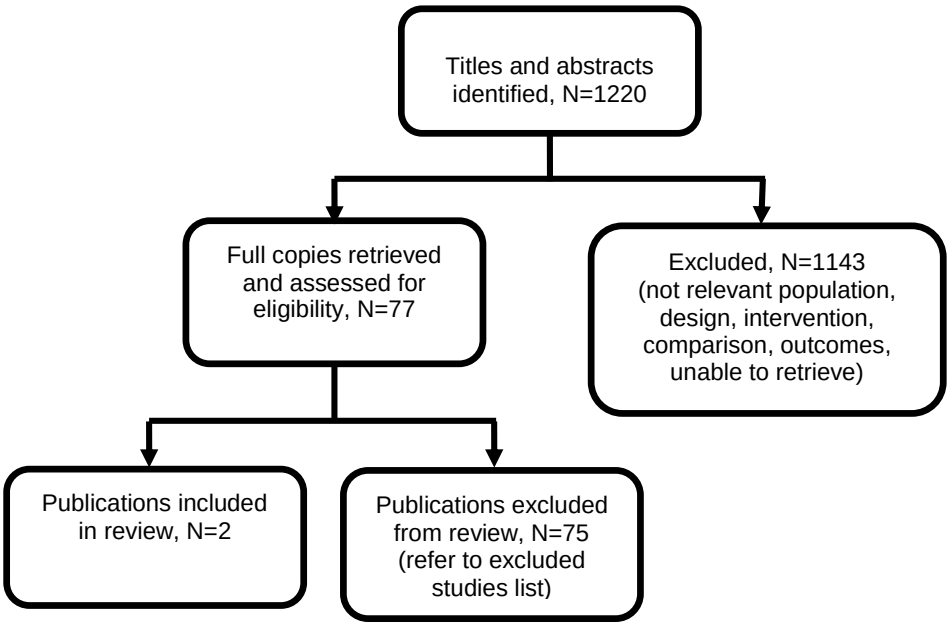


Figure 2: Study selection flow chart – systematic reviews



1 Appendix D – Clinical evidence tables

2 Clinical evidence tables for review question: What is the essential content of postnatal care contacts for women and babies?

3 Table 4: Clinical evidence tables – guidelines

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
Full citation American College of Obstetricians and Gynaecologists, 'Committee Opinion' on optimizing postpartum care, 2018 **Ref Id** 922033 **Country/ies where the study was carried out** US **Study type** Committee opinion **Aim of the study** Aim is not clearly stated but it was developed by the presidential task force on redefining the postpartum visit. **Study dates** Not reported **Source of funding**	Not reported	**Recommendations relating to the assessment and care of the mother (physical)** • To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs. • The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being.	**Scope and purpose (61%)** The overall objective of the guideline, the health question and the population are not explicitly stated but can be inferred from the introduction. **Stakeholder involvement (39%)** Very limited information was provided the composition of the committee and it is unclear whether there was any patient involvement. Target audience for the guideline is alluded to but not explicitly stated. **Rigour of development (17%)** No information is provided about methods of searching for or selecting evidence, There is no discussion of the quality of evidence or how recommendations were developed from the evidence. It is unclear if benefits, side effects and risk were formally considered. There is no explicit link between the evidence and the recommendations and it is not clear if the guideline was reviewed prior to publication. No procedure for updating the guideline is provided.

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
Authors state that there was no commercial involvement in the development of the publication			**Clarity of presentation (72%)** Recommendations are clear and specific. Some different options are presented. Presentation of key recommendations could be improved. **Applicability (42%)** There is some guidance about facilitators and barriers to application and how to implement the recommendations. There is some limited information about resource implications but no discussion of monitoring/auditing criteria. **Editorial independence (67%)** There was no commercial involvement in the guideline. The guideline states that a disclosure statement was received from all contributors and that these were dealt with according to ACOG's disclosure policy, but does not report whether or not there were any conflicts.
Full citation Beyondblue, Depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. A guideline for primary care health professionals, 2011 **Ref Id** 922043	Women in the perinatal period (defined as pregnancy and the following year)	**Recommendations relating to provision of advice and information for parents or immediate family** • Women in the perinatal period may benefit from being provided with reliable advice on lifestyle issues and sleep, as well as assistance in planning how this advice can be incorporated into	**Scope and purpose (83%)** The overall objective of the guideline and the health question and clearly defined. The population is defined but could be stated more explicitly. **Stakeholder involvement (94%)** There is detailed information about the specialities, institutions and roles of the committee members and workshops were held with consumers and carers. Target

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
Country/ies where the study was carried out Australia **Study type** Clinical guideline **Aim of the study** To make recommendations for key areas of perinatal mental health care **Study dates** Studies published between 2006 and 2008 to 2009 (depending on review); reviews conducted December 2008 to July 2009 **Source of funding** No funding was received from pharmaceutical companies		their daily activities during this time. **Recommendations relating to assessment and care of the mother (mental health/emotional well-being)** • The EPDS should be used by health professionals as a component of the assessment of all women in the postnatal period for symptoms of depression or co-occurring depression and anxiety. • A score of 13 or more can be used for detecting symptoms of major depression in the postnatal period. • Non-directive counselling in the context of home visits can be considered as part of the management of mild to moderate depression for women in the postnatal period. • Psychoeducation for women and, where appropriate, their significant other(s) should be a routine component of care in the perinatal period. This should include discussion of mental health and provision of educational materials. • As early as practical in pregnancy and 6–12 weeks after a birth, all women should be	audience for the guideline is clearly defined. **Rigour of development (85%)** Systematic methods were used to search the literature; the guidelines report that full details are available on the website but these do not seem to be accessible since the guideline has been updated by other guidance (COPE). Minimal information is provided about inclusion and exclusion criteria. The process for assessing the quality of evidence is clearly presented and summary tables are included. The process or developing recommendations is explicitly described. There is some discussion of the benefits and risks associated with recommendations and a workshop was conducted on the benefits and harms of pharmacological treatment. There is an explicit link between the evidence and recommendations and the guideline was subject to stakeholder consultation prior to publication. The process for updating the guideline is described but lacks a bit of detail. **Clarity of presentation (89%)** Recommendations are clear and specific and different options are presented. Recommendations are grouped under relevant subheadings and in an algorithm and are presented separately from good practice points which were based on lower quality evidence.

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
		asked questions around psychosocial domains as part of normal care. If a woman affirms the presence of psychosocial factors, she should be asked whether she would like help with any of these issues. • All women should complete the EPDS at least once, preferably twice, in both the antenatal period and the postnatal period (ideally 6–12 weeks after the birth). Administration of the EPDS can be readily integrated with existing routine antenatal and postnatal care. • Assessing the mother–infant interaction should be an integral part of the care of women in the postnatal period. • Where significant difficulties are observed with the mother–infant interaction and/or there is concern about the mother's mental health, the risk of harm to the infant should be assessed. **Recommendations relating to the assessment of support available to the mother and baby from the partner or family** • Involving members of a woman's support network in her care as early as practical provides opportunities for all involved to	**Applicability (67%)** There is some discussion of the applicability of the guideline in terms of facilitators/barriers, processes for implementation and costs associated with the guidance. There is some discussion of monitoring but there is a lack of explicit criteria. **Editorial independence (75%)** No funding was received from pharmaceutical companies. Other sources of funding are reported but their role in the guideline is not fully discussed. The guideline does not include a statement about the role of the funding body. The process for dealing with conflicts of interests within the guideline committee is clearly described but interests themselves are not presented.

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
		gain an understanding of the impact of pregnancy and early parenthood on emotional health and well-being. It also enables assessment of psychosocial factors affecting family members and family relationships.	
Full citation Centre of Perinatal Excellence (COPE), Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline. [online] Available at: https://www.cope.org.au/wp-content/uploads/2018/05/COPE-Perinatal-MH-Guideline_Final-2018.pdf[online [Accessed on 22 July 2019]. , 2017 **Ref Id** 1078618 **Country/ies where the study was carried out** Australia **Study type** Clinical guideline **Aim of the study** To summarise evidence on screening, preventing and treating mental health problems in the perinatal period **Study dates**	Women who are pregnant or within the first year after birth	**Recommendations relating to the assessment and care of the mother (mental health/emotional well-being)** • Assess psychosocial risk factors as early as practical in pregnancy and again after the birth. • Use the Edinburgh Postnatal Depression Scale (EPDS) to screen women for a possible depressive disorder in the perinatal period. • Arrange further assessment of perinatal woman with an EPDS score of 13 or more. • For a woman with an EPDS score between 10 and 12, monitor and repeat the EPDS 2–4 weeks later as her score may increase subsequently. • For a woman with an EPDS score between 10 and 12, monitor and repeat the EPDS 2–4 weeks later as her score may increase subsequently. • Discuss with the woman the possible impact of psychosocial risk factors (she has endorsed)	**Scope and purpose (100%)** The overall objective of the guideline, the health question and the population was clearly defined. **Stakeholder involvement (100%)** The specialities, institutions and role of committee members and the target audience for the guideline is clearly defined. Views of the target population were captured through representation on the committee and consultation. **Rigour of development (94%)** Systematic methods were used to search the literature and a full search strategy is provided. The process for selecting studies and inclusion/exclusion criteria are clearly presented. Appropriate tools were used to assess quality of included studies and full results of these are presented; GRADE/an adapted GRADE approach was used to assess overall quality of evidence and the results of this are clearly presented. The process of formulating recommendations is described in detail and there is an explicit consideration of benefits and harms of recommendations. There is a link between

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
Searches were conducted June 2016 to April 2017 **Source of funding** Australian Government Department of Health		on her mental health and provide information about available assistance. • Assess the mother-infant interaction as an integral part of postnatal care and refer to a parent-infant therapist as available and appropriate.	the evidence and recommendations but this could be made more explicit. The guideline was thoroughly reviewed prior to publication by methodologists, peer reviewers and through public consultation. Some information is provided about the update process but it lacks some detail. **Clarity of presentation (100%)** Recommendations are specific and concise and different options are clearly presented. Related recommendations are grouped under subheadings and a distinction is made between evidence based recommendations, consensus based recommendations and general practice points. **Applicability (83%)** The guideline presented a systematic discussion of facilitators and barriers to the guideline and advice for implementation. There is some discussion of resource implications but this is a bit limited (possibly due to the fact that overall resource impact was thought to be low. There is some limited discussion of monitoring/auditing criteria. **Editorial independence (100%)** The guideline states that the guideline was developed independently form the funding body, the process for dealing with conflicts of interests is clearly described and

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
			relevant interests of committee members are reported.
Full citation The Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians & Gynaecologists, CEU Clinical Guidance: Contraception After Pregnancy, 2017 **Ref Id** 922034 **Country/ies where the study was carried out** UK **Study type** Clinical guideline **Aim of the study** To provide guidelines to promote a collaborative and consistent approach to providing high quality contraceptive care to women after pregnancy. **Study dates** Studies published up to November 2016 **Source of funding** FSRH funds the development of its own guidelines	Women after childbirth, abortion, ectopic pregnancy, miscarriage or gestational trophoblastic disease (GTD)	**Recommendations relating to provision of advice and information for parents or immediate family** • Maternity services (including services providing antenatal, intrapartum and postpartum care) should give women opportunities to discuss their fertility intentions, contraception and preconception planning. (GPP) • Women should be informed about the effectiveness of the different contraceptive methods, including the superior effectiveness of long-acting reversible contraception (LARC), when choosing an appropriate method to use after childbirth. (GPP) • Women should be advised that an interpregnancy interval (IPI) of less than 12 months between childbirth and conceiving again is associated with an increased risk of preterm birth, low birthweight and small for gestational age (SGA) babies. (B) • Women should be advised that although contraception is not required in the first 21 days after childbirth, most methods can be safely initiated immediately, with	**Scope and purpose (100%)** The overall objective of the guideline, the health question and the population were clearly defined. **Stakeholder involvement (72%)** Detailed information was provided about the specialities, institutions and role of committee members and the target audience for the guideline is clearly defined. It is unclear whether there was any patient involvement. **Rigour of development (83%)** Systematic methods were used to search the literature and a full search strategy is provided. Limited information is provided about criteria for selecting evidence. Evidence was assessed using GRADE methodology and the level of evidence contributing to each recommendation is clearly reported. However, GRADE tables/discussion of strength and limitations is not included. The process of developing recommendations from the evidence and consideration of benefits, side effects and risk were formally described but lack some detail. The evidence is explicitly linked to the recommendations. The guideline was reviewed prior to publication and a list of independent reviewers is provided. The process for decided when an update is needed is clearly described.

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
		the exception of combined hormonal contraception (CHC). (D) • Women who are breastfeeding should be informed that the available evidence indicates that progestogen-only methods of contraception (LNG-IUS, IMP, POI and POP) have no adverse effects on lactation, infant growth or development. (A) • Women who are breastfeeding should be informed that there is currently limited evidence regarding the effects of CHC use on breastfeeding. However, the better quality studies of early initiation of CHC found no adverse effects on either breastfeeding performance (duration of breastfeeding, exclusivity and timing of initiation of supplemental feeding) or on infant outcomes (growth, health and development). (B) • Women may be advised that, if they are less than 6 months postpartum, amenorrhoeic and fully breastfeeding, the lactational amenorrhoea method (LAM) is a highly effective method of contraception. (C) • Women using LAM should be advised that the risk of pregnancy is increased if the frequency of breastfeeding	**Clarity of presentation (100%)** Recommendations are clear and specific. Different options are provided and recommendations are grouped under relevant subheadings. **Applicability (67%)** There is some discussion of the applicability of the guideline in terms of resource implications and facilitators/barriers. The guideline provides clear criteria for auditing. **Editorial independence (58%)** FSRH fund their own guidelines and no other funding was received. Therefore, the funding body would have influenced the guideline but FSRH is a charitable organisation as opposed to a commercial organisation. The guideline states that none of the committee members or the independent reviews had competing interests that prevented their participation, but these interest are not reported.

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
		decreases (e.g. through stopping night feeds, starting or increasing supplementary feeding, use of dummies/pacifiers, expressing milk), when menstruation returns or when more than 6 months after childbirth. (C)	
Full citation Fleming, N., O'Driscoll, T., Becker, G., Spitzer, R. F., Allen, L., Millar, D., Brain, P., Dalziel, N., Dubuc, E., Hakim, J., Murphy, D., Spitzer, R., Adolescent Pregnancy Guidelines, Journal of obstetrics and gynaecology Canada : JOGC = Journal d'obstetrique et gynecologie du Canada : JOGC, 37, 740-759, 2015 **Ref Id** 496039 **Country/ies where the study was carried out** Canada **Study type** Clinical guideline **Aim of the study** To develop evidence-based guidelines for the care of pregnant adolescents in Canada (including special populations) **Study dates**	Pregnant adolescents - no further information reported	**Recommendations relating to subgroups (adolescent mothers)** • Breastfeeding should be recommended and sufficient support given to this population at high risk for discontinuation. • Postpartum care programs should be available to support adolescent parents and their children, to improve the mothers' knowledge of parenting, to increase breastfeeding rates, to screen for and manage postpartum depression, to increase birth intervals, and to decrease repeated unintended pregnancy rates.	**Scope and purpose (89%)** The overall objective of the guideline and the health question was clearly defined. The population was specified (adolescents) but not defined. **Stakeholder involvement (56%)** Limited information was provided about the specialities, institutions or role of committee members and it is unclear whether there was any patient involvement. Target audience for the guideline is clearly defined. **Rigour of development (50%)** Systematic methods were used to search the literature but a full search strategy is not provided. Some information is provided about inclusion/exclusion criteria but there is not a full protocol. Limited information is provided about the quality of the evidence. The process of developing recommendations from the evidence is not described and it is unclear if benefits, side effects and risk were formally considered. A link between the evidence and recommendations is provided and the guideline was reviewed prior to publication.

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
Studies published between 1990 and July 2013 **Source of funding** No sources of funding reported			No procedure for updating the guideline is provided. **Clarity of presentation (72%)** Recommendations are not very concise and include rationale for making recommendations as well as action that should be taken. Some different options are presented. Related recommendations are grouped under subheadings. **Applicability (21%)** There is some limited discussion of the applicability of the guideline in terms of resource implications and facilitators/barriers. **Editorial independence (33%)** No sources of funding were reported. The guideline states that a disclosure statement was received from all contributors, but not whether or not there were any competing interests.
Full citation National Maternity Review, Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care, 2016 **Ref Id** 922038 **Country/ies where the study was carried out**	Maternity services in England	**Recommendations relating to the provision of advice and information for parents or immediate family** • Unbiased information should be made available to all women to help them make their decisions and develop their care plan drawing on the latest evidence, and assessment of their individual needs, and what	**Scope and purpose (72%)** The overall objective of the guideline and the health question were clearly defined. The population is not explicitly stated but it is possible to infer it applies to those served by maternity services in England. **Stakeholder involvement (78%)** Information was provided about the institutions of committee members but information about their roles was somewhat

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
England **Study type** Service guideline **Aim of the study** To make recommendations for safe and efficient maternity services (including midwife-led services), ensure women are supported to make safe and appropriate choices about their maternity care and care of their babies, to support NHS staff to provide responsive care and consider the challenges of achieve these objectives in geographically isolated areas **Study dates** Guideline developed during 2015 **Source of funding** Review was commissioned by NHS England; source of funding not explicitly reported		services are available locally. This should be through their digital maternity tool.	limited. An extensive programme of stakeholder engagement is clearly described. The target audience is discussed in the context of individual recommendations. **Rigour of development (19%)** There is limited to no discussion about how the literature was searched, how studies were selected for inclusion or the quality of the evidence. There is no discussion of the process for making recommendations and there is not a formal link between evidence and recommendations. It is unclear if the benefits, risks and side effects of recommendations were formally considered. The guideline went out for consultation with stakeholders prior to publication. There is no procedure for updating the guideline. **Clarity of presentation (67%)** Recommendations are relatively clear and specific and different options are outlined. Recommendations are only clearly presented in an appendix but lack concise subheadings. **Applicability (75%)** There is some guidance on how the guideline might be implemented and some discussion of the resource implications and facilitators/barriers. The guideline provides some information for monitoring if

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
			recommendations have been successfully implemented and timeframes for this. **Editorial independence (33%)** The guideline does not include a statement about the role of the funding body or the interests of the committee.
Full citation National Institute for Health and Clinical Excellence , National Institute for Health and Clinical Excellence , Postnatal Care: Routine Postnatal Care of Women and their Babies (CG37), 2006 **Ref Id** 922046 **Country/ies where the study was carried out** England **Study type** Clinical guideline **Aim of the study** To identify the 'core care' that everyone women and baby should receive in the 6 to 8 weeks after birth **Study dates** Guideline developed between 2003 and 2006; studies included up to August 2005	Women and babies in the 6 to 8 weeks after birth; excludes care for pre-existing conditions	**Recommendations relating to provision of advice and information for parents or immediate family** • Women should be offered relevant and timely information to enable them to promote their own and their babies' health and well-being and to recognise and respond to problems. • At each postnatal contact the healthcare professional should: ○ offer consistent information and clear explanations to empower the woman to take care of her own health and that of her baby, and to recognise symptoms that may require discussion. **Recommendations relating to the assessment and care of the mother (physical)** • At each postnatal contact the healthcare professional should: ○ ask the woman about her health and well-being and that	**Scope and purpose (100%)** The overall objective of the guideline, the health question and the population were clearly defined. **Stakeholder involvement (100%)** Detailed information was provided about the specialities, institutions and roles of the committee members and there were three lay members included on the committee. Target audience for the guideline is clearly defined. **Rigour of development (81%)** Systematic methods were used to search the literature and full search strategies are available in an appendix. The process for selecting studies for inclusion is described but full inclusion/exclusion criteria is not reported. The level/quality of evidence is provided in evidence statements but there is limited discussion of strengths/limitations. The process of developing recommendations is explicitly described and there is an explicit link between the evidence and recommendations. There is some discussion of the benefits and risks of recommendations but it could be more

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
Source of funding Department of Health and Social Care (taken from 'who we are' page of NICE website)		of her baby. This should include asking women about their experience of common physical health problems. Any symptoms reported by the woman or identified through clinical observations should be assessed. ○ encourage the woman and her family to report any concerns in relation to their physical, social, mental or emotional health, discuss issues and ask questions. **Recommendations relating to the assessment and care of the mother (mental health/emotional well-being)** • Women should be offered an opportunity to talk about their birth experiences and to ask questions about the care they received during labour. **General principles** • Each postnatal contact should be provided in accordance with the principles of individualised care. In order to deliver the core care recommended in this guideline, postnatal services should be planned locally to achieve the most efficient and effective service for women and their babies.	explicit. The guideline was subject to stakeholder consultation prior to publication. Information about the process for updates is provide on the NICE website. **Clarity of presentation (89%)** Most recommendations are specific and concise and some different options are provided. Key recommendations are presented separately. **Applicability (67%)** There is a lack of discussion about facilitators and barriers to applying the guidance. NICE provides some general advice about implementing guidance but this is not specific to the topic. The resource impact of the guideline has been considered throughout. The guideline reports some auditing criteria. **Editorial independence (58%)** The guideline does not include a statement about the role of the funding body. The process for recording conflicts of interests is discussed but a statement of interests is not provided.

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
Full citation Scottish Intercollegiate Guidelines Network , Scottish Intercollegiate Guidelines Network , Management of Perinatal Mood Disorder, 2012 **Ref Id** 922045 **Country/ies where the study was carried out** Scotland **Study type** Clinical guideline **Aim of the study** To provide recommendations for the management of antenatal and postnatal mood and anxiety disorders **Study dates** Studies published between 1999 and 2010 (for most searches; detail not provided about exceptions to this) **Source of funding** No sources of funding reported	Not reported	**Recommendations relating to the assessment and care of the mother (mental/emotional well-being)** • Cognitive behavioural therapies should be considered for treatment of mild to moderate depression in the postnatal period.	**Scope and purpose (78%)** The overall objective of the guideline and the health question were clearly defined. The population is not explicitly stated but can be inferred from the remit and the recommendations. **Stakeholder involvement (83%)** There is clear information about the specialities, institutions and roles of the committee members; there was one lay representative on the committee. The target audience is clearly defined. **Rigour of development (67%)** The literature was searched in a systematic way but full search strategies were not provided. There is minimal information about inclusion and exclusion criteria. There is no discussion of the process for making recommendations. There is some consideration of the benefits, risks and side effects of recommendations but this could be more explicit. There is a clear link between the evidence and the recommendations and the guideline was reviewed prior to publication. Some information is provided about the process for updating the guideline. **Clarity of presentation (78%)** Recommendations are specific and clear. There is a lack of information about different options. Key recommendations are

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
			presented under a separate heading and easy to identify. **Applicability (58%)** There is limited discussion of facilitators/barriers and this is mainly in the context of resource implications. There is no real advice on how to implement the guidance as the section on implementation mainly addresses resource implications. Recommendations with the potential for a resource impact are highlighted but resource implications are not discussed throughout. Some suggested auditing criteria is provided. **Editorial independence (50%)** The guideline does not include a statement about the role of the funding body. The guideline reported that all members of the committee made declaration of interests that are available on request.
Full citation UNICEF, Baby Friendly Standards **Ref Id** 922040 **Country/ies where the study was carried out** UK **Study type**	Maternity settings, neonatal units, community health care services and children's centres	**Recommendations relating to provision of advice and information for parents or immediate family** • Support mothers to make informed decisions regarding the introduction of food or fluids other than breastmilk **Recommendations relating to the assessment and care of the baby**	**Scope and purpose (56%)** The objective of the guideline and the health question are reported but could be much clearer. The population is not explicitly stated but it is possible to infer it applies to those served by the services listed in the population. **Stakeholder involvement (28%)** This guidance does not appear to have been developed by a formal committee. The contribution of various professionals are acknowledged but limited information is

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
Clinical and service guideline **Aim of the study** To increase breastfeeding initiation and to support healthcare professionals in enabling close mother-baby relationships **Study dates** Not reported **Source of funding** No sources of funding reported		• Support parents to have a close and loving relationship with their baby • Support all mothers and babies to initiate a close relationship and feeding soon after birth • Enable mothers to get breastfeeding off to a good start	provided about their specialities, institutions or roles. It is unclear whether there was any patient involvement. The target audience is reported but lacks detail. **Rigour of development (35%)** The literature was searched in a systematic way but limited information is provided. No information is provided about inclusion and exclusion criteria and the quality of evidence is not formally discussed. There is no discussion of the process for making recommendations and it is unclear if the benefits, risks and side effects of recommendations were formally considered. There is a link between the evidence and recommendations but it could be more explicit. It is unclear if the guideline was formally reviewed prior to publication although the contribution of experts is acknowledged. The guideline reports that it will be updated periodically but the process for this is not reported. **Clarity of presentation (56%)** Recommendations are quite vague and different options are not discussed. Recommendations are clearly presented using subheadings. **Applicability (67%)** There is explicit advice on how the guideline might be implemented and criteria for monitoring/auditing. There is minimal/no discussion of facilitators and barriers to

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
			implementing the guideline. There is minimal discussion of resource implications and this mainly focuses on costs savings associated with increased breastfeeding. **Editorial independence (50%)** The guideline does not include a statement about the role of the funding body or the interests of the committee.
Full citation World Health Organization, WHO recommendations on postnatal care of the mother and newborn, 2013 **Ref Id** 922037 **Country/ies where the study was carried out** International **Study type** Clinical guideline **Aim of the study** To provide guidelines that address the timing, number, and place of postnatal contacts and the content of postnatal care during the first 6 weeks after birth **Study dates** Systematic reviews were conducted between 2010 and 2012 and the guideline	Mothers and newborns in resource limited settings in low and middle income countries	**Recommendations relating to provision of advice and information for parents or immediate family** • Immunization should be promoted as per existing WHO guidelines. • All women should be given information about the physiological process of recovery after birth, and that some health problems are common, with advice to report any health concerns to a healthcare professional, in particular: ○ Signs and symptoms of PPH: sudden and profuse blood loss or persistent increased blood loss, faintness, dizziness, palpitations/tachycardia. ○ Signs and symptoms of pre-eclampsia/eclampsia: headaches accompanied by one or more of the symptoms of visual disturbances, nausea, vomiting, epigastric or	**Scope and purpose (100%)** The overall objective of the guideline, the health question and the population were clearly defined. **Stakeholder involvement (61%)** Limited information was provided about the specialities of the committee members and it is unclear whether there was any patient involvement. Target audience for the guideline is clearly defined. **Rigour of development (83%)** Systematic methods were used to search the literature but a full search strategy is not provided. Some information is provided about inclusion/exclusion criteria but there is not a full protocol. GRADE was used to assess the quality of the evidence and GRADE profiles are reported; the overall quality, strengths and limitations of evidence for recommendations are discussed. The process of developing recommendations from the evidence is described and the benefits, side effects and risks were formally considered and

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
development group formulated recommendations in September 2012 **Source of funding** United States Agency for International Development		hypochondrial pain, feeling faint, convulsions (in the first few days after birth). ○ Signs and symptoms of infection: fever, shivering, abdominal pain and/or offensive vaginal loss. ○ Signs and symptoms of thromboembolism: unilateral calf pain, redness or swelling of calves, shortness of breath or chest pain. • Women should be counselled on nutrition. • Women should be counselled on hygiene, especially handwashing. • Women should be counselled on birth spacing and family planning. Contraceptive options should be discussed, and contraceptive methods should be provided if requested. • Women should be counselled on safer sex including use of condoms. **Recommendations relating to the assessment and care of the baby** • The following signs should be assessed during each postnatal care contact and the newborn should be referred for further	documented for each recommendation. A link between the evidence and recommendations is provided. It is unclear if the guideline was formally reviewed prior to publication although some observers provided comments. The process for updating the guideline is described but lacks some detail. **Clarity of presentation (94%)** Recommendations are clear and specific. Some different options are provided and recommendations are grouped under relevant subheadings. **Applicability (75%)** There is some discussion of the applicability of the guideline in terms of facilitators/barriers and a clear discussion of resource implications. There is a clear discussion of the process for implementing guidelines. The guideline reports that monitoring will be built into implementation, but not what criteria will be used. **Editorial independence (58%)** The guideline does not include a statement about the role of the funding body. There is some, limited discussion of competing interests of committee members and that these did not preclude participation.

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
		evaluation if any of the signs is present: ○ stopped feeding well, history of convulsions, fast breathing (breathing rate ≥60 per minute), severe chest in-drawing, no spontaneous movement, fever (temperature ≥37.5 °C), low body temperature (temperature <35.5 °C), any jaundice in first 24 hours of life, or yellow palms and soles at any age. • The family should be encouraged to seek health care early if they identify any of the above danger signs in-between postnatal care visits. • Appropriate clothing of the baby for ambient temperature is recommended. This means one to two layers of clothes more than adults, and use of hats/caps. • The mother and baby should not be separated and should stay in the same room 24hours a day. • Communication and play with the newborn should be encouraged. • Breastfeeding progress should be assessed at each postnatal contact.	

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
		Recommendations relating to the assessment and care of the mother (physical) • All postpartum women should have regular assessment of vaginal bleeding, uterine contraction, fundal height, temperature and heart rate (pulse) routinely during the first 24 hours starting from the first hour after birth. • Blood pressure should be measured shortly after birth. If normal, the second blood pressure measurement should be taken within six hours. • Urine void should be documented within six hours. • At each subsequent postnatal contact, enquiries should continue to be made about general well-being and assessments made regarding the following: micturition and urinary incontinence, bowel function, healing of any perineal wound, headache, fatigue, back pain, perineal pain and perineal hygiene, breast pain, uterine tenderness and lochia. • All women should be asked about resumption of sexual intercourse and possible dyspareunia as part of an	

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
		assessment of overall well-being two to six weeks after birth. • All women should be encouraged to mobilize as soon as appropriate following the birth. They should be encouraged to take gentle exercise and make time to rest during the postnatal period. **Recommendations relating to the assessment and care of the mother (mental health/emotional well-being)** • At 10–14 days after birth, all women should be asked about resolution of mild, transitory postpartum depression ("maternal blues"). If symptoms have not resolved, the woman's psychological well-being should continue to be assessed for postnatal depression, and if symptoms persist, evaluated. • Psychosocial support by a trained person is recommended for the prevention of postpartum depression among women at high risk of developing this condition. • Health professionals should provide an opportunity for women to discuss their birth experience during their hospital stay.	

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
		Recommendations relating to the assessment of the support available to the mother and baby from the partner or family • At each postnatal contact, women should be asked about their emotional well-being, what family and social support they have and their usual coping strategies for dealing with day-to-day matters. All women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern. **Recommendations relating to assessing the risk of domestic violence** • Women should be observed for any risks, signs and symptoms of domestic abuse.	
Full citation Wilkinson J, Bass C, Diem S, Gravley A, Harvey L, Hayes R, Johnson K, Maciosek M, McKeon K, Milteer L, et al., Institute for Clinical Systems Improvement , Preventive Services for Children and Adolescents, 2012 **Ref Id** 922048	Children/adolescents under age 18 who are average risk and do not have any symptoms of illness	**Recommendations relating to the provision of advice and information for parents or immediate family member** • Clinicians must recommend immunizations for infants, children and adolescents for age-appropriate vaccines (strong rec) • Promotion and support of breastfeeding should be	**Scope and purpose (100%)** The overall objective, health questions and population of the guideline are clearly described. **Stakeholder involvement (61%)** The specialities, institutions and roles of committee members are clearly described. It is unclear whether there was any patient involvement. Definition of target audience is

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
Country/ies where the study was carried out US **Study type** Clinical guideline **Aim of the study** To increase the rate of paediatric patients that are up-to-date with level I preventative services (defined as neonatal screening, childhood immunisations and chlamydia screening) **Study dates** Not reported **Source of funding** The Institute for Clinical Systems Improvement (non-profit organisation)		recommended (strong rec, low quality evidence) • Clinicians should routinely present unbiased information to parents and families regarding the potential risks and benefits of circumcision, in a process of shared decision-making. While not uniformly recommended, there is evidence that the benefits of infant male circumcision are sufficient to justify health care access and third-party payment to all families desiring the procedure for their infant. Often, the decision to have an infant circumcised goes beyond strictly medical considerations, and often reflects religious, cultural or other beliefs, values and preferences (strong rec, mixed evidence).	a bit vague and appears to be generic to all ICSI guidance. **Rigour of development (58%)** A search was conducted in collaboration with a medical librarian but no further detail is provided. No information is provided about methods of selecting evidence. GRADE was used to assess the quality of evidence and the overall quality of evidence is provided; however, GRADE profiles are not presented and there is limited discussion of strengths and limitations. Some limited information is provided about the process of developing recommendations. The guideline states that the benefits and harms of recommendations was discussed when developing recommendations and there is some discussion of this throughout. There is an explicit link between evidence and recommendations. The guideline was reviewed prior to publication but there is no information about the process for updating the guideline. **Clarity of presentation (50%)** Most of the recommendations are specific and clear but some are not very concise or do not include a clear action. There is minimal discussion of different options and recommendations are dispersed throughout the document which does not make them easy to identify.

Study details	Population	Recommendations	Notes on quality assessment using AGREE II
			Applicability (54%) Barriers/facilitators to implementation are not clearly discussed/presented. Advice for implementing the guideline is clearly reported. There is some discussion of the cost-effectiveness of interventions but minimal discussion of resource impact. Criteria for monitoring/auditing is not clearly presented. **Editorial independence (100%)** The guideline states that the recommendations were based on the committee's independent evaluation of the evidence and that the ICSI does not have control over the content. The process for dealing with conflicts of interests is clearly described and the relevant interests of all members are reported.

ACOG: American College of Obstetricians & Gynecologists; AGREE: Appraisal of Guidelines for Research and Evaluation; CEU: clinical effectiveness unit; CHC: combined hormonal contraception; COPE: Centre of Perinatal Excellence; EPDS: Edinburgh Postnatal Depression Scale; FSRH: Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists; GRADE: Grading of Recommendations Assessment, Development and Evaluation; GTD: gestational trophoblastic disease; ICSI: Institute for Clinical Systems Improvement; IMP: implant; IPI: interpregnancy interval; LAM: lactational amenorrhea method; LARC: long-acting reversible contraception; LMG-IUS: levonorgestrel-releasing intrauterine system; MH: mental health; NHS: National Health Service; NICE: National Institute for Health and Care Excellence; POI: progestogen-only implant; POP: progestogen-only pill; PPH: postpartum haemorrhage; SGA: small for gestational age; UNICEF: United Nations Children's Fund; WHO: World Health Organization

1 **Table 5: Clinical evidence tables – systematic reviews**

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Full citation Shaw, E., Levitt, C., Wong, S., Kaczorowski, J., Systematic review of the literature on postpartum care: Effectiveness of postpartum support to improve maternal parenting, mental health, quality of life, and physical health, Birth, 33, 210-220, 2006 **Ref Id** 687351 **Country/ies where the study was carried out** Australia, Canada, Ireland, UK, US **Study type** Systematic review of RCTs	**Sample size** N=22 studies included (Of interest for this review: n=6 studies primiparous women; n=2 studies with women at high risk for family dysfunction, abuse or postpartum depression; n=2 studies with unmarried, primiparous teenagers) N=14,436 women included (Of interest for this review: n=3,720) n=12,171 women with follow-up available (Of interest for this review: n=3,091) **Characteristics** <u>Primiparous women:</u> All studies enrolled primiparous women and the majority of studies (n=5) only enrolled women with uncomplicated pregnancies (this was not reported for the remaining study). The	Studies were eligible if they include postpartum support interventions, defined as an interpersonal interaction between women postpartum and a trained individual or healthcare professional. No further information is reported about restrictions on the format, intensity or duration of support interventions and no details are reported for eligible comparisons.	**Interventions:** Home visits were the intervention in 4 of the studies of interest (n=2 primiparous, n=1 high risk, n=1 unmarried, primiparous teenagers); these ranged from 2 visits (the timing of which were not reported) to monthly visits for 1 year. These interventions were delivered by nurses (n=3) and trained mothers (n=1). Limited information is reported about the content of the visits. Two of the studies (n=1 primiparous, n=1 high risk) used telephone support as an intervention. For 1 of these studies, there were two groups, the first of which received a phone call from a public health nurse to assess and advise on mother and infant health (timing of which not reported) and the second of which received a reminder about a parent-baby group from a health department clerk. Telephone support in the other study was delivered by trained mothers with a history of postnatal depression (no further information reported). Two studies (n=1 primiparous,	**Key findings** <u>Primiparous women</u> • "In primiparous women, no improved parenting outcomes resulted from a public health nurse telephone call made at 1 to 2 weeks post discharge, home visits by a public health nurse, or a single midwifery home visit (10,24,27) compared with controls." (page 217) • "In contrast, in low-income primiparous women in North Carolina, United States, frequent educational visits to a pediatrician (at weeks 2, 4, 8, 15, 21, and 27) showed statistically significant improvements in maternal parenting skills (interaction, cooperation, appropriateness of	Methodological quality was assessed using the ROBIS tool: **Study eligibility criteria - High concern** Did the review adhere to pre-defined objectives and eligibility criteria? Unclear - Eligibility criteria lacks detail Were the eligibility criteria appropriate for the review question? Unclear - Eligibility criteria lacks detail Were eligibility criteria unambiguous? No - No information is reported about restrictions on the format, intensity or duration of support interventions or eligible comparisons Were all restrictions in eligibility criteria based on study characteristics appropriate? Unclear - Eligibility criteria lacks detail Were any restrictions in eligibility criteria based on sources of information appropriate? No - Grey literature and non-English language papers were excluded (Taken from Levitt 2004)

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Aim of the study To determine the effectiveness of postpartum support programs for improving maternal knowledge, attitudes, parenting skills, maternal physical and mental health, and quality of life. **Study dates** Articles published up to end of 2004 (search updated in 2005 but date is not specified) **Source of funding** Bureau of Reproductive and Child Health, Health Canada, Ottawa, Canada	age range for included women was only reported for one study (>16 years old). Three of the studies recruited women from the community, 3 from hospitals and 1 from primary care clinics. Two studies only included women living in deprived areas/with a low family income. <u>Women at high risk for family dysfunction, abuse or postpartum depression:</u> 1 study enrolled women with live births, in the community, at risk for family dysfunction or child abuse (no further information reported); 1 study enrolled new mothers over 18 years old, in the community, with single births and risk of postpartum depression. The age range of included women was not reported for either study.		n=1 unmarried, primiparous teenagers) delivered an educational intervention; this was a one off session from a nurse-midwife on day 3 or 4 after birth in one study and a multidisciplinary intervention from a social worker, nurse practitioner and paediatrician in the other study (duration and timing of which were not reported). Limited information is reported about the content of the educational interventions. The intervention for one study (primiparous women) was enhanced paediatrician visits, which discussed mother-infant interactions and infant cognitive development, over a 6 month period. The final study (primiparous women) comprised 3 groups, 1 received a self-help manual 2 weeks after birth, 1 received an invitation to a support group and another group received both the manual and the invitation. **Control:** All of the studies of home visits compared them against standard care, although the definition of	play, and sensitivity) (23)." (page 217) • "The only other trial that used maternal physical health as an outcome in Dublin, Ireland, provided trained community support worker visits to primiparous postpartum women. They reported improvements in fatigue, ‘‘feeling miserable,’’ and wanting to stay indoors (14). This study did not use a validated measure of mental health, physical health, or quality of life." (page 218) <u>Women at high risk for family dysfunction, abuse or postpartum depression</u> • "... in women at high risk for family dysfunction and child abuse, 6 weekly nurse home	**Identification and selection of studies - High concern** Did the search include an appropriate range of databases/electronic sources for published and unpublished reports? No - Authors did not include sources for unpublished data Were methods additional to database searching used to identify relevant reports? Yes Were the terms and structure of the search strategy likely to retrieve as many eligible studies as possible? Yes Were restrictions based on date, publication format, or language appropriate? No - Grey literature and non-English language papers were excluded (Taken from Levitt 2004) Were efforts made to minimise errors in selection of studies? Probably No - Full texts from the 1999 literature search were independently assessed by two authors but it is unclear if this was done following updates to the search. Abstracts do not appear to have been assessed by two reviewers (Taken from Levitt 2004)

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
	Unmarried, primiparous teenagers: 1 study enrolled African-American women ≤17 years old, in hospital, who were unwed, on Medicaid and had uncomplicated first pregnancies; 1 study enrolled primiparous women <18 years old, from a teenage pregnancy clinic, with no known fetal anomalies. **Inclusion criteria** The wider literature search included RCTs examining therapeutic or preventative interventions initiated during the first year after birth; full-text published in English; study conducted in Canada, the USA, Europe, Australia or New Zealand. (Taken from Levitt 2004) The current review included postpartum support interventions. Studies must have		standard care included 1 home visit, 1 clinic visit, a screening phone call, or no home visit (with no further information reported). Telephone support was compared against standard care, described as standard community care or information package. The multidisciplinary educational intervention was compared against standard 'well baby' care (details of which not reported) and the other educational intervention was compared against written instructions only. The enhanced paediatrician visits were compared against the same schedule of visits without the enhanced discussions (standard care). The final study (self-help manual and support group) was compared against standard care (no further information reported).	visits and case conferencing by a pediatrician and social worker did produce a statistically significant improvement in both home environment quality using the HOME inventory (Home Observation for Measurement of the Environment), which assesses quality of maternal interaction skills), and parenting stress using the self-reported Parenting Stress Index (8)." (page 217) • "In the first study, women in Queensland, Australia, who were identified as being at risk for family dysfunction or abuse, received nurse home visits weekly for 6 weeks, in addition to case conferencing with a	**Data collection and study appraisal - High concern** Were efforts made to minimise error in data collection? Unclear - Structured data extraction forms were used and reviewers received training on how to complete these. The authors note that the teams met to discuss data extraction and achieve consensus but it is not clear that detailed checking of extracted data occurred. (Taken from Levitt 2004) Were sufficient study characteristics available for both review authors and readers to be able to interpret the results? No - Limited information is reported about characteristics of women included in studies (particularly age range) and content of interventions Were all relevant study results collected for use in the synthesis? Probably Yes - Studies were combined narratively, so results were not required in a specific format. However, it is unclear whether any outcomes were sufficiently reported in included studies. Was risk of bias (or methodological quality)

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
	reported at least one of the following outcomes: maternal knowledge, attitudes and skills related to parenting, maternal mental health, maternal quality of life, or maternal physical health. **Exclusion criteria** The wider literature search excluded studies of lactation suppression, endometritis, hypertensive disorders, postoperative analgesia after caesarean section, antenatal or intrapartum interventions. (Taken from Levitt 2004) The current review excluded studies that only reported utilisation of health services.			pediatrician and social worker (8). A statistically significant reduction in women with an Edinburgh Postnatal Depression Scale score greater than 12 was seen in primiparous patients only... (page 218) • "In the second study, in Vancouver, Canada, peer support was provided to women identified as being at high risk for postpartum depression (9). Fewer women in the intervention group had Edinburgh Postnatal Depression Scale scores greater than 12 at 8 weeks..." (page 218) • "Maternal satisfaction was higher in all intervention groups	formally assessed using appropriate criteria? Probably No - Methodological quality was assessed using a published tool (Jadad 1996) but this tool only assesses 3 domains (randomisation, blinding and attrition) Were efforts made to minimise errors in risk or bias assessment? Yes **Synthesis and findings - High concern** Did the syntheses include all studies that it should? Unclear - Risk of selective reporting in primary studies was not assessed Were all predefined analyses followed or departures explained? Unclear - Results are combined narratively but authors do not discuss any methods for synthesis Was the synthesis appropriate given the nature and similarity in the research questions, study designs and outcomes across included studies? Unclear - The authors report that the patient populations, interventions and outcomes identified from the 1999 search were too heterogeneous to meta-analyse. However, it is

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
				that included enhanced home visiting, as were the costs associated with these programs." (page 218) - 4 trials, including one study of women at high risk for family dysfunction **Conclusions** • "Given that only one other randomized controlled trial addressed maternal physical health, no conclusions can be drawn about the impact of postpartum support on this outcome." (page 219) <u>Primiparous women</u> • "It is difficult to evaluate the impact of postpartum support on mental health in primiparous women. They were	unclear if they assessed heterogeneity when the searches were updated and whether they tried to explore reasons for heterogeneity (Taken from Levitt 2004) Was between-studies variation (heterogeneity) minimal or addressed in the synthesis? Yes Were the findings robust, e.g., as demonstrated through funnel plot or sensitivity analyses? Yes Were biases in primary studies minimal or addressed in the synthesis? No - Only 14 out of the 22 included studies scored 3 out of 5 or greater **Overall risk of bias - High risk of bias** Did the interpretation of findings address all of the concerns identified in the phase 2 assessment? No Was the relevance of identified studies to the review's research question appropriately considered? Yes Did the reviewers avoid emphasising results on the basis of their statistical significance? No

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
				only specifically targeted in one trial that reported this outcome, and that showed no impact on Edinburgh Postnatal Depression Scale scores from a single public health telephone call." (page 219) <u>Women at high risk for family dysfunction, abuse or postpartum depression</u> • "In selected women, with previously identified risk factors, postpartum support programs show some promising results. Low-income primiparous women and those at high risk for family dysfunction showed improvements in parenting knowledge, confidence, or infant-child	**Other information** The authors noted that the trials in high risk populations have limited generalizability and did not use very definitive outcomes (only examined parenting knowledge and confidence). They also note that the review is limited as it does not include infant outcomes.

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
				interaction with either nursing visits and case conferencing or frequent educational visits to a paediatrician." (page 218) • "A similar pattern was seen in the studies that examined maternal mental health. When women at high risk for postpartum depression or family dysfunction were targeted for intervention, either nurse visits combined with case conferencing or a less intensive peer support program improved maternal mental health outcomes." (page 219) • "As expected, both maternal satisfaction and costs were higher with home visitation programs. With the exception of the	

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
				one trial involving women at high risk for family dysfunction, this increased satisfaction and costs did not translate into additional improved outcomes." (page 291)	
Full citation Turnbull, C., Osborn, D. A., Home visits during pregnancy and after birth for women with an alcohol or drug problem, Cochrane Database of Systematic Reviews, 1, CD004456, 2012 **Ref Id** 365140 Country/ies where the study was carried out Australia; US **Study type**	**Sample size** N=7 studies included N=950 mother-infant pairs included n=803 mother-infant pairs had sufficient outcome data reported **Characteristics** Definition of substance misuse: 3 studies enrolled women with self-reported drug/alcohol use, 1 study enrolled mothers or babies with positive toxicology results for cocaine and 2 studies enrolled women using illicit drugs based on either self-report or positive toxicology (mother or baby). One study	Studies were eligible if they included home visits (of any duration) that started during pregnancy or the postnatal period from individuals or teams including doctors (obstetricians, GPs, paediatricians), nurses (midwives, drug and alcohol workers, early childhood nurses), social workers, counsellors or trained lay people. Home visits could be compared to a different method of home visits and/or no home visits/standard care.	**Interventions:** Women were enrolled during pregnancy or in the postnatal period. Home visits were conducted by research midwives (n=1), community health nurses (n=1), paediatric nurses (n=1), paraprofessional advocates (n=1), nurse midwives (n=1), trained 'black' specialists with prior experience in drug treatment services (n=1), and African-American lay women (n=1). One study provided 2 antenatal home visits followed by visits in the postnatal period; the remaining studies all started visits in the postnatal period. Home visits lasted up 6 months (n=2), 18 months (n=3) or 3 years (n=1) and visits occurred approximately once (n=3) or twice a month	**Key findings** • "...a short-term, intense intervention by trained counsellors in postpartum women with a drug problem can increase the number of women attending drug and alcohol services. However, the effects of this intervention were not maintained over a longer period of time and longer-term childhood and psychosocial outcomes were not reported." (page 15) - from 1 study of good methodological quality	Methodological quality was assessed using the ROBIS tool: **Study eligibility criteria - Low concern** Did the review adhere to pre-defined objectives and eligibility criteria? Probably Yes Were the eligibility criteria appropriate for the review question? Probably Yes - Including studies where greater than 50% of the women had a substance misuse problem may not be comparable with other studies as the content of home visits may not be tailored to women with substance misuse problems (however, women in this trial were provided with

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
Systematic review of RCTs or quasi-randomised studies **Aim of the study** To examine the impact of home visits during pregnancy and the postnatal period for women with substance misuse problems. **Study dates** Articles published up to 30th November 2011 **Source of funding** No sources of funding reported	enrolled teenagers at antenatal appointments; this study was not limited to teenagers with substance misuse problems but over 50% were using alcohol and or illicit drugs at the start of the pregnancy. Ethnicity: 4 studies enrolled mainly Africa-American women. **Inclusion criteria** Individual or cluster RCT or quasi-randomised studies; compared home visits (that started during pregnancy or after birth) to either no home visits or a different type of home visit; women with alcohol and or drug problems (or where greater than 50% of the women had a substance misuse problem); reported drug and alcohol related outcomes, pregnancy and		(n=3); visits were more frequent (roughly weekly) for the first 4 to 6 weeks for 3 of these studies and for the first 6 months for the study where visits continued up to 3 years. For the remaining study, women received between 1 and 4 visits over an 8 week period. The duration of visits was not reported (n=3), lasted 20 minutes to an hour (n=1), 1 hour (n=1), 1 to 2 hours (n=1) or 1 to 4 hours (n=1). The content of visits included: parent skills training (n=4); developmental interventions using the Hawaii Early Learning Program (n=3); information about and/or facilitating enrolment into substance abuse programs (n=3); general health monitoring, advice and assessment of well-being (n=3); modelling/facilitating mother/infant interactions (n=2); providing information about immunisations (n=2); providing links to community services (n=2); emotional support (n=1) and relaxation and stress management techniques (n=1).	• "... did not demonstrate any health benefits to mother or infant from eight home visits over six months by a midwife." (page 15) - from 1 study of good methodological quality • "...no significant difference in infant death." (page 15) - from 2 studies of good methodological quality • " Effects on longer-term development were inconsistent, with Black 1994 reporting no difference in the Bayley MDI or PDI at 18 months and Schuler 2000 reporting significant improvements in the Bayley PDI for infants receiving intervention. A post hoc subgroup analysis by Schuler 2000 according to	information on drug and alcohol use and services). Were eligibility criteria unambiguous? Yes Were all restrictions in eligibility criteria based on study characteristics appropriate? Yes Were any restrictions in eligibility criteria based on sources of information appropriate? Yes Identification and selection of studies - Unclear concern Did the search include an appropriate range of databases/electronic sources for published and unpublished reports? Yes Were methods additional to database searching used to identify relevant reports? Yes Were the terms and structure of the search strategy likely to retrieve as many eligible studies as possible? Unclear - Search terms did not include postnatal or postpartum Were restrictions based on date, publication format, or language appropriate? Yes Were efforts made to minimise errors in selection of studies? Yes

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
	puerperium outcomes, infant/child outcomes, or psychosocial outcomes. **Exclusion criteria** Studies that did not report risk of drug/alcohol use.		**Control:** For 6 of the 7 studies, the control group did not receive any home visits. In the remaining study, the control group received short monthly visits from a lay person.	pattern of maternal drug use should be treated with caution. In this analysis, Schuler 2000 reported that the greatest effect of home visiting on development was seen in infants of mothers with no ongoing drug use." (page 16 - from 2 studies of poor methodological quality **Conclusions** • "This review failed to find evidence that home visits reduced continuing drug or alcohol use." (page 15) • "Interventions varied, although three trials performed a developmental intervention incorporating the Carolina Preschool Curriculum and Hawaii Early Learning Program. There was no	**Data collection and study appraisal - Low concern** Were efforts made to minimise error in data collection? Yes Were sufficient study characteristics available for both review authors and readers to be able to interpret the results? Yes Were all relevant study results collected for use in the synthesis? Probably Yes - Authors report desired format for dichotomous and continuous data and contacting authors where information was unclear, but do not report if/how they dealt with data that wasn't in the required format Was risk of bias (or methodological quality) formally assessed using appropriate criteria? Yes Were efforts made to minimise errors in risk or bias assessment? Yes **Synthesis and findings - High concern** Did the syntheses include all studies that it should? Unclear - Three of the included studies had unclear risk of selective reporting so not clear

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
				consistent evidence that this developmental intervention had a significant effect on the infants' mental or psychomotor development. Four of the seven trials had substantial losses to follow-up that limit any conclusions from them." (page 16) • "Some benefits to home visits were reported, including increased enrolment in and attendance for drug and alcohol treatment services from an intense program of trained counsellor home visits..." (page 16) • Implications for practice • "Whilst there is promising evidence that a brief intensive intervention by trained counsellors may encourage women to attend	if all results were available to the reviewers. Were all predefined analyses followed or departures explained? No - Authors did not pre-specify subgroup analysis based on visit including a developmental intervention and did not justify including this. Was the synthesis appropriate given the nature and similarity in the research questions, study designs and outcomes across included studies? Yes Was between-studies variation (heterogeneity) minimal or addressed in the synthesis? Yes Were the findings robust, e.g., as demonstrated through funnel plot or sensitivity analyses? Probably No - Authors report that only 2 of the included studies were judged to have 'good methodology'. Although subgroup analysis was conducted looking at the results of just these studies, there was no comparison with studies with poor methodology. Were biases in primary studies minimal or addressed in the synthesis? Yes

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
				drug and alcohol treatment services for a few weeks, there is no clear evidence of longer term or more substantive benefit." (page 18) • "There is insufficient evidence at present to recommend the routine use of home visits, any particular model of home visits or any specific home interventions in women with a drug or alcohol problem." (page 18)	**Overall risk of bias - High risk of bias** Did the interpretation of findings address all of the concerns identified in the phase 2 assessment? No Was the relevance of identified studies to the review's research question appropriately considered? Yes Did the reviewers avoid emphasising results on the basis of their statistical significance? Yes **Other information** Authors note that the conclusions or the review are impacted by methodological issues with many of the included studies, the wide spectrum of interventions included, lack of consistency of findings between studies, lack of reporting of key outcomes (e.g., ongoing risk of drug or alcohol use). Also, only one study included a specific substance use intervention and no studies included home visits from social workers or multidisciplinary teams). Authors also comment that intensity of visits from

Study details	Participants	Interventions	Methods	Outcomes and Results	Comments
					midwives in included studies are lower than those that have previously shown to have a beneficial effect for high risk families. Finally, authors state that the review was substantially underpowered.

GP: general practitioner; HOME: Home Observation for Measurement of the Environment; MDI: Mental Development Index; PDI: Physical Development Index; RCT: randomised controlled trial; ROBIS: risk of bias in systematic reviews

Appendix E – Forest plots

Forest plots for review question: What is the essential content of postnatal care contacts for women and babies?

Forest plots are not appropriate for formal consensus and no meta-analysis was conducted on the basis of the systematic reviews.

Appendix F – AGREE II tables

Appraisal of Guideline Research and Evaluation version 2 (AGREE II) tables for review question: What is the essential content of postnatal care contacts for women and babies?

Table 6: AGREE II quality assessment of included guidelines

		Domains						
Guideline reference	**Year**	**Scope and purpose %**	**Stakeholder involvement %**	**Rigour of development %**	**Clarity of presentation %**	**Applicability %**	**Editorial Independence %**	**Overall rating %**
ACOG 2018 American College of Obstetricians and Gynaecologists, 'Committee Opinion' on optimizing postpartum care, 2018	2018	61	39	17	72	42	67	**50**
Beyond Blue 2011 Beyond Blue, Depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. A guideline for primary care health professionals, 2011	2011	83	94	85	89	67	75	**85**
COPE 2017 Centre of Perinatal Excellence, Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline	2017	100	100	94	100	83	100	**96**

Domains								
Guideline reference	**Year**	**Scope and purpose %**	**Stakeholder involvement %**	**Rigour of development %**	**Clarity of presentation %**	**Applicability %**	**Editorial Independence %**	**Overall rating %**
[online] Available at: https://www.cope.org.au/wp-content/uploads/2018/05/COPE-Perinatal-MH-Guideline_Final-2018.pdf[online [Accessed on 22 July 2019], 2017								
FSRH 2017 Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians & Gynaecologists, CEU Clinical Guidance: Contraception After Pregnancy, 2017	2017	100	72	83	100	67	58	**84**
Fleming 2015 Fleming, N., O'Driscoll, T., Becker, G., Spitzer, R. F., Allen, L., Millar, D., Brain, P., Dalziel, N., Dubuc, E., Hakim, J., Murphy, D., Spitzer, R., Adolescent Pregnancy Guidelines, Journal of obstetrics and gynaecology Canada, 37, 740-759, 2015	2015	89	56	50	72	21	33	**59**
NICE 2006	2006	100	100	81	89	67	58	**85**

		Domains						
Guideline reference	**Year**	**Scope and purpose %**	**Stakeholder involvement %**	**Rigour of development %**	**Clarity of presentation %**	**Applicability %**	**Editorial Independence %**	**Overall rating %**
National Institute for Health and Clinical Excellence, Postnatal Care: Routine Postnatal Care of Women and their Babies (CG37), 2006								
National Maternity Review 2016 National Maternity Review, Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care, 2016	2016	72	78	19	67	75	33	**58**
SIGN 2012 Scottish Intercollegiate Guidelines Network, Management of Perinatal Mood Disorder, 2012	2012	78	83	67	78	58	50	**73**
UNICEF 2012 UNICEF, Baby Friendly Standards, London, UK	2012	56	28	35	56	67	50	**54**
Wilkinson 2012 Wilkinson J, Bass C, Diem S, Gravley A, Harvey L, Hayes R, Johnson K, Maciosek M, McKeon K, Milteer L, et al., Institute for	2012	100	61	58	50	54	100	**70**

		Domains						
Guideline reference	**Year**	**Scope and purpose %**	**Stakeholder involvement %**	**Rigour of development %**	**Clarity of presentation %**	**Applicability %**	**Editorial Independence %**	**Overall rating %**
Clinical Systems Improvement, Preventive Services for Children and Adolescents, 2012								
WHO 2013 World Health Organization, WHO recommendations on postnatal care of the mother and newborn, 2013	2013	100	61	83	94	75	58	**83**

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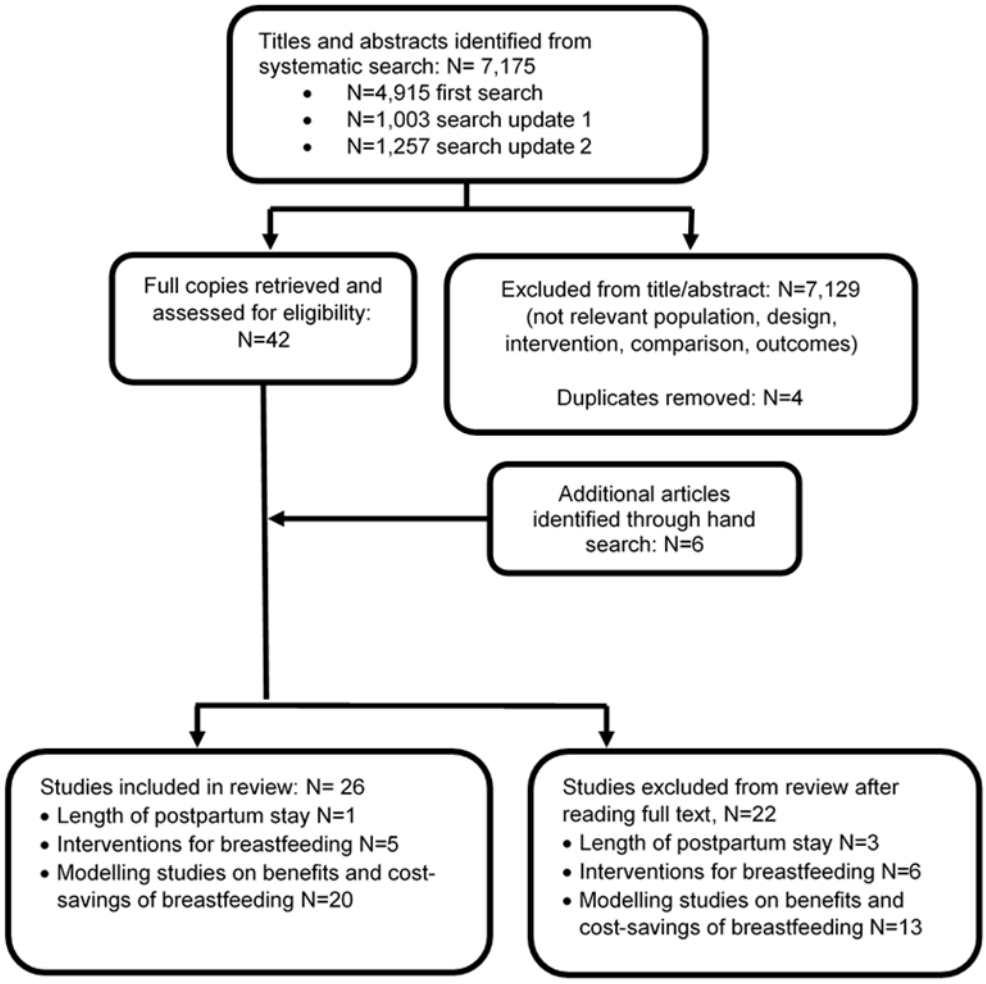
Appendix G – Economic evidence study selection

Economic evidence study selection for review question: What is the essential content of postnatal care contacts for women and babies?

A global health economics search was undertaken for all areas covered in the guideline. Figure 3 shows the flow diagram of the selection process for economic evaluations of postnatal care interventions, including modelling studies on the benefits and cost-savings of breastfeeding.

Figure 3. Flow diagram of selection process for economic evaluations of postnatal care interventions and modelling studies on the benefits and cost-savings of breastfeeding



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Appendix H – Economic evidence tables

Economic evidence tables for review question: What is the essential content of postnatal care contacts for women and babies?

No economic evidence was identified which was applicable to this review question.

Appendix I – Economic evidence profiles

Economic evidence profiles for review question: What is the essential content of postnatal care contacts for women and babies?

No economic evidence was identified which was applicable to this review question.

Appendix J – Economic analysis

Economic analysis for review question: What is the essential content of postnatal care contacts for women and babies?

No economic analysis was conducted for this review question.

Appendix K – Excluded studies

Excluded clinical and economic studies for review question: What is the essential content of postnatal care contacts for women and babies?

Clinical studies

Table 7: Excluded studies and reasons for their exclusion – guidelines

Study	Reason for exclusion
American College of, Obstetricians, Gynecologists Committee on Health Care for Undeserved, Women, ACOG Committee Opinion No. 343: psychosocial risk factors: perinatal screening and intervention, Obstetrics & Gynecology, 108, 469-77, 2006	Updated by ACOG 2018 guidance.
American College of, Obstetricians, Gynecologists' Committee on Obstetric, Practice, Association of Women's Health, Obstetric, Neonatal, Nurses, Committee Opinion No. 666: Optimizing Postpartum Care, Obstetrics & GynecologyObstet Gynecol, 127, e187-92, 2016	Updated by ACOG 2018 guidance.
American College of, Obstetricians, Gynecologists,, ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists Number 76, October 2006: postpartum hemorrhage, Obstetrics & GynecologyObstet Gynecol, 108, 1039-47, 2006	None of the recommendations are for routine care.
Anonymous,, Guidelines for Professional Registered Nurse Staffing for Perinatal Units Executive Summary, JOGNN - Journal of Obstetric, Gynecologic, and Neonatal Nursing, 40, 131-134, 2011	Recommendations refer to staffing and not content of PNC contacts.
Aquino, M. R., Olander, E. K., Needle, J. J., Bryar, R. M., Midwives' and health visitors' collaborative relationships: A systematic review of qualitative and quantitative studies, International Journal of Nursing StudiesInt J Nurs Stud, 62, 193-206, 2016	Systematic review (not guideline) - no recommendations provided.
Ashmore, S., NICE's new postnatal guidelines recommend the implementation of UNICEF's Baby Friendly Initiative, The practising midwife, 9, 37, 2006	Not a guideline. Description of the NICE PNC guideline in relation to the BFI.
Austin, M. P., Middleton, P., Reilly, N., Highet, N., Detection and management of perinatal mood disorders in the primary health care context: The australian beyondblue clinical practice guidelines for depression and related disorders (Anxiety, Bipolar Disorder and Puerperal Psychosis), Journal of Paediatrics and Child Health, 1), 5, 2011	Conference abstract.
Beake,S., Bick,D., Weavers,A., Revising care to meet maternal needs post birth: an overview of	No recommendations provided.

Study	Reason for exclusion
the hospital to home postnatal study, Practising Midwife, 15, 10-13, 2012	
Berry, S. A., Laam, L. A., Wary, A. A., Mateer, H. O., Cassagnol, H. P., McKinley, K. E., Nolan, R. A., ProvenCare perinatal: a model for delivering evidence/ guideline-based care for perinatal populations, Joint Commission journal on quality and patient safety / Joint Commission Resources, 37, 229-239, 2011	No recommendations provided.
Cook, E., Avery, M., Frisvold, M., Formulating evidence-based guidelines for certified nurse-midwives and certified midwives attending home births, Journal of Midwifery and Women's Health, 59, 153-159, 2014	No recommendations provided.
Delaney, M., Roggensack, A., No. 214-Guidelines for the Management of Pregnancy at 41+0 to 42+0 Weeks, Journal of Obstetrics and Gynaecology Canada, 39, e164-e174, 2017	No relevant recommendations provided - all recommendations relate to antenatal care.
Golubnitschaja, O., Costigliola, V., Common origin but individual outcomes: Time for new guidelines in personalized healthcare, Personalized Medicine, 7, 561-568, 2010	No recommendations provided.
Haran, C., van Driel, M., Mitchell, B. L., Brodribb, W. E., Clinical guidelines for postpartum women and infants in primary care-a systematic review, BMC Pregnancy & Childbirth, 14, 51, 2014	Not a guideline (systematic review).
Hilton, I., Application of the perinatal oral health guidelines in clinical practice, Journal of the California Dental Association, 38, 673-679, 2010	No recommendations provided.
Kominiarek, M. A., Chauhan, S. P., Obesity Before, During, and After Pregnancy: A Review and Comparison of Five National Guidelines, American Journal of PerinatologyAm J Perinatol, 33, 433-41, 2016	No recommendations provided.
Logsdon, M. C., Koniak-Griffin, D., Social support in postpartum adolescents: Guidelines for nursing assessments and interventions, JOGNN - Journal of Obstetric, Gynecologic, and Neonatal Nursing, 34, 761-768, 2005	No recommendations provided.
McQueen, K., Dennis, C. L., Development of a postpartum depression best practice guideline: A review of the systematic process, Journal of Nursing Care Quality, 22, 199-204, 2007	Review of the process behind the development of the guideline.
Neiman, S., Carter, S., Van Sell, S., Kindred, C., Best practice guidelines for the nurse practitioner regarding screening, prevention, and management of postpartum depression, Critical Care Nursing Quarterly, 33, 212-8, 2010	Recommendations only relate to identification of postpartum depression.
NICE, Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. Clinical guideline [CG110], 2010	Recommendations relate to pregnancy only.

Study	Reason for exclusion
Royal Australian College of General Practitioners, Royal Australian College of General Practitioners, Guidelines for Preventive Activities in General Practice, 2012	No relevant recommendations.
Royal Berkshire NHS Foundation Trust, Postnatal Care Guideline (GL890) , 2015	This guideline is based on other mainly national guidance on postnatal care. It has not been produced on the basis of a systematic review of evidence or guidance.
Royal College of Midwives, Postnatal care planning, 2014	Recommendations based on survey results and relating mainly to staffing, planning and continuity of care.
Venkateswaran, M., Morkrid, K., Fjeldheim, I., Ghanem, B., Salman, R., Frederik Froen, J., The effectiveness of interactive checklists within an individual case-based eRegistry for maternal and child health: A cluster randomized trial protocol, Tropical Medicine and International Health, 1), 430-431, 2015	Conference abstract.
Wilson, I. E., Kaushik, N., Frank, T. L., Improving documentation and clinical practice in the 6-8 week baby check in uk general practices, Archives of Disease in Childhood, 3), A177, 2015	Conference abstract.

Table 8: Excluded studies and reasons for their exclusion – systematic reviews

Study	Reason for exclusion
Alderdice,F., McNeill,J., Lynn,F., A systematic review of systematic reviews of interventions to improve maternal mental health and well-being, Midwifery, 29, 389-399, 2013	Sufficient evidence available from guidelines - Assessment and care of mother (mental health).
Almeida, L. M., Caldas, J., Ayres-de-Campos, D., Salcedo-Barrientos, D., Dias, S., Maternal healthcare in migrants: a systematic review, Maternal & Child Health Journal, 17, 1346-54, 2013	Review includes multiple study designs (not limited to RCTs and/or qualitative studies).
Aquino, M. R., Olander, E. K., Needle, J. J., Bryar, R. M., Midwives' and health visitors' collaborative relationships: A systematic review of qualitative and quantitative studies, International Journal of Nursing StudiesInt J Nurs Stud, 62, 193-206, 2016	Outside scope of question: methods for, and effectiveness of, collaboration between midwives and health visitors.
Austin, M. P., Universal psychosocial assessment and depression screening in the perinatal period-the debate continues, Archives of Women's Mental Health, 18 (2), 309, 2015	Conference abstract.
Bard, E., Knight, M., Plugge, E., Perinatal health care services for imprisoned pregnant women and associated outcomes: A systematic review, BMC Pregnancy and Childbirth, 16 (1) (no pagination), 2016	Review includes multiple study designs (not limited to RCTs and/or qualitative studies).
Barlow, J., Bennett, C., Midgley, N., Larkin, S. K., Wei, Y., Parentâ€• infant psychotherapy for	Population (not the postnatal period).

Study	Reason for exclusion
improving parental and infant mental health, Cochrane Database of Systematic Reviews, 2015	
Bastos, M. H., Furuta, M., Small, R., McKenzieâ€• McHarg, K., Bick, D., Debriefing interventions for the prevention of psychological trauma in women following childbirth, Cochrane Database of Systematic Reviews, 2015	Sufficient evidence available from guidelines - Assessment and care of mother (mental health).
Bayes, S., Ewens, B., Registered nurses' experiences of caring for pregnant and postpartum women in general hospital settings: a systematic review and meta-synthesis of qualitative data, Journal of Clinical Nursing, 26, 599-608, 2017	Outside scope of question: nurses experience of providing care to pregnant or postpartum women in non-maternity settings (i.e., not related to routine postnatal care).
Bennett, C., Macdonald, G., Dennis, J. A., Coren, E., Patterson, J., Astin, M., Abbott, J., Homeâ€• based support for disadvantaged adult mothers, Cochrane Database of Systematic Reviews, 2008	Withdrawn from publication.
Boath, E., Bradley, E., Henshaw, C., The prevention of postnatal depression: A narrative systematic review, Journal of Psychosomatic Obstetrics and Gynecology, 26, 185-192, 2005	Sufficient evidence available from guidelines - Assessment and care of mother (mental health).
Bonfill, X., Roque, M., Aller, M. B., Osorio, D., Foradada, C., Vives, A., Rigau, D., Development of quality of care indicators from systematic reviews: the case of hospital delivery, Implementation science : IS, 8, 42, 2013	Outside scope of question: Primarily related to antenatal care and care during delivery; only one of the care indicators is related to postnatal care.
Brodribb, W. E., Zakarija-Grkovic, I., Hawley, G., Mitchell, B., Mathews, A., Postpartum health professional contact for improving maternal and infant health outcomes for healthy women and their infants, Cochrane Database of Systematic Reviews, 2013 (12) (no pagination), 2013	Protocol for review (updated protocol, Kellie 2017, withdrawn from publication).
Bryanton, J., Beck, C. T., Montelpare, W., Postnatal parental education for optimizing infant general health and parentâ€• infant relationships, Cochrane Database of Systematic Reviews, 2013	Sufficient evidence available from guidelines - Provision of advice and information.
Byatt, N., Levin, L. L., Ziedonis, D., Simas, T. A. M., Allison, J., Enhancing participation in depression care in outpatient perinatal care settings a systematic review, Obstetrics and Gynecology, 126, 1048-1058, 2015	Review includes multiple study designs (not limited to RCTs and/or qualitative studies.
Camacho, E. M., Shields, G. E., Cost-effectiveness of interventions for perinatal anxiety and/or depression: A systematic review, BMJ Open, 8 (8) (no pagination), 2018	Sufficient evidence available from guidelines - Assessment and care of mother (mental health).
Campos, S., Kapp, J. M., Simoes, E. J., The Evidence Base for the Maternal, Infant, and Early Childhood Home Visiting Program Constructs, Public Health Reports., 2018	Sufficient evidence available from guidelines - Assessment and care of mother and baby.

Study	Reason for exclusion
Dennis, C. L., Fung, K., Grigoriadis, S., Robinson, G. E., Romans, S., Ross, L., Traditional postpartum practices and rituals: A qualitative systematic review, Women's Health, 3, 487-502, 2007	Outside scope of question - Cross-cultural review of postpartum traditions.
Dixon, S., Dantas, J. A., Best practice for community-based management of postnatal depression in developing countries: A systematic review, Health care for women international, 38, 118-143, 2017	Population outside scope of question - Low and middle income countries.
Fleming, N., O'Driscoll, T., Becker, G., Spitzer, R. F., Allen, L., Millar, D., Brain, P., Dalziel, N., Dubuc, E., Hakim, J., Murphy, D., Spitzer, R., Adolescent Pregnancy Guidelines, Journal of obstetrics and gynaecology Canada : JOGC = Journal d'obstetrique et gynecologie du Canada : JOGC, 37, 740-759, 2015	Included in search for guidelines.
Ford, E., Shakespeare, J., Elias, F., Ayers, S., Recognition and management of perinatal depression and anxiety by general practitioners: A systematic review, Family Practice, 34, 11-19, 2017	Sufficient evidence available from guidelines - Assessment and care of mother (mental health).
Fox, D. M., Systematic reviews and health policy: The influence of a project on perinatal care since 1988, Milbank Quarterly, 89, 425-449, 2011	Outside scope of question - Discussion of the impact of systematic reviews on health policies.
Gogia, S., Ramji, S., Gupta, P., Gera, T., Shah, D., Mathew, J. L., Mohan, P., Panda, R., Community based newborn care: A systematic review and meta-analysis of evidence: UNICEF-PHFI series on newborn and child health, India, Indian Pediatrics, 48, 537-546, 2011	Population outside scope of question - Primarily low and middle income countries.
Guterman, N. B., Bellamy, J. L., Banman, A., Promoting father involvement in early home visiting services for vulnerable families: Findings from a pilot study of "Dads matter", Child Abuse and Neglect, 76, 261-272, 2018	Study design outside scope of question - Pilot study of home visiting intervention for fathers.
Haran, C., van Driel, M., Mitchell, B. L., Brodribb, W. E., Clinical guidelines for postpartum women and infants in primary care-a systematic review, BMC Pregnancy & Childbirth, 14, 51, 2014	Included in search for guidelines.
Helsloot, K., Walraevens, M., Besauw, S. V., Van Parys, A. S., Devos, H., Holsbeeck, A. V., Roelens, K., A systematic approach towards the development of quality indicators for postnatal care after discharge in Flanders, Belgium, Midwifery, 48, 60-68, 2017	Review includes multiple study designs (not limited to RCTs and/or qualitative studies).
Howard-Grabman, L., Miltenburg, A. S., Marston, C., Portela, A., Factors affecting effective community participation in maternal and newborn health programme planning, implementation and quality of care interventions,	Population outside scope of question - Low and middle income countries.

Study	Reason for exclusion
BMC Pregnancy ChildbirthBMC pregnancy and childbirth, 17, 2017	
Jahanfar, S., Howard, L. M., Medley, N., Interventions for preventing or reducing domestic violence against pregnant women, Cochrane Database of Systematic Reviews, 2014 (11) (no pagination), 2014	Condition/ issue (not the content of postnatal care).
Jennings, M. C., Pradhan, S., Schleiff, M., Sacks, E., Freeman, P. A., Gupta, S., Rassekh, B. M., Perry, H. B., Comprehensive review of the evidence regarding the effectiveness of community-based primary health care in improving maternal, neonatal and child health: 2. maternal health findings, Journal of global health, 7, 010902, 2017	Review includes multiple study designs (not limited to RCTs and/or qualitative studies).
Kapustin,J.F., Postpartum management for gestational diabetes mellitus: Policy and practice implications, Journal of the American Academy of Nurse Practitioners, 20, 547-554, 2008	Sufficient evidence available from guidelines - Assessment and care of mother (physical health).
Kellie, F. J., Postpartum health professional contact for improving maternal and infant health outcomes for healthy women and their infants, Cochrane Database of Systematic Reviews, 2017 (6) (no pagination), 2017	Withdrawn from publication (protocol for review).
Lara-Cinisomo, S., Girdler, S. S., Grewen, K., Meltzer-Brody, S., A Biopsychosocial Conceptual Framework of Postpartum Depression Risk in Immigrant and U.S.-born Latina Mothers in the United States, Women's Health Issues, 26, 336-343, 2016	Review includes multiple study designs (not limited to RCTs and/or qualitative studies).
Lassi, Z. S., Das, J. K., Salam, R. A., Bhutta, Z. A., Evidence from community level inputs to improve quality of care for maternal and newborn health: interventions and findings, Reproductive Health, 11, 2014	Systematic review of reviews - Included reviews include multiple study designs (not limited to RCTs and/or qualitative studies).
Lavender, T. J., Ebert, L., Jones, D., An evaluation of perinatal mental health interventions: An integrative literature review, Women and Birth, 29, 399-406, 2016	Sufficient evidence available from guidelines - Assessment and care of mother (mental health).
Lavender, T., Richens, Y., Milan, S. J., Smyth, R. M. D., Dowswell, T., Telephone support for women during pregnancy and the first six weeks postpartum, Cochrane Database of Systematic Reviews, 2013 (7) (no pagination), 2013	Outside scope of the question - Interventions either did not cover routine postnatal care or there is sufficient evidence from guidelines (Provision of advice and information; assessment and care of mother (mental health)).
Lima, I. C. V., Santos, V. F., Alexandre, H. O., Pedrosa, N. L., Farias, O. D. O., Galvao, M. T. G., Scientific production of nursing care about the child born exposed to HIV, Sexually Transmitted Infections, 2), A239, 2015	Conference abstract.
Magann,E.F., McKelvey,S.S., Hitt,W.C., Smith,M.V., Azam,G.A., Lowery,C.L., The use of telemedicine in obstetrics: A review of the	Review includes multiple study designs (not limited to RCTs and/or qualitative studies); also, only 2 studies were conducted in postnatal period.

Study	Reason for exclusion
literature, Obstetrical and Gynecological Survey, 66, 170-178, 2011	
Magee, L., von Dadelszen, P., Prevention and treatment of postpartum hypertension, Cochrane Database of Systematic Reviews, CD004351, 2013	Sufficient evidence available from guidelines - Assessment and care of mother (physical health).
Marsh, W., Colbourne, D. M., Way, S., Hundley, V. A., Would a student midwife run postnatal clinic make a valuable addition to midwifery education in the UK?--a systematic review, Nurse Education Today, 35, 480-6, 2015	Review only includes non-comparative studies.
Martinez Lopez, J. A., Garcia Vivar, M. L., Caliz, R., Freire, M., Galindo, M., Hernandez, M. V., Lopez Longo, F. J., Martinez Taboada, V., Pego Reigosa, J. M., Rubio, E., Trujillo, E., Vela-Casasempere, P., Recommendations for the evaluation and management of patients with rheumatic autoimmune and inflammatory diseases during the reproductive age, pregnancy, postpartum and breastfeeding, Reumatologia Clinica, 13, 264-281, 2017	Outside scope of guideline - Management of pre-existing condition; not routine postnatal care.
McFadden, A., Gavine, A., Renfrew, M. J., Wade, A., Buchanan, P., Taylor, J. L., Veitch, E., Rennie, A. M., Crowther, S. A., Neiman, S., et al.,, Support for healthy breastfeeding mothers with healthy term babies, Cochrane Database of Systematic Reviews, 2017	Sufficient evidence available from guidelines - Assessment and care of mother and baby.
McIntyre,M.J., Safety of non-medically led primary maternity care models: a critical review of the international literature, Australian Health Review, 36, 140-147, 2012	Outside scope of question - Safety of non-medically led maternity care.
Miller, T. R., Projected Outcomes of Nurse-Family Partnership Home Visitation During 1996-2013, USA, Prevention Science, 16, 765-77, 2015	Review includes multiple study designs (not limited to RCTs and/or qualitative studies).
Moore, E. R., Bergman, N., Anderson, G. C., Medley, N., Early skinâ€• toâ€• skin contact for mothers and their healthy newborn infants, Cochrane Database of Systematic Reviews, 2016	Outside scope of question - Effect of early skin-to-skin contact.
Morrell, C. J., Sutcliffe, P., Stevens, J., Dennis, C. L., Henshaw, C., Cantrell, A., Spiby, H., Stewart-Brown, S., Slade, P., Harvey, R., The prevention of postnatal depression: Anhta evidence synthesis following a systematic review of quantitative studies, Archives of Women's Mental Health, 18 (2), 289-290, 2015	Conference abstract.
Moss, S. B., Pierce, J., Montoya, C. C., Smith, P. O., Can counseling prevent or treat postpartum depression?, Journal of Family Practice, 58, 152-154, 2009	Sufficient evidence available from guidelines - Assessment and care of mother (mental health).
Myors, K. A., Schmied, V., Johnson, M., Cleary, M., Collaboration and integrated services for	Sufficient evidence available from guidelines - Assessment and care of mother (mental health).

Study	Reason for exclusion
perinatal mental health: An integrative review, Child and Adolescent Mental Health, 18, 1-10, 2013	
Naohiro, Y., Dowswell, T., Shuko, N., Rintaro, M., Cochrane in context: Schedules for home visits in the early postpartum period, Evidence-Based Child Health, 9, 100-102, 2014	Commentary.
Newland, R., Baldwin, S., Demeza, K., Changing practice: a review of the first contact service, Community practitioner : the journal of the Community Practitioners' & Health Visitors' Association, 79, 319-323, 2006	Non-systematic review.
Noonan, M., Doody, O., Jomeen, J., Galvin, R., Midwives' perceptions and experiences of caring for women who experience perinatal mental health problems: An integrative review, MidwiferyMidwifery, 45, 56-71, 2017	Sufficient evidence available from guidelines - Assessment and care of mother (mental health).
O'Connor, E., Rossom, R. C., Henninger, M., Groom, H. C., Burda, B. U., Primary care screening for and treatment of depression in pregnant and postpartumwomen evidence report and systematic review for the US preventive services task force, JAMA - Journal of the American Medical Association, 315, 388-406, 2016	Sufficient evidence available from guidelines - Assessment and care of mother (mental health).
Patnode, C. D., Henninger, M. L., Senger, C. A., Perdue, L. A., Whitlock, E. P., Primary care interventions to support breastfeeding: Updated evidence report and systematic review for the US preventive services task force, JAMA - Journal of the American Medical Association, 316, 1694-1705, 2016	Sufficient evidence available from guidelines - Assessment and care of mother and baby.
Paulden, M., Palmer, S., Hewitt, C., Gilbody, S., Screening for postnatal depression in primary care: Cost-effectiveness analysis, BMJ (Online), 340, 253, 2010	Study design outside scope of question - Cost-effectiveness analysis.
Perry, M., Becerra, F., Kavanagh, J., Serre, A., Vargas, E., Becerril, V., Community-based interventions for improving maternal health and for reducing maternal health inequalities in high-income countries: A systematic map of research, Globalization and Health, 10 (1) (no pagination), 2015	Insufficient information presented for subgroups of interest.
Potter, C. L., Systematic literature review of the use of lay support models in postnatal depression, European Psychiatry. Conference: 19th European Congress of Psychiatry, EPA, 26, 2011	Conference abstract.
Raven, J., Hofman, J., Adegoke, A., van den Broek, N., Methodology and tools for quality improvement in maternal and newborn health care, International Journal of Gynecology & Obstetrics, 114, 4-9, 2011	Population outside scope of question - Low income countries.

Study	Reason for exclusion
Romero, A. M. O., de Rodriguez, L. M., de Cardenas, C. H. R., Coping adaptation process during puerperium, Colombia Medica, 43, 168-175, 2012	Insufficient presentation of methods and results of review but appears to include multiple study designs (not limited to RCTs and/or qualitative studies).
Rowan, P. J., Duckett, S. A., Wang, J. E., State mandates regarding postpartum depression, Psychiatric Services, 66, 324-328, 2015	Outside scope of question - Systematic review of state level peripartum mental health policies.
Salam, R. A., Lassi, Z. S., Das, J. K., Bhutta, Z. A., Evidence from district level inputs to improve quality of care for maternal and newborn health: interventions and findings, Reproductive Health, 11, 2014	Systematic review of reviews - Included reviews include multiple study designs (not limited to RCTs and/or qualitative studies).
Salam, R. A., Mansoor, T., Mallick, D., Lassi, Z. S., Das, J. K., Bhutta, Z. A., Essential childbirth and postnatal interventions for improved maternal and neonatal health, Reproductive Health, 11 (no pagination), 2014	Outside scope of the question - Interventions either did not cover routine postnatal care or there is sufficient evidence from guidelines (Provision of advice and information; assessment and care of mother and baby).
Santiago Md.a, C., Figueiredo, M. H., Immigrant women's perspective on prenatal and postpartum care: systematic review, Journal of immigrant and minority health, 17, 276-284, 2015	Review includes multiple study designs (not limited to RCTs and/or qualitative studies).
Schmied, V., Beake, S., Sheehan, A., McCourt, C., Dykes, F., Women's perceptions and experiences of breastfeeding support: a metasynthesis, Birth, 38, 49-60, 2011	Sufficient evidence available from guidelines - Assessment and care of mother and baby.
Seeman, M. V., Clinical interventions for women with schizophrenia: Pregnancy, Acta Psychiatrica Scandinavica, 127, 12-22, 2012	Outside scope of guideline - Management of pre-existing condition; not routine postnatal care.
Seward, N., Neuman, M., Colbourn, T., Osrin, D., Lewycka, S., Azad, K., Costello, A., Das, S., Fottrell, E., Kuddus, A., Manandhar, D., Nair, N., Nambiar, B., Shah More, N., Phiri, T., Tripathy, P., Prost, A., Effects of women's groups practising participatory learning and action on preventive and care-seeking behaviours to reduce neonatal mortality: A meta-analysis of cluster-randomised trials, PLoS Medicine, 14 (12) (no pagination), 2017	Population outside scope - Low and middle outcome countries.
Sit, D., Rothschild, A. J., Wisner, K. L., A review of postpartum psychosis, Journal of Women's Health, 15, 352-368, 2006	Sufficient evidence available from guidelines - Assessment and care of mother (mental health).
Sitrin,D., Guenther,T., Murray,J., Pilgrim,N., Rubayet,S., Ligowe,R., Pun,B., Malla,H., Moran,A., Reaching Mothers and Babies with Early Postnatal Home Visits: The Implementation Realities of Achieving High Coverage in Large-Scale Programs, PLoS ONE, 8, -, 2013	Study design and population outside scope of question - Cross-sectional surveys in low and middle income countries.
Smith, E. K., Gopalan, P., Glance, J. B., Azzam, P. N., Postpartum depression screening: A review for psychiatrists, Harvard Review of Psychiatry, 24, 173-187, 2016	Sufficient evidence available from guidelines - Assessment and care of mother (mental health).

Study	Reason for exclusion
Sonalkar, S., Mody, S., Gaffield, M. E., Outreach and integration programs to promote family planning in the extended postpartum period, International Journal of Gynecology and Obstetrics, 124, 193-197, 2014	Outside scope of question - Impact of family planning interventions during the postnatal period.
Thomas, S. D., Hudgins, J. L., Sutherland, D. E., Ange, B. L., Mobley, S. C., Perinatal program evaluations: methods, impacts, and future goals, Maternal and Child Health Journal, 19, 1440-1446, 2015	Review includes multiple study designs (not limited to RCTs and/or qualitative studies).
Thurman, S. E., Allen, P. J., Integrating lactation consultants into primary health care services: are lactation consultants affecting breastfeeding success?, Pediatric nursing, 34, 419-425, 2008	Review includes multiple study designs (not limited to RCTs and/or qualitative studies).
Walsh, D., A review of evidence around postnatal care and breastfeeding, Obstetrics, Gynaecology and Reproductive Medicine, 21, 346-350, 2011	Non-systematic review.
Whitford, H. M., Wallis, S. K., Dowswell, T., West, H. M., Renfrew, M. J., Breastfeeding education and support for women with twins or higher order multiples, Cochrane Database of Systematic Reviews, 2017 (2) (no pagination), 2017	Does not plug gaps identified by a review of relevant guidelines.
Wiklund, I., Wiklund, J., Pettersson, V., Bostrom, A. M., New parents' experience of information and sense of security related to postnatal care: A systematic review, Sexual and Reproductive Healthcare, 17, 35-42, 2018	Does not plug gaps identified by a review of relevant guidelines.
Yonemoto, N., Dowswell, T., Nagai, S., Mori, R., Schedules for home visits in the early postpartum period, Database of Abstracts of Reviews of Effects, 5-99, 2014	Abstract.
Yonemoto, N., Dowswell, T., Nagai, S., Mori, R., Schedules for home visits in the early postpartum period, Cochrane Database of Systematic Reviews, CD009326, 2013	Sufficient evidence available from guidelines - Assessment and care of mother and baby.
Yonemoto, N., Dowswell, T., Nagai, S., Mori, R., Schedules for home visits in the early postpartum period, Cochrane Database of Systematic Reviews, 8, CD009326, 2017	Sufficient evidence available from guidelines - Assessment and care of mother and baby.

Economic studies

No economic evidence was identified for this review.

Appendix L – Research recommendations

Research recommendations for review question: What is the essential content of postnatal care contacts for women and babies?

No research recommendations were made for this review question.

Appendix M – Nominal group technique

Additional information related to review question: What is the essential content of postnatal care contacts for women and babies?

Table 9: Round 1 nominal group technique questionnaire for review question: What is the essential content of postnatal care contacts for women and babies?

Name:										
The provision of advice										
	Strongly disagree								Strongly agree	Insufficient knowledge
1. Give women advice on lifestyle issues (such as diet, sleep and hygiene) in the postnatal period.	1	2	3	4	5	6	7	8	9	☐
Comments:										
2. Give women relevant, clear information about their own and their babies' health and well-being so they can recognise and respond to concerns.	1	2	3	4	5	6	7	8	9	☐
Comments:										
3. Recommend and actively support breastfeeding.	1	2	3	4	5	6	7	8	9	☐

Comments:										
4. Recommend immunization to parents, as per existing WHO guidelines.	1	2	3	4	5	6	7	8	9	☐
Comments:										
5. Tell women about the effectiveness of different contraceptive methods including any adverse effects.	1	2	3	4	5	6	7	8	9	☐
Comments:										
6. Tell women about the physiological process of recovery after birth.	1	2	3	4	5	6	7	8	9	☐
Comments:										
The assessment and care of mother (physical)										
	Strongly disagree								**Strongly agree**	**Insufficient knowledge**
7. In the first postpartum visit conduct a comprehensive assessment of the mother's physical well-being.	1	2	3	4	5	6	7	8	9	☐
Comments:										

8. At every postnatal contact, assess for urinary incontinence and bowel function.	1	2	3	4	5	6	7	8	9	☐
Comments:										
9. At every postnatal contact, assess the following: healing of any perineal wound, perineal pain and perineal hygiene.	1	2	3	4	5	6	7	8	9	☐
Comments:										
10. At every postnatal contact, assess the following: headache, fatigue and back pain.	1	2	3	4	5	6	7	8	9	☐
Comments:										
11. At every postnatal contact, assess the following: breast pain, uterine tenderness and lochia.	1	2	3	4	5	6	7	8	9	☐
Comments:										
12. Ask women about resumption of sexual intercourse two to six weeks after birth.	1	2	3	4	5	6	7	8	9	☐
Comments:										
The assessment and care of mother (mental health/ emotional well-being)										

	Strongly disagree								Strongly agree	Insufficient knowledge
13. In the first postpartum visit conduct a comprehensive assessment of the mother's social and psychological well-being.	1	2	3	4	5	6	7	8	9	☐
Comments:										
14. All women should be assessed for symptoms of depression and anxiety using the Edinburgh Postnatal Depression Scale (EPDS).	1	2	3	4	5	6	7	8	9	☐
Comments:										
15. If major depression in the postnatal period is indicated by the EPDS, women should be referred for further assessment.	1	2	3	4	5	6	7	8	9	☐
Comments:										
16. If mild to moderate depression is identified, use non directive counselling in the context of home visits in the postnatal period.	1	2	3	4	5	6	7	8	9	☐
Comments:										
17. Psychoeducation for women should be a routine part of postnatal contacts and should include discussion of mental health and provision of educational material.	1	2	3	4	5	6	7	8	9	☐
Comments:										

18. Where appropriate involve partners in psychoeducation for women and discussions about mental health.	1	2	3	4	5	6	7	8	9	☐
Comments:										
19. Women should be given the opportunity to talk about their birth experience in the first postnatal contact.	1	2	3	4	5	6	7	8	9	☐
Comments:										
20. For women identified as being at risk of postpartum depression, peer support should be provided throughout the postnatal period.	1	2	3	4	5	6	7	8	9	☐
Comments:										

The assessment and care of baby										
	Strongly disagree								Strongly agree	Insufficient knowledge
21. Support parents to have a close and loving relationship with their baby including encouragement of play and communication.	1	2	3	4	5	6	7	8	9	☐
Comments:										
22. Assess feeding progress at every postnatal contact.	1	2	3	4	5	6	7	8	9	☐

Comments:										
23. The following signs should be assessed during every postnatal contact and refer for further evaluation if any are present; stopped feeding well, history of convulsions, fast breathing (breathing rate ≥60 per minute), severe chest in-drawing, no spontaneous movement, fever (temperature ≥37.5 °C), low body temperature (temperature <35.5 °C), any jaundice in first 24 hours of life, or yellow palms and soles at any age.	1	2	3	4	5	6	7	8	9	☐
Comments:										
Assessment of the support available to mother and baby from the partner & family										
	Strongly disagree								**Strongly agree**	**Insufficient knowledge**
24. At every postnatal care contact ask women what family and social support they have.	1	2	3	4	5	6	7	8	9	☐
Comments:										
25. Observe relationship or family dynamics by involving the woman's partner and/ or support network during postnatal care contacts.	1	2	3	4	5	6	7	8	9	☐
Comments:										

Assessment of the risk of domestic violence										
	Strongly disagree								Strongly agree	Insufficient knowledge
26. At every postnatal care contact, observe women for any risks, signs and symptoms of domestic abuse.	1	2	3	4	5	6	7	8	9	☐
Comments:										

Specific to subgroups (adolescent mothers)										
	Strongly disagree								Strongly agree	Insufficient knowledge
27. Provide postnatal care programmes tailored to adolescent parents to improve their knowledge of parenting and provide contraceptive counselling.	1	2	3	4	5	6	7	8	9	☐
Comments:										
28. Give targeted breastfeeding support to adolescent mothers.	1	2	3	4	5	6	7	8	9	☐

Comments:										
Specific to subgroups (women with substance misuse problems)										
	Strongly disagree								Strongly agree	Insufficient knowledge
29. For women with substance misuse problems, provide trained counsellors with the aim of encouraging attendance at drug and alcohol treatment services.	1	2	3	4	5	6	7	8	9	☐
Comments:										
Specific subgroups (primiparous v. multiparous)										
	Strongly disagree								Strongly agree	Insufficient knowledge
30. Provide primiparous women with targeted education, with the aim of promoting parenting skills such as interaction, cooperation, appropriateness of play and sensitivity.	1	2	3	4	5	6	7	8	9	☐
Comments:										
Specific subgroups (safeguarding concerns have been identified)										

	Strongly disagree								Strongly agree	Insufficient knowledge
31. Where there is a high risk of family dysfunction, provide women with case conferencing throughout the postnatal period.	1	2	3	4	5	6	7	8	9	☐
Comments:										
32. Where there is a high risk of family dysfunction, provide women with additional home visits throughout the postnatal period.	1	2	3	4	5	6	7	8	9	☐
Comments:										
33. Where there is a high risk of family dysfunction, provide women with a peer support programme throughout the postnatal period.	1	2	3	4	5	6	7	8	9	☐
Comments:										

General principles										
	Strongly disagree								Strongly agree	Insufficient knowledge
34. Provide postnatal care contact in accordance with the principles of person-centred care.	1	2	3	4	5	6	7	8	9	☐

Comments:

1

Table 10: Round 2 nominal group technique questionnaire for review question: What is the essential content of postnatal care contacts for women and babies?

Name:										
The assessment and care of mother (physical)										
	Strongly disagree								Strongly agree	Insufficient knowledge
10. At each postnatal contact, enquire about any physical symptoms or concerns.	1	2	3	4	5	6	7	8	9	☐
Comments:										
12. Talk to women about the resumption of sexual intercourse, including painful sex.	1	2	3	4	5	6	7	8	9	☐
Comments:										
The assessment and care of mother (mental health/ emotional well-being)										
	Strongly disagree								Strongly agree	Insufficient knowledge
Comments:										

14. All women should be assessed for symptoms of depression and anxiety and offered appropriate support throughout the postnatal period.	1	2	3	4	5	6	7	8	9	☐
Comments:										
16. If mild to moderate depression is identified, refer women for counselling and to additional appropriate support services.	1	2	3	4	5	6	7	8	9	☐
Comments:										
The assessment and care of baby										
	Strongly disagree								**Strongly agree**	**Insufficient knowledge**
21. Throughout the postnatal period support parents with tools and techniques to encourage bonding and social interaction with their baby.	1	2	3	4	5	6	7	8	9	☐
Comments:										
23. Assess infants for specific signs and symptoms of ill health at every postnatal contact and ensure the parents are informed of potentially significant signs and symptoms.	1	2	3	4	5	6	7	8	9	☐
Comments:										
Assessment of the support available to mother and baby from the partner & family										

	Strongly disagree								Strongly agree	Insufficient knowledge
25. Give women the opportunity to discuss relationship or family dynamics in a one to one environment.	1	2	3	4	5	6	7	8	9	☐
Comments:										
Specific to subgroups (adolescent mothers)										
	Strongly disagree								Strongly agree	Insufficient knowledge
28. Give targeted breastfeeding support to women who report breastfeeding concerns and base support on individual needs and circumstances. *(NB. This revised statement no longer belongs with the 'adolescent mothers' subgroup of statements. This will be clarified during any subsequent discussions about the drafting of recommendations related to this statement).*	1	2	3	4	5	6	7	8	9	☐
Comments:										
Specific to subgroups (women with substance misuse problems)										

	Strongly disagree								Strongly agree	Insufficient knowledge
29. For women with substance misuse problems and their baby, provide support from specialist healthcare professionals. Also provide support to women from trained counsellors and encourage attendance at drug and alcohol treatment centres.	1	2	3	4	5	6	7	8	9	☐
Comments:										

Specific subgroups (safeguarding concerns have been identified)										
	Strongly disagree								Strongly agree	Insufficient knowledge
33. Where there is a high risk of family dysfunction (for example, conflict, abuse or neglect), consider signposting women to appropriate community services, including peer support programmes where available.	1	2	3	4	5	6	7	8	9	☐
Comments:										

1

Table 11: Round 1 statements with percentage agreement for review question: What is the essential content of postnatal care contacts for women and babies?

Statement number	Statement	Consensus percentage in round 1	Action taken
Provision of advice			
1.	Give women advice on lifestyle issues (such as diet, sleep and hygiene) in the postnatal period.	89%	Carried forward to committee discussion
2.	Give women relevant, clear information about their own and their babies' health and well-being so they can recognise and respond to concerns.	89%	Carried forward to committee discussion
3.	Recommend and actively support breastfeeding.	89%	Carried forward to committee discussion
4.	Recommend immunization to parents, as per existing WHO guidelines.	100%	Carried forward to committee discussion
5.	Tell women about the effectiveness of different contraceptive methods including any adverse effects.	100%	Carried forward to committee discussion
6.	Tell women about the physiological process of recovery after birth.	89%	Carried forward to committee discussion
Assessment and care of the mother (physical)			
7.	In the first postpartum visit conduct a comprehensive assessment of the mother's physical well-being.	89%	Carried forward to committee discussion
8.	At every postnatal contact, assess for urinary incontinence and bowel function.	88%	Carried forward to committee discussion
9.	At every postnatal contact, assess for urinary incontinence and bowel function.	89%	Carried forward to committee discussion
10.	At every postnatal contact, assess the following: headache, fatigue and back pain.	57%	Carried forward to round 2
11.	At every postnatal contact, assess the following: breast pain, uterine tenderness and lochia.	86%	Carried forward to committee discussion

Statement number	Statement	Consensus percentage in round 1	Action taken
12.	Ask women about resumption of sexual intercourse two to six weeks after birth.	43%	Carried forward to round 2
The assessment and care of the mother (mental health/emotional well-being)			
13.	In the first postpartum visit conduct a comprehensive assessment of the mother's social and psychological well-being.	100%	Carried forward to committee discussion
14.	All women should be assessed for symptoms of depression and anxiety using the Edinburgh Postnatal Depression Scale (EPDS).	43%	Carried forward to round 2
15.	If major depression in the postnatal period is indicated by the EPDS, women should be referred for further assessment.	100%	Carried forward to committee discussion
16.	If mild to moderate depression is identified, use non directive counselling in the context of home visits in the postnatal period.	67%	Carried forward to round 2
17.	Psychoeducation for women should be a routine part of postnatal contacts and should include discussion of mental health and provision of educational material.	83%	Carried forward to committee discussion
18.	Where appropriate involve partners in psychoeducation for women and discussions about mental health.	100%	Carried forward to committee discussion
19.	Women should be given the opportunity to talk about their birth experience in the first postnatal contact.	89%	Carried forward to committee discussion
20.	For women identified as being at risk of postpartum depression, peer support should be provided throughout the postnatal period.	44%	Discarded after round 1
The assessment and care of the baby			
21.	Support parents to have a close and loving relationship with their baby including encouragement of play and communication.	78%	Carried forward to round 2
22.	Assess feeding progress at every postnatal contact.	100%	Carried forward to committee discussion
23.	The following signs should be assessed during every postnatal contact and refer for further evaluation if any are present; stopped feeding well, history of convulsions, fast breathing (breathing rate ≥60 per minute), severe chest in-drawing, no spontaneous movement, fever (temperature ≥37.5 °C), low body temperature (temperature <35.5 °C), any jaundice in first 24 hours of life, or yellow palms and soles at any age.	50%	Carried forward to round 2

Statement number	Statement	Consensus percentage in round 1	Action taken
Assessment of the support available to mother and baby from the partner and family			
24.	At every postnatal care contact ask women what family and social support they have.	56%	Discarded after round 1
25.	Observe relationship or family dynamics by involving the woman's partner and/ or support network during postnatal care contacts.	75%	Carried forward to round 2
Assessment of the risk of domestic violence			
26.	At every postnatal care contact, observe women for any risks, signs and symptoms of domestic abuse.	100%	Carried forward to committee discussion
Specific to subgroups (adolescent mothers)			
27.	Provide postnatal care programmes tailored to adolescent parents to improve their knowledge of parenting and provide contraceptive counselling.	100%	Carried forward to committee discussion
28.	Give targeted breastfeeding support to adolescent mothers.	78%	Carried forward to round 2
Specific to subgroups (women with substance misuse problems)			
29.	For women with substance misuse problems, provide trained counsellors with the aim of encouraging attendance at drug and alcohol treatment services.	67%	Carried forward to round 2
Specific subgroups (primiparous v. multiparous)			
30.	Provide primiparous women with targeted education, with the aim of promoting parenting skills such as interaction, cooperation, appropriateness of play and sensitivity.	44%	Discarded after round 1
Specific subgroups (safeguarding concerns have been identified)			
31.	Where there is a high risk of family dysfunction, provide women with case conferencing throughout the postnatal period.	80%	Carried forward to committee discussion
32.	Where there is a high risk of family dysfunction, provide women with additional home visits throughout the postnatal period.	100%	Carried forward to committee discussion
33.	Where there is a high risk of family dysfunction, provide women with a peer support programme throughout the postnatal period.	63%	Carried forward to round 2
General principles			
34.	Provide postnatal care contact in accordance with the principles of person-centred care.	100%	Carried forward to committee discussion

1

Table 12: Round 2 statements with percentage agreement for review question: What is the essential content of postnatal care contacts for women and babies?

Statement number	Statement	Consensus percentage in round 2	Action taken
Assessment and care of the mother (physical)			
10.	At each postnatal contact, enquire about any physical symptoms or concerns.	89%	Carried forward to committee discussion
12.	Talk to women about the resumption of sexual intercourse, including painful sex.	75%	Discarded after round 2
The assessment and care of the mother (mental health/emotional well-being)			
14.	All women should be assessed for symptoms of depression and anxiety and offered appropriate support throughout the postnatal period.	89%	Carried forward to committee discussion
16.	If mild to moderate depression is identified, refer women for counselling and to additional appropriate support services.	71%	Discarded after round 2
The assessment and care of the baby			
21.	Throughout the postnatal period support parents with tools and techniques to encourage bonding and social interaction with their baby.	100%	Carried forward to committee discussion
23.	Assess infants for specific signs and symptoms of ill health at every postnatal contact and ensure the parents are informed of potentially significant signs and symptoms.	67%	Discarded after round 2
Assessment of the support available to mother and baby from the partner and family			
25.	Give women the opportunity to discuss relationship or family dynamics in a one to one environment.	89%	Carried forward to committee discussion
Specific to subgroups (adolescent mothers)			
28.	Give targeted breastfeeding support to women who report breastfeeding concerns and base support on individual needs and circumstances. (NB. This revised statement no longer belongs with the 'adolescent mothers' subgroup of statements. This will be clarified during any subsequent discussions about the drafting of recommendations related to this statement).	100%	Carried forward to committee discussion
Specific to subgroups (women with substance misuse problems)			
29.	For women with substance misuse problems and their baby, provide support from specialist healthcare professionals. Also provide support to women from trained counsellors and encourage attendance at drug and alcohol treatment centres.	78%	Discarded after round 2
Specific subgroups (safeguarding concerns have been identified)			
33.	Where there is a high risk of family dysfunction (for example, conflict, abuse or neglect), consider	88%	Carried forward to

Statement number	Statement	Consensus percentage in round 2	Action taken
	signposting women to appropriate community services, including peer support programmes where available.		committee discussion

** Statement numbers correspond to the numbering used in round 1 (see Table 11 but the text of each statement incorporates redrafting to take account of comments provided by the committee in round 1)*