FAQs: Questions about Pregnancy and Delivery during COVID-19

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***All OB policies in this document reflect current practice at HUP. If you don’t plan to deliver at HUP, please check with your OB provider about policies at the hospital where you will deliver.

Are there any data on vertical transmission?

To date, there is very little data on vertical transmission. A few small case series suggest that congenital and perinatal transmission to newborns from infected women may occur, likely infrequently.

Are there data about the severity of pediatric illness broken down by age group (maybe neonate, 3-6mo, 6-1y, 1-2y, >2y?)

Pediatric data demonstrate that children of all ages are susceptible to SARS-CoV-2, and that infants under 1 year of age are at risk for severe disease although this still is a relatively rare outcome.

For women with upcoming deliveries, what are the risks/benefits to being induced closer to 39w if that falls in the next 1-2 weeks to avoid the peak surge time in Philadelphia?

Currently, recommendations for mode of delivery do not differ among COVID-19 positive or negative mothers. To date, COVID-19 infection does not appear to have had as negative an impact on pregnant women as infection with the coronaviruses that cause SARS and MERS (which caused severe and often fatal illness among pregnant women) or infection with influenza (which causes disproportionate illness and death among pregnant women in the third trimester of gestation). If a woman has a particular preference for mode of delivery, this should be discussed with her obstetrician.

I am a healthcare worker and pregnant. Should I stop working?

All healthcare workers should use infection control precautions based on published internal guidelines. When possible, pregnant healthcare workers should try to mitigate risk of exposure. Decisions to stop working should be individualized and based on medical history and other factors that can increase risk for complications related to COVID-19. Current HUP guidelines (updated 4/4/20):

Pregnant caregivers should avoid direct contact with patients with COVID-19 and persons under investigation for COVID-19 or influenza. Pregnant caregivers with immunocompromised state or significant underlying cardiac or lung disease should discuss the option to fill clinical or support roles remotely or virtually with their manager or HR business partner. At 37 weeks, we recommend pregnant caregivers avoid direct patient care and be given the opportunity to be redeployed, work remotely and/or go out on leave with a transition to FMLA once they deliver.
**What precautions should I take to attend a delivery from a mother with COVID-19?**

Use gown and gloves, with either an N95 respiratory mask and eye protection goggles; or with an air-purifying respirator that provides eye protection. This protection is needed given both the increased likelihood of maternal virus aerosols and the potential need to perform newborn resuscitation that can generate aerosols (bag-mask ventilation, intubation, suctioning, oxygen at a flow >2 LPM/kg, continuous positive airway pressure and/or positive pressure ventilation).

**Can mother and well newborns room-in?**

While difficult, temporary separation of mother and newborn will minimize the risk of postnatal infant infection from maternal respiratory secretions. Ideally admit infant to an area separate from unaffected infants and use gowns, glove, eye protection goggles and standard procedural masks for care of well newborns. Any temporary separation of mother and newborn is acknowledged to be challenging. If mother chooses to room-in despite recommendations; or if your center cannot provide the infant a separate area, the infant should remain at least 6 feet from mother. Curtain placement or use of an isolette may facilitate separation.

**Can the baby breast feed?**

Studies to date have not found SARS-CoV-2 in breast milk. Mothers may express breast milk after appropriate breast and hand hygiene, and this may be fed to infant by uninfected caregivers. If the mother requests direct breastfeeding, she should comply with strict preventive precautions, including the use of mask and meticulous breast and hand hygiene.

**What should I do if the baby requires intensive care?**

Infants requiring neonatal intensive care optimally should be admitted to a single patient room with the potential for negative room pressure (or other air filtration system.) If this is not available, or if you must cohort multiple COVID-exposed infants, maintain at least 6 feet between infants and/or place them in air temperature-controlled isolettes. Use gown and gloves, with either an N95 respiratory mask and eye protection goggles; or with an air-purifying respirator that provides eye protection, for care of infants requiring supplemental oxygen at a flow >2 LPM/kg, continuous positive airway pressure, or mechanical ventilation.

**Should babies be tested to determine if they are infected with SARS-CoV-2?**

If available, testing well newborns will facilitate plans for care after hospital discharge; will determine the need for ongoing precautions and use of personal protective equipment among hospitalized infants; and will contribute to our understanding of viral transmission and newborn illness.

- Newborns should be bathed after birth to remove virus potentially present on skin surfaces.
Testing should be done first at ~24 hours of age

Repeat testing should be done ~48 hours of age, unless the infant is discharged home prior to this time

Use one swab to sample first the throat and then the nasopharynx. Place single swab in one viral transport media tube and send to lab for molecular testing

For infants who are positive on their initial testing, follow-up testing of combined throat/nasopharynx specimens should be done at 48-72 hour intervals until two consecutive negative tests

**When the baby is ready for hospital discharge?**

Discharge newborns based on your center’s normal criteria.

**If infant SARS-CoV-2 testing is positive**, but infant has no symptoms of COVID-19, plan for frequent outpatient follow-up (either by phone, telemedicine, or in-office) through 14 days after birth. Use precautions to prevent household spread from infant to caregivers; see [https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html) for guidance on use of standard procedural masks, gloves and hand hygiene in the home environment.

**If infant SARS-CoV-2 testing is negative**, discharge ideally to the care of a designated healthy caregiver. While challenging in the home environment, mother should maintain a distance of at least 6 feet when possible, and use a mask and hand-hygiene when directly caring for the infant, until EITHER (a) she has been afebrile for 72 hours without use of antipyretics, and (b) at least 7 days have passed since her symptoms first appeared; OR she has negative results of a SARS-CoV-2 test from at least two consecutive specimens collected ≥24 hours apart. Other caregivers in the home who are persons under investigation (PUIs) for COVID-19 should use standard procedural masks and hand hygiene when within 6 feet of the newborn until their status is resolved. Every effort should be given to provide education to all caregivers of the infant, which includes not only written education but also verbal education in person, via telephone or virtually. Interpreter services should be utilized where appropriate.

**If baby cannot be tested**, then treat the baby as if virus-positive for the 14-day period of observation. Mother should still maintain precautions until she meets the criteria for non-infectivity as above.

**When can the mother and her partner visit their newborn if the baby is in the NICU?**

Mothers with COVID-19 should not visit infants requiring neonatal intensive care until all of the following are met: (1) resolution of fever without the use of antipyretics for at least 72 hours and (2) improvement (but not full resolution) in respiratory symptoms, and (3) negative results of a SARS-CoV-2 test from at least two consecutive specimens collected ≥24 hours apart. Non-maternal parents who are PUIs should not visit infants requiring ongoing hospital care until they are determined to be uninfected by molecular testing and/or clinical criteria. Non-maternal parents who...
FAQ on Breastfeeding for Parents who are Health Care Workers

Compiled by Dr. Eimear Kitt, Assistant Professor Pediatrics at Children’s Hospital of Philadelphia

If a parent of a young child is diagnosed with COVID 19, or is exposed needing to self-isolate, what is the recommendation about caring for the child or children of that caregiver?

In an ideal world, we would live in a bubble while self-isolating after an exposure to or being diagnosed with COVID 19. In reality, self-isolation is very difficult (if not impossible) if you have a young child or other dependent person living with you. Here is some general guidance and tips on safely doing so.

● We know that COVID 19 is primarily transmitted through respiratory droplets, and is more likely to happen when you are symptomatic. Asymptomatic transmission is possible, but is less likely.

● It is important to note that the majority of children do well when infected with COVID 19. This is not entirely understood, but, thankfully, the likelihood that your child would have complications if they became infected with COVID 19 is low.

● If you have had an exposure or have been diagnosed with COVID 19, the best way to protect your family from COVID 19 is to do the following:
   ○ If you are not well enough to care for their child or children, a healthy caregiver should be identified if possible.
   ○ You should wear a disposable facemask at all times until 14 days after your exposure or symptom onset.
   ○ Strict and frequent hand hygiene is important. Make sure to wash hands for 20 seconds.
   ○ Avoid sharing personal items like food and drinks with children and partners.
   ○ Sleep in a separate room/living space away from unexposed persons and use a separate bathroom if possible.
   ○ Clean the sick room and bathroom frequently.

Recommendations for a breastfeeding parent who is COVID positive or COVID exposed.

The decision to breastfeed belongs to the caregiver(s) of the child. It is important to know that, to date, there have been no instances of COVID 19 detected in breastmilk and there are substantial health and emotional benefits that are well described to breastfeeding in general.
· The primary concern currently is the risk of transmitting the virus through respiratory droplets while directly breastfeeding the infant.

· If a mother who is COVID positive chooses to directly breastfeed her infant, there are precautionary measures that can and should be taken.

  o If the caregiver is COVID positive, has decided to breastfeed and feels physically well enough to do so, the caregiver should wear a mask while doing so. Frequent hand washing is also important, before and after touching your baby.

  o The same recommendation is true for COVID exposed parents who wish to breastfeed; wear a mask and practice strict hand hygiene. These precautions should continue for the designated exposure period.

  o If the caregiver is COVID positive and too unwell to breastfeed a child, an alternative is to consider pumping breast milk so an alternative caregiver can feed your baby breast milk.

· General precautions would include hand hygiene before and after pumping, routinely cleaning pump/bottle parts after each use, and routinely clean and disinfect surfaces they have touched.