ACOG
The American College of Obstetricians and Gynecologists

COVID-19 FAQs for Obstetrician-Gynecologists, Obstetrics

At this time very little is known about COVID-19, particularly related to its effect on pregnant women and infants, and there currently are no recommendations specific to pregnant women regarding the evaluation or management of COVID-19.

As ACOG members continue providing patient care during this time, we understand that both they and their patients have questions about women's health during the pandemic. These FAQs are developed by several Task Forces, assembled of practicing obstetrician-gynecologists and ACOG members with expertise in obstetrics, maternal-fetal medicine, gynecology, gynecologic subspecialties, pediatric and adolescent gynecology, infectious disease, hospital systems, telehealth, and ethics, who are on the frontline caring for patients during this pandemic.

These FAQs are based on expert opinion and are intended to supplement the Centers for Disease Control and Prevention (CDC) guidance and the American College of Obstetricians and Gynecologists (ACOG) Practice Advisory with information on how to optimize obstetric care in the context of COVID-19. The COVID-19 pandemic is a rapidly evolving situation and ACOG encourages local facilities and systems, with input from their obstetric care professionals, to develop innovative protocols that meet the health care needs of their patients while considering CDC guidance, guidance from local and state health departments, community spread, health care personnel availability, geography, access to readily available local resources, and coordination with other centers.

This is a rapidly changing landscape, and FAQs will be added or modified on a regular basis as the pandemic evolves and additional information becomes available. For additional information, see the Physician FAQs.

Patients: Please refer to this page for information on coronavirus, pregnancy, and breastfeeding.

Staffing, Personnel, and Hospital Resources

Q: When can an obstetric practitioner with suspected or confirmed COVID-19 return to work? When they return to work, what personal protective equipment (PPE) do they need to wear on a regular basis? REVISED

Last updated May 15, 2020 at 3:01 p.m. EST.

Obstetricians or other obstetric practitioners can return to work when they meet the CDC criteria to discontinue transmission-based precautions:

Symptomatic Patients With COVID-19:

Symptom-based strategy

- At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (eg, cough, shortness of breath), **and**
- At least 10 days have passed since symptoms first appeared.

Test-based strategy

- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected 24 hours or greater apart (total of two negative specimens), **and**
- Resolution of fever without the use of fever-reducing medications, **and**
- Improvement in respiratory symptoms (eg, cough, shortness of breath).

- Improvement is based on clinical assessment, which might include observations such as cessation of sputum production, decreased frequency and intensity of nonproductive cough, and improvement in shortness of breath (eg, no O_2 requirement).

Asymptomatic Patients With Laboratory-confirmed COVID-19:

Test-based strategy

Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected 24 hours or greater apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Time-based strategy

Ten days have passed since the date of their first positive COVID-19 diagnostic test, assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the symptom-based or test-based strategy should be used. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

After returning to work, health care practitioners (HCP) should:

- Wear a facemask for source control (having the infected person wear a cloth face covering or facemask over their mouth and nose to contain their respiratory secretions) at all times while in the health care facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
    - As with other respiratory illnesses, a residual nonproductive cough may persist for weeks after the illness has otherwise resolved. This is also the case for SARS-CoV-2 infection. Therefore, it is possible that an HCP will meet the criteria for returning to work, but still have lingering symptoms.
    - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated (see **What personal protective**

equipment (PPE) should clinicians and patients wear for potential or confirmed COVID-19 patients?).

- Self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms recur or worsen.

Q: Should pregnant health care personnel be transferred to roles where they are not providing in-person patient care to help reduce their risk?

Last updated April 22, 2020 at 3:15 p.m. EST.

ACOG is proud to support the health care personnel around the country who continue to care for patients during this time and is grateful for their tremendous service. Obstetrician-gynecologists are essential to providing high-quality health care, whether related to COVID-19 or not. Undoubtably, working in patient care during this pandemic is understandably leading to concern and uncertainty for health care personnel, including pregnant health care personnel. This is a rapidly evolving area and ACOG is actively monitoring the situation.

We recognize that the health care setting poses unique risks for exposure to COVID-19. If feasible and based on staffing availability:

- Health care facilities may consider limiting exposure of pregnant health care personnel to patients with confirmed or suspected COVID-19 infection (see the CDC's recommendations).
- Pregnant individuals with comorbidities may be at increased risk of severe illness consistent with the general population with similar comorbidities. Thus, any recommendations related to the work environment specific to health care personnel with comorbidities also should be applied to pregnant health care personnel with similar comorbidities.
- As a risk mitigation strategy, removing pregnant health care personnel from direct patient care where there is a higher risk of exposure may be considered once they reach 37 0/7 weeks gestation (or at least 14 days before anticipated delivery) to reduce the risk that the pregnant health care personnel would be infected at the time of delivery. This risk mitigation approach has the potential to reduce the chance that pregnant health care personnel and their neonates are considered persons under investigation (PUI) at the time of birth, and potentially reduce the need for significant health care resources. This consideration would be

most effective if risk of exposure is minimized, which may include self-quarantine until delivery to the extent possible. Pregnant health care personnel may continue to work in patient-facing roles until their delivery if they chose to do so.

Pregnant health care personnel should follow CDC risk assessment and infection control guidelines, including use of appropriate personal protective equipment (PPE) for health care personnel exposed to patients with suspected or confirmed COVID-19. Adherence to recommended infection prevention and control practices is critically important for protecting all health care personnel in health care settings. Health care personnel are not ethically obligated to provide care to high-risk patients without adequate protections in place (see COVID-19 FAQs for Obstetrician-Gynecologists, Ethics).

These suggestions are based on risk to the pregnant individual. Historically, pregnant individuals have been thought to be at increased risk of severe morbidity and mortality from specific respiratory infections. However, with regard to COVID-19, the limited data available do not currently indicate that pregnant individuals are at increased risk for infection or severe morbidity (eg, need for ICU admission or mortality) compared with nonpregnant individuals in the general population. In addition, to date there is no conclusive evidence of fetal risk or of vertical transmission of COVID-19.

We understand that pregnant individuals are experiencing increased concern due to COVID-19, and we appreciate that these are unsettling times. ACOG will continue to diligently monitor the literature to provide our members with the best available and most current guidance. Should new literature indicate any increased risks to pregnant individuals compared to nonpregnant individuals from COVID-19, ACOG will update our recommendations accordingly.

Q: Why are ACOG's recommendations regarding pregnant health care personnel different from the Royal College of Obstetricians and Gynaecologists' (RCOG) recommendations?

Last updated April 22, 2020 at 3:15 p.m. EST.

ACOG is aware of RCOG's occupational health advice for pregnant health care personnel. As described in the RCOG document, an individual's response to viral infections varies among different women and different viruses. RCOG considers influenza and pregnancy as a comparator in developing the current guidance. RCOG's current recommendations are based on the expected COVID-19 disease course in pregnancy based on other viral illnesses, including severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS), with a suggestion that the maternal risks appeared to

increase in the third trimester. These same findings, however, have not been demonstrated specifically for COVID-19.

As with previous infectious disease outbreaks (eg., H1N1 influenza, Ebola, Zika), ACOG's recommendations for COVID-19 are consistent with those of the Centers for Disease Control and Prevention (CDC). The CDC has not recommended removing pregnant health care personnel from work due to any previous outbreaks (Rasmussen 2011, CDC), although during the 2014 Ebola outbreak they did recommend against pregnant health care personnel caring for patients with Ebola Virus Disease because of the known severity of the maternal and fetal illness. For other previous outbreaks, and now in response to COVID-19, the CDC has not proposed removing pregnant health care personnel because of COVID-19 alone, but suggests that appropriate efforts to minimize exposure, especially during higher-risk procedures, be taken wherever feasible (Rasmussen 2011, CDC).

The available medical literature specific to COVID-19 currently does not suggest that pregnant individuals are at increased risk of infection, severe morbidity, or mortality compared to nonpregnant individuals, including later in pregnancy. ACOG suggests following the recommendations listed in the frequently asked question regarding health care personnel. As noted in our recommendations, we understand that many pregnant health care workers are experiencing increased concern because of the current COVID-19 crisis, and we recognize that the health care setting poses unique risks of exposure to COVID-19. As such, ACOG recommends that, where feasible and based on staffing availability, health care facilities may consider limiting exposure of pregnant health care personnel to patients with confirmed or suspected COVID-19 infection, per the CDC's recommendations.

This is a rapidly evolving area, and ACOG will continue to diligently monitor the literature to provide our members with the best available and most current guidance. Should new literature indicate any increased risks to pregnant individuals compared with nonpregnant individuals from COVID-19, ACOG will update our recommendations accordingly.

Q: What personal protective equipment (PPE) should health care professionals wear to reduce their risk of COVID-19 infection? REVISED

Last update May 15, 2020 at 3:13 p.m. EST

COVID-19 infection is highly contagious, and this must be taken into consideration when planning intrapartum care. **All medical staff caring for potential or confirmed COVID-19 patients should use personal protective equipment (PPE) listed below, including respirators (eg, N95 respirators).** In

areas where universal testing is not employed and adequate PPE is available, universal PPE, including respirators (eg, N95 respirators) is recommended until the patient's status is known. Importantly, all medical staff should be trained in and adhere to proper donning and doffing of PPE. Personal protective equipment recommended by the Centers for Disease Control and Prevention (CDC) is listed below, and CDC provides strategies for how to optimize the supply of PPE. ACOG and SMFM have also made statements regarding the urgent need for PPE in obstetrics.

Although there is understandable emphasis on facial protection, data from the SARS outbreak suggest that the comprehensive array of recommended PPE (listed below) used alongside hand hygiene and environmental cleaning leads to the optimal decreased risk of transmission of respiratory viruses, and this is likely true for COVID-19.

CDC Recommended Personal Protective Equipment:

- Respirator or Facemask (cloth face coverings are NOT PPE and should not be worn for the care of patients with known or suspected COVID-19 or in other situations where a respirator or facemask is warranted)
    - Put on a respirator or facemask (if a respirator is not available) before entry into the patient's room or care area
    - N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol-generating procedure. Disposable respirators and facemasks should be removed and discarded after exiting the patient's room or care area and closing the door. Perform hand hygiene after discarding the respirator or facemask.
        - If reusable respirators (eg, powered air purifying respirators [PAPRs]) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions before re-use.
    - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19.
- Eye Protection
    - Put on eye protection (ie, goggles or a disposable face shield that covers the front and sides of the face) upon entry to the patient's room or care area. Personal eyeglasses and

contact lenses are NOT considered adequate eye protection.

- Remove eye protection before leaving the patient's room or care area.
- Reusable eye protection (eg, goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions before re-use.
- Disposable eye protection should be discarded after use.

- Gloves
  - Put on clean, nonsterile gloves upon entry into the patient's room or care area.
  - Change gloves if they become torn or heavily contaminated.
  - Remove and discard gloves when leaving the patient's room or care area, and immediately perform hand hygiene.
- Gown
  - Put on a clean isolation gown upon entry into the patient's room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient's room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.
  - If there are shortages of gowns, they should be prioritized for:
    - Aerosol-generating procedures
    - Care activities where splashes and sprays are anticipated
    - High-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of the health care practitioner. Examples include:
      - Dressing
      - Bathing/showering
      - Transferring
      - Providing hygiene
      - Changing linens
      - Changing briefs or assisting with toileting
      - Device care or use
      - Wound care

During N95 respirator shortages, facilities might need to prioritize N95 respirator use for aerosol-generating procedures* and use facemasks for other types of health care. Even during a shortage, it is important that medical staff use appropriate forms of PPE, including surgical masks. During shortages, facilities are encouraged to take steps that facilitate the protection of medical staff and enable personnel to protect themselves. Finally, although individual physicians, after careful consideration, may opt to provide care without adequate PPE, physicians are not ethically obligated to provide care to high-risk patients without protections in place.

*ACOG continues to review questions and data regarding the potential for aerosolization in the context of forceful exhalation during the second stage of labor. According to the CDC, based on limited data, forceful exhalation during the second stage of labor would not be expected to generate aerosols to the same extent as procedures more commonly considered to be aerosol-generating (such as bronchoscopy, intubation, and open suctioning). See CDC's Obstetrical FAQs for more information about the second stage of labor and aerosol-generating procedures.

Q: How can facilities prepare obstetric care clinicians to respond to COVID-19?

Last updated March 23, 2020 at 11:30 p.m. EST.

Hospitals that provide maternity services should create, or—if already established—mobilize their perinatal subcommittee in charge of disaster preparedness (likely to include representatives from obstetric, pediatric, family medicine, and anesthesia teams among others) (Committee Opinion 726).

In some areas with high prevalence and community spread, a shortage of obstetric health care personnel may occur. Regardless of whether an area is currently experiencing wide community spread, ACOG encourages all facilities to begin strategizing how to expand their obstetric work force. Facilities should consider rapid credentialing and privileging of temporary obstetric care clinicians not currently practicing obstetrics to enable augmentation of the work force (Committee Opinion 726), retraining these individuals as necessary, and ensuring proper insurance coverage.

Additionally, if not already doing so, facilities are encouraged to find innovative ways to collaborate with family physicians, midwives who are certified by the American Midwifery Certification Board (or its predecessor organizations) or whose education and licensure meet the International Confederation of Midwives *Global Standards for Midwifery Education*, and other obstetric care professionals.

Q: How can elective procedures be managed to optimize personnel and resources?

Last updated March 23, 2020 at 11:30 p.m. EST.

In areas where COVID-19 is particularly prevalent or where there is particular stress on the health care system, it may be advantageous to identify and modify surgical scheduling, including for procedures that are medically indicated, when a patient's health and safety would not be harmed by such delay.

For obstetrics, it may be appropriate to temporarily consider tubal sterilization only when performing cesarean birth (unless the patient is considered high risk) and all others as elective, so long as an alternative form of contraception is provided (eg, immediate postpartum long-acting reversible contraception), if desired by the patient. However, any decision regarding which procedures to consider elective should be made on a local and regional level, considering the risks and resources specific to each area. Obstetric and gynecologic procedures for which a delay will negatively affect patient health and safety should not be delayed. This includes gynecologic procedures and procedures related to pregnancy for which delay would harm patient health.

See ACOG's Joint Statement on Elective Surgery for additional information.

Q: What is the best approach to cleaning surfaces?

Last updated March 26, 2020 at 8:00 a.m. EST.

Clinicians should follow CDC guidance in regards to properly cleaning surfaces.

Q: How can facilities prepare to manage an influx of obstetric patients with COVID-19?

Last updated April 21, 2020 at 3:30 p.m. EST.

One public health intervention to reduce exposure risk is cohorting—co-locating patients with suspected or confirmed COVID-19 into a designated area of the hospital. Although not all facilities are able to create an independent obstetrics COVID-19 unit, attempts to designate specific locations for

the purposes of containment have the intention of limiting the exposure of unaffected patients and staff (SMFM).

Q: Should facilities consider special scheduling tactics to preserve the obstetric work force?

Last updated April 21, 2020 at 3:30 p.m. EST.

Yes, facilities can consider strategies such as:

- For hospitals that have the staffing capacity, consider using a designated team of trained clinicians to care for patients in these designated COVID-19 units or spaces (SMFM)
- Proactively log staff who enter and leave these designated COVID-19 units or spaces to enable systematic tracking of potential exposure. (SMFM)
    - This tracking could be considered more broadly for all patient rooms (ie, those off the cohorted unit), depending on local epidemiology, to facilitate tracking of exposures in cases where COVID-19 specific PPE is not being used.
    - Tracking is performed by asking clinicians entering the room to log their name and time of entry. Logging can be done by documentation of all clinical encounters within the electronic medical record or via a physical document placed just outside the patient's room.

Q: What aspects need to be considered regarding the resumption of routinely recommended obstetric care schedules and services? NEW

Last updated May 12, 2020 at 3:40 p.m. EST.

Practices, hospitals, and health care systems are beginning to identify and consider how to safely resume care for non-COVID-19-related issues, such as preventive services, primary care, and non-urgent surgeries. ACOG recognizes the importance of using a data-driven approach to base decisions regarding re-opening specific areas and services. There are a number of aspects that need to be considered, including timing and scaling up of healthcare services, logistics in outpatient and inpatient facilities, COVID-19 testing and surveillance, current community prevalence, use of personal protective

equipment (PPE), COVID-19 effect on the health care workforce, and others. An ACOG Position Statement has been developed that addresses these considerations in general and relevant to resumption of comprehensive routine women's health care. It is important to recognize that strategies for resuming care will need to be developed on an individualized basis at the local, state, and regional level as national, regional, and local regulations and circumstances will influence the pace of, and approach to, resuming aspects of routine women's health care.

The Centers for Medicare and Medicaid Services (CMS) has released suggested guidance regarding the timing of resumption of elective surgeries as well as non-surgical care. CMS and the White House recommend that hospitals should not resume surgical scheduling until the state or local regions meet "Gating Criteria", including a downward trend in the rate of COVID-19 positive tests and patients with symptoms for at least 14 days, that hospitals must be able to treat all patients without resorting to crisis care, and must have robust testing in place for at-risk healthcare workers.

CMS strongly encourages maximizing the use of all telehealth modalities. The COVID-19 pandemic has resulted in a number of policy changes designed to enhance implementation of telehealth, and it is likely that some of the telehealth implementation strategies can be maintained in a resumption of care process. Consideration may be given to a phased approach to increasing non-urgent visits, with an emphasis on virtual visits early on and gradually increasing in-person visits. Planning for virtual visits must account for the types of visits that could be conducted virtually, recognizing that aspects such as physical examination, radiology, or laboratory testing would require an in-person visit. Some systems may consider maintaining telehealth in the provision of care on a more permanent basis especially if telehealth services were safe, effective, and well-received by the patient community.

Key considerations include:

- Surgery: Guidance from the American College of Surgeons and a joint document from the American College of Surgeons, the American Society of Anesthesiologists, the Association of periOperative Registered Nurses, and the American Hospital Association are available. Policies and processes in these documents may be helpful in developing or modifying approaches to surgical obstetric care as well as nonobstetric surgery during pregnancy (Committee Opinion 775).
- COVID-19 testing: Widespread testing capabilities are essential to monitor and to inform adjustments to a phased approach in resuming routine care. Depending on local prevalence, capacity, and supply, some hospitals have implemented universal testing on labor and delivery units to identify patients with COVID-19. COVID-19 testing strategies may be

determined based on community prevalence, facility capacity, availability of test kits, and test characteristics (type, sensitivity, specificity) of available tests, among other factors.

- Policies regarding optimizing PPE availability and use, masking, and hand hygiene for clinicians, staff, and patients also are necessary both in the outpatient and inpatient settings, including labor and delivery and surgery. Several systems are implementing masking for both patients and clinicians in outpatient settings, and types of PPE used in the labor and delivery or surgical setting may be determined based on admission or preoperative testing.
- Outpatient visits: Facilities are using a variety of approaches, including:
  - Universal mask policy for clinicians, staff, patients, and visitors. Patients are encouraged to use cloth facial coverings to preserve mask supplies for medical use.
  - Limiting the number of visitors and attendants.
  - Changing waiting room and clinic space to accommodate physical distancing (for example, spacing of furniture in the waiting area and marking floors and elevators).
  - Considering having patients wait off-site and notified when to enter the clinic space.
  - Hand hygiene stations for patients before entering the facility or waiting room.
  - Maximizing use of all telehealth modalities.
  - Preserving in-person visits for those patients requiring physical evaluation or interventions (such as ultrasonography, blood draws, and immunizations).
  - Consolidating visits so that patients do not have to return to the facility or move among several locations for laboratory tests or ultrasonography.
  - Prioritizing in-person visits for those with greatest medical need, followed by elective visits.
  - Employing an extended hours strategy to space visits and to maintain physical spacing in the care and waiting areas.
- Screening: Screening patients for in-person visits may include strategies similar to those used during the height of COVID-19, including pre-appointment phone screening, symptom and temperature checks at the building entrance, and possible masking. Facilities may consider routine screening for women and visitors in labor and delivery units until the local prevalence has significantly decreased. CMS suggests establishing “Non-COVID-19 Care” zones that would screen all patients for COVID-19 symptoms.

General Considerations

Q: Is there a personal protective equipment (PPE) shortage?

Last updated April 8, 2020 at 11:00 a.m. EST.

Yes, many facilities are currently experiencing a PPE shortage, and CDC provides strategies for how to optimize the supply of PPE. ACOG and SMFM have also made statements regarding the urgent need for PPE in obstetrics. (See also **What personal protective equipment (PPE) should clinicians and patients wear for potential or confirmed COVID-19 patients?**)

Q: What are the criteria to discontinue transmission-based precautions for previously COVID-19 positive patients? REVISED

Last updated May 15, 2020 at 2:55 p.m. EST.

According to CDC's guidance, discontinuation of transmission-based precautions in the health care setting for an individual with confirmed COVID-19 should be made using either a symptom-based (ie, time-since-illness-onset and time-since-recovery strategy) or time-based strategy, or a test-based strategy as described below (CDC). Patients who are discharged home for required isolation or who are treated as outpatients with a diagnosis of COVID-19 should follow discontinuation of isolation precautions guidance from the CDC.

Symptomatic Patients With COVID-19:

Symptom-based Strategy

- At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (eg, cough, shortness of breath), **and**
- At least 10 days have passed since symptoms first appeared.

Test-based Strategy

- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected

24 hours or greater apart (total of two negative specimens), **and**

- Resolution of fever without the use of fever-reducing medications, **and**
- Improvement in respiratory symptoms (eg, cough, shortness of breath).

Asymptomatic Patients With Laboratory-confirmed COVID-19:

Test-based strategy

Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected 24 hours or greater apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Time-based strategy

Ten days have passed since the date of their first positive COVID-19 diagnostic test, assuming they have not subsequently developed symptoms since their positive test. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

Q: Does pregnancy increase the need for critical care in the setting of COVID-19 infection?

Last update April 8, 2020 at 11:00 a.m. EST.

The limited data currently available do not indicate that pregnant individuals are at an increased risk of infection or severe morbidity (eg, need for ICU admission or mortality) compared with nonpregnant individuals in the general population. Pregnant patients with comorbidities may be at increased risk for severe illness consistent with the general population with similar comorbidities. Clinical management of COVID-19 includes prompt implementation of recommended infection prevention and control measures and supportive management of complications; in some cases, this may include critical care if indicated.

If a pregnancy is complicated by critical illness, the woman should ideally be cared for at a Level III or IV hospital with obstetric services and an adult ICU (Obstetric Care Consensus 9 "Levels of Maternal Care"). COVID-19 status alone is not necessarily a reason to transfer noncritically ill pregnant women with suspected or confirmed COVID-19, but care location planning should be based on the levels of maternal and neonatal care (Obstetric Care Consensus 9 "Levels of Maternal Care", AAP's Levels of Neonatal Care).

Facility-level factors may influence the decision to transfer a patient to a higher level of care. These factors include lack of adequate staff to care for a critically ill patient, need for frequent assessments, special equipment, and access to trials for novel treatments. When a request is made to transfer a patient to a higher level of care for facility-level factors, a discussion between the transferring health care practitioner and the intensive care practitioners regarding the current limitations of care on the obstetric unit may help facilitate rapid transfer (Practice Bulletin 211).

The Society for Maternal-Fetal Medicine is offering components of their Critical Care Course at no cost in the face of the COVID-19 pandemic: Pulmonary Hypertension, Pulmonary Embolism, Hemodynamic Monitoring and Mechanical Ventilation, Sepsis, and ARDS/Respiratory Failure. The society also offers a Critical Care Basics webinar.

The Society of Critical Care Medicine also offers a series of resources in response to COVID-19.

Q: Does COVID-19 present an increased risk of severe morbidity and mortality for pregnant women compared with nonpregnant women?

Last updated April 23, 2020 at 4:45 p.m. EST

Historically, respiratory infections in pregnant women have been thought to increase their risk for severe morbidity and mortality. With regard to COVID-19, the limited data currently available do not indicate that pregnant individuals are at an increased risk of infection or severe morbidity (eg, need for ICU admission or mortality) compared with nonpregnant individuals in the general population. Pregnant patients with comorbidities may be at increased risk for severe illness consistent with the general population with similar comorbidities. To date, there is no conclusive evidence of vertical transmission of COVID-19. ACOG will continue to diligently monitor the literature for any COVID-19 risk signals in pregnancy.

All individuals, including pregnant individuals, are encouraged to take precautions to avoid exposure to COVID-19 as the situation evolves. We understand that many pregnant individuals are experiencing

increased stress and anxiety due to COVID-19. When counseling pregnant patients about COVID-19, it is important to acknowledge that these are unsettling times. Clinicians are encouraged to share ACOG's patient resources as appropriate.

ACOG is working to address the concerns that have been raised about the effect of COVID-19 in pregnant individuals and encourages all of our members and any clinician who cares for pregnant patients with known or suspected COVID-19 to submit information to an appropriate COVID-19 registry such as PRIORITY to augment the collective knowledge about the effect of COVID-19 during pregnancy.

Q: Should pregnant patients wear a mask or a cloth facial covering? REVISED

Last updated May 15, 2020 at 3:10 p.m. EST.

Pregnant patients should follow the same recommendations as the general population as outlined by the CDC with regard to wearing a mask or a cloth facial covering. All persons entering a health care facility should wear a cloth face covering or facemask. Patients with suspected or confirmed COVID-19 should be instructed to wear a facemask or cloth face covering when interacting with HCP or when leaving their room. Patients also should adhere to respiratory hygiene, cough etiquette, and hand hygiene and follow triage procedures throughout the duration of the visit.

Outside of the health care setting, masks should be worn by those experiencing symptoms of COVID-19 or those with confirmed COVID-19 when they are in public or around other individuals. For other individuals, especially those in areas of significant community-based spread, the CDC recommends wearing cloth face coverings in public settings where other social distancing measures are difficult to maintain (eg, grocery stores and pharmacies).

The cloth facial coverings recommended are not surgical masks or N95 respirators. Surgical masks and N95 respirators are critical PPE supplies that must continue to be reserved for health care workers and other medical first responders, as recommended by current CDC guidance.

Consistent with recommendations for the general population, masks should be worn when feasible. However, in the setting of second stage of labor, pushing while wearing a facemask may be difficult and forceful exhalation may significantly reduce the effectiveness of a mask in preventing the spread of the virus by respiratory droplets. This situation further underscores the need for all health care personnel to use appropriate PPE while caring for a person with suspected or confirmed COVID-19. Even in the setting of COVID-19, delayed pushing is not recommended as a strategy to avoid forced

exhalation due to the adverse maternal outcomes associated with delayed pushing (Committee Opinion No. 766).

Q: How should screening for intimate partner violence and domestic violence proceed during the COVID-19 pandemic? NEW

Last updated May 13, 2020 at 2:57 p.m. EST.

The risk of intimate partner violence is increased in the context of recommendations to shelter in place, physical distancing, financial hardships, and potential isolation and quarantine. The severity of intimate partner violence may escalate during pregnancy or the postpartum period. ACOG recommends screening all patients for intimate partner violence at periodic intervals throughout obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup) (Guidelines for Perinatal Care, 8th edition; Committee Opinion 518). Screening all patients multiple times is important because some women do not or cannot disclose abuse each time they are asked. During the COVID-19 pandemic, screening may need to be provided by telehealth. Unfortunately, screening for intimate partner violence by telehealth may not allow women the privacy or safety needed to disclose abuse. In addition to possibly screening during prenatal telehealth appointments, screening is important to perform during in-person appointments and at hospital admission in a private and safe setting with the patient alone and not in the presence of a partner, friends, family, or caregiver. Obstetrician–gynecologists and other obstetric care professionals should proactively identify local resources and be prepared to offer or provide referrals for social work services, mental health care, or additional resources for patients who disclose intimate partner violence. It may be necessary to provide these services or other enhanced resources by phone, electronically, or by telehealth where possible.

For additional information, see ACOG Committee Opinion 518, Intimate Partner Violence.

Additional key resources include:

- National Domestic Violence Hotline (24-hour, toll-free): call 800-799-SAFE (7233) and 800-787-3224 (TTY), text LOVEIS to 22522, or use the live chat option at www.thehotline.org.
- National Health Resource Center on Domestic Violence
- Futures Without Violence

(These links are for resource purposes only and should not be considered developed or endorsed by the American College of Obstetricians and Gynecologists.)

Q: How can I help my pregnant and postpartum patients manage stress, anxiety, and depression? NEW

Last updated May 13, 2020 at 3:00 p.m. EST.

Perinatal mood and anxiety disorders are among the most common complications that occur in pregnancy or in the first 12 months after delivery. Especially during this challenging time, obstetrician–gynecologists and other maternal health care professionals should screen all pregnant individuals at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool (Committee Opinion 757) . Even if an individual is screened during pregnancy, additional screening also should occur during the postpartum period (Committee Opinion 757). Obstetrician–gynecologists and other maternal health care professionals should reassure patients that even during this time, there are effective treatment and support options. If you are concerned that your patient may be at imminent risk of harm to self or others, refer them to emergency services for further evaluation.

Additional key resources include:

- The Lifeline4Moms Perinatal Mental Health Toolkit: provides information and algorithms for screening, assessment, and treatment of perinatal mental health conditions.
- Lifeline4Moms Network of Perinatal Psychiatry Access Programs: if you are in CA, FL, LA, MA, MI, NC, RI, VT, WA, or WI, visit the program's website for contact information. Clinicians can call with questions regarding the diagnosis and management of perinatal mood and anxiety disorders. Some programs also provide mental health resources and referrals.
- Postpartum Support International's Perinatal Psychiatric Consult Line: available to all clinicians throughout the U.S. Call 800-944-4773 (extension 4) or visit the website to schedule a 1:1 consultation by phone with a perinatal psychiatry expert.
- Postpartum Support International's online facilitated support group meetings: for your patients to connect with other pregnant and postpartum women. Patients can call 1-800-944-4773 (#1 Español or #2 English) or text 503-894-9453 (English) or 971-420-0294 (Español).

(These links are for resource purposes only and should not be considered developed or endorsed by the American College of Obstetricians and Gynecologists.)

Q: How should visitation rules be modified in the setting of the COVID-19 pandemic? REVISED

Last updated May 13, 2020 at 3:05 p.m. EST.

Modifications to visitation policies should be made on an individual facility level and based on community spread, local and state recommendations or regulations, and infection control and space considerations (eg, whether postpartum recovery rooms are individual or shared, while adhering to appropriate social distancing). In both the inpatient and outpatient settings, it is recommended that the number of visitors be reduced to the minimum necessary, with visitors limited to those essential for the pregnant individual's well-being (emotional support persons). Visitors should be screened for symptoms of acute respiratory illness and should not be allowed entry if fever or respiratory symptoms are present; in those instances, a different, asymptomatic visitor can be allowed to provide support. Hospitals may consider routinely evaluating visitors for symptoms. Use of alternative mechanisms for patient and visitor interactions, such as video-call applications, can be encouraged for any additional support persons. The Centers for Disease Control and Prevention (CDC) provides additional suggested guidance for managing visitors in inpatient obstetric health care settings.

When counseling patients about any modified visitation policies, obstetrician–gynecologists and other obstetric care professionals should acknowledge the importance of support persons and also communicate that any policies that temporarily limit visitors or support persons are being implemented for the safety of the patient, her newborn, and the community.

Labor, delivery, and postpartum support may be especially important to improve outcomes for individuals from communities traditionally underserved or mistreated within the health care system. In considering visitation policies, institutions should be mindful of how restrictions might differentially and negatively affect these communities, which in many areas are also disproportionately affected by COVID-19.

Q: What are key factors in considering or applying universal diagnostic testing in labor and delivery units? NEW

Last updated May 15, 2020 at 3:25 p.m. EST.

Pregnant women admitted for labor and delivery with suspected COVID-19 or who develop symptoms suggestive of COVID-19 during admission should be prioritized for testing (CDC, ACOG Practice Advisory). In addition, facilities may consider additional molecular (eg, PCR by nasopharyngeal swab) testing strategies, such as universal testing because there is the potential for asymptomatic patients to present to labor and delivery units, particularly in high prevalence areas.

Key factors in considering expanded or universal testing in labor and delivery units include:

- Prevalence of COVID-19. Expanded or universal testing has the potential to identify asymptomatic COVID-19 positive patients presenting to labor and delivery units. As such, and given the considerations listed below, this approach is likely most beneficial in areas where there is wide community spread with the potential for many asymptomatic individuals.
- Testing capacity. If universal testing is being considered for a labor and delivery unit, testing capacity must include the ability to provide rapid results (eg, up to a few hours) in order to affect care during labor. Other types of expanded testing (non-rapid) may be appropriate for situations when a longer turnaround time is acceptable, such as pre-admission testing for scheduled deliveries.
- Test characteristics. Due to variation in the type of diagnostic tests being offered and the local prevalence of COVID-19, the predictive capability of rapid tests will vary by location. Because of the emergence of many COVID-19 tests that have different characteristics, the sensitivity, specificity, and predictive values may vary widely from test to test. Both false-negative and false-positive results can adversely affect patient management and outcomes and misdirect critical resources. In areas of low prevalence, the positive predictive value may be particularly low, depending on the test being used. In communities where COVID-19 is more prevalent, adverse outcomes associated with false-negatives may have a greater negative impact.
- Declining testing. Individuals may decline testing for a variety of reasons including stigma, mistrust, and fear of possible mother–baby separation. Facilities should have a plan for the care of individuals who decline COVID-19 testing.

Of note, serological (antibody) tests are non-diagnostic for acute COVID-19 infection, and it is unknown whether the presence of antibodies confers immunity (WHO). Although the FDA has allowed the conduct of some serological testing, obstetricians should be aware of their limitations. Serological (antibody) tests should not be used as the sole basis to diagnose COVID-19; instead, it should be used as information about whether a person may have previously been exposed. The FDA's authorized tests, including serological tests, are listed on the Emergency Use Authorization (EUA) page.

Prenatal Care

Q: How can obstetrician–gynecologists counsel pregnant patients regarding the safety of working in the non-health care environment? REVISED

Last update May15, 2020 at 3:20 p.m. EST.

Health care professionals are being asked about unique requests for work accommodations specific to COVID-19. If a pregnant individual requests a letter to support a COVID-19-specific work accommodation, maternal health care professionals can respond to the request in the context of the risk to the pregnant individual taking into account the particular patient's circumstances. ACOG recommends that employers follow current CDC guidance and direction from local and state health departments, which may include advice on how to increase social distancing (such as remote working when possible). Many locations in the United States are now under stay-at-home orders or have ordered nonessential businesses to close. All individuals, including pregnant individuals, are encouraged to take precautions to avoid exposure to COVID-19.

Pregnant individuals may continue to work until they deliver. However, as a risk mitigation strategy, assigning pregnant individuals who work in essential services to roles where there is reduced risk of exposure once they reach 37 0/7 weeks of gestation (or at least 14 days before anticipated delivery) may be considered to reduce the risk that the pregnant individual would be infected at the time of delivery, and potentially reduce the need for significant health care resources. This consideration would be most effective if risk of exposure is minimized, which may include self-quarantine until delivery to the extent possible.

Requests for leave will depend on the patient's comorbidities and the individual work situation (see Committee Opinion No. 733, Employment Considerations During Pregnancy and the Postpartum

Period, for more information on writing a work accommodation note and key resources to provide patients).

We understand that our patients are experiencing increased stress and anxiety because of COVID-19. When counseling pregnant patients about COVID-19, it is important to acknowledge that these are unsettling times (see **How can I help my pregnant and postpartum patients manage stress, anxiety, and depression?**). Health care professionals are encouraged to share ACOG's patient resources as appropriate. ACOG will continue to diligently monitor the literature for any COVID-19 risk signals in pregnancy.

Q: Is it appropriate to modify prenatal care delivery to decrease the risk of COVID-19 spread and exposure?

Last updated March 23, 2020 at 11:30 p.m. EST.

Yes. Alternate prenatal care delivery approaches have been proposed as a strategy in the effort to control the spread of COVID-19 among patients, caregivers, and staff. Although evidence is limited regarding the safety and efficacy of these approaches, ACOG recognizes the need to implement innovative strategies during this rapidly evolving public health emergency, with consideration of differences in care settings and population risks. Any decision to modify prenatal care delivery should be made at the local and individual level.

- Obstetrician–gynecologists and other obstetric care clinicians should continue to provide medically necessary prenatal care, referrals, and consultations.
- Obstetric care clinicians should be prepared to explain the rationale for any change in prenatal care or delivery scheduling, emphasizing that these modifications have been made in order to limit the risk of exposure to the virus for the mother and the fetus or infant.
- It is recommended that the patient–physician discussion regarding a plan for alternate prenatal care in the setting of the COVID-19 pandemic be documented in the medical record.

Some examples of approaches to modifying prenatal care that may be considered are listed below. However, modifying or reducing care is only appropriate because the risk of inadvertent exposure from receiving or delivering care can be high at this time; normal care approaches and schedules should

resume when this risk subsides. Plans for modified care are best made at the local level with consideration of patient populations and available resources.

- Spacing out appointments.
  - Health care clinicians may choose to continue in-person prenatal care appointments for patients who are not sick, if staffing is available, but space out in-person appointment times where appropriate to reduce the number of patients in the office or facility at one time.
  - This may be accompanied by postponing some nonemergent gynecologic or well-woman appointments to facilitate social distancing and to maintain availability to accommodate medically necessary appointments; appointments for which a delay will negatively affect patient health and safety should not be delayed.

- Alternate or reduced prenatal care schedules.
  - Consider grouping components of care together (eg, vaccinations, glucose screenings, etc) (Committee Opinion 718) to reduce the number of in-person visits.
  - Examples of alternate or reduced prenatal care schedules are listed below as resources. These examples are shared with the express permission of their developers, and without identification when requested. These examples, along with relevant journal publications listed below, are for resource purposes only and should not be considered developed or endorsed by the American College of Obstetricians and Gynecologists.
    - Examples of Alternate or Reduced Prenatal Care Schedules

Q: Can telehealth strategies help assist obstetric care delivery?

Last updated March 23, 2020 at 11:30 p.m. EST.

Yes, and ACOG encourages practices and facilities that do not yet have the infrastructure to offer telehealth to begin strategizing how telehealth could be integrated into their services as appropriate. Importantly, the ability to access telemedicine may vary by patient resources and some assessment of this—although often challenging in times of crisis—will be necessary to ensure equitable care.

As part of the COVID-19 emergency response, several new federal telehealth allowances have been made. These may be subject to ongoing changes; please see ACOG's Managing Patients Remotely: Billing for Digital and Telehealth Services for the latest information on federal policy changes and coding advice.

The Department of Health and Human Services Office for Civil Rights has announced that it will exercise enforcement discretion and waive penalties for HIPAA violations against health care clinicians who serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. See HHS.gov for more information on the Department of Health and Human Services response to COVID-19 and HIPAA.

The Drug Enforcement Administration has released guidance allowing health care clinicians registered by the administration to issue prescriptions for controlled substances without an in-person medical evaluation for the duration of the public health emergency (see specific guidelines here).

Q: Should I screen patients before they come in for in-person appointments?

Last updated March 23, 2020 at 11:30 p.m. EST.

Health care clinicians can also consider an approach (eg. phone, telehealth) to implement routine screening of patients, and their guests if permitted, for potential exposure or COVID-19 symptoms (cough, sore throat, fever) before their in-person appointment to prevent any potential persons under investigation from entering the facility. Patients should be instructed to call ahead and discuss the need to reschedule their appointment if they develop symptoms of a respiratory infection (eg, cough, sore throat, fever) on the day they are scheduled to be seen. This can be done through phone calls before appointments asking about recent travel, potential exposure, and symptoms. Proactive communication to all patients (ie, via email, text, recorded phone calls) advising individuals with possible exposure to or symptoms of COVID-19 to call the office first also may be considered. Additionally, health care clinicians should confirm whether a person is currently undergoing testing for COVID-19.

If, after screening, the patient reports symptoms of or exposure to a person with COVID-19, that patient should be instructed not to come to the health care facility for their appointment and health care clinicians should contact the local or state health department to report the patient as a possible person under investigation (PUI).

Q: Which antenatal fetal surveillance and ultrasound examinations are essential to continue as recommended?

Last updated March 23, 2020 at 11:30 p.m. EST.

Antenatal fetal surveillance and ultrasonography (Practice Bulletin 175) should continue as medically indicated when possible. Elective ultrasound examinations should not be performed (Practice Bulletin 175), and ultrasonography should be used prudently and only when its use is expected to answer a relevant clinical question or otherwise provide medical benefit to the patient (Committee Opinion 723).

It may be appropriate to postpone or cancel some testing or examinations if the risk of exposure and infection within the community outweighs the benefit of testing. However, this should be a decision made at the local practice or facility level, balancing the risks and benefits of decreased exposure, completing the test, and site capacity. As with other components of prenatal care, reducing care is only appropriate because the risk of inadvertent exposure from receiving or delivering care can be high at this time; normal antenatal testing or ultrasonography scheduling should resume when this risk subsides.

Any modifications made to care should be relayed to patients with a discussion of the altered balance of risks and -benefits of coming to the office for testing or ultrasonography in the setting of a global pandemic, and should be documented in the medical record.

Q: Do patients with suspected or confirmed COVID-19 need additional antenatal fetal surveillance?

Last updated March 26, 2020 at 8:00 a.m. EST.

During acute illness, fetal management should be similar to that provided to any ill pregnant person.

Very little is known about the natural history of pregnancy after a patient recovers from COVID-19. In the setting of a mild infection, management similar to that for a patient recovering from influenza is reasonable. Given how little is known about this infection, a detailed mid-trimester anatomy ultrasound examination may be considered following first-trimester maternal infection (SMFM Coronavirus COVID-19 and Pregnancy). For those experiencing illness later in pregnancy, it is reasonable to

consider sonographic assessment of fetal growth in the third trimester (SMFM Coronavirus COVID-19 and Pregnancy).

Q: Are there any special considerations regarding use of low-dose aspirin or other nonsteroidal anti-inflammatory drugs (NSAIDs) during pregnancy or the postpartum period in a patient with suspected or confirmed COVID-19?

Last updated March 23, 2020 at 11:30 p.m. EST.

ACOG is aware of news reports suggesting that the use of nonsteroidal antiinflammatory drugs (NSAIDs), such as ibuprofen, could worsen COVID-19. ACOG also is aware of the Lancet article hypothesizing that NSAIDs (ibuprofen in particular) could aggravate COVID-19 symptoms, although pregnancy was not specifically addressed in this article.

Currently, ACOG is not aware of scientific evidence connecting the use of NSAIDs, like ibuprofen, with worsening COVID-19 symptoms. As such, and because of the prevalence of low-dose aspirin use during pregnancy and the importance of low-dose aspirin in preeclampsia prevention (Committee Opinion 743, Practice Bulletin 202), low-dose aspirin should continue to be offered to pregnant and postpartum women as medically indicated. For patients with suspected or confirmed COVID-19 for whom low-dose aspirin would be indicated, modifications to care may be individualized.

ACOG continues to monitor the situation and the FDA continues to investigate the issue.

Q: Are there special considerations regarding recommended use of antenatal corticosteroids for a patient with suspected or confirmed COVID-19?

Last updated April 29, 2020 at 4:00 p.m. EST.

For the general population, the CDC recommends that corticosteroids should be avoided because of the potential for prolonging viral replication as observed in MERS-CoV patients, unless indicated for other reasons (CDC). However, for pregnant patients, ACOG is not aware of scientific evidence specific to the use of antenatal corticoid steroid use for fetal maturation in a pregnant patient with suspected or confirmed COVID-19.

As such, ACOG suggests the following modifications during the COVID-19 pandemic:

- Before 34 0/7 Weeks of Gestation

  Because of the well-established benefit of antenatal corticosteroid administration with decreased neonatal morbidity and mortality, antenatal corticosteroids should continue to be offered as recommended (Committee Opinion 713, Practice Bulletin 171) for pregnant patients with suspected or confirmed COVID-19 who are between 24 0/7 weeks and 33 6/7 weeks of gestation and at risk of preterm birth within 7 days. Modifications to care for these patients may be individualized, weighing the neonatal benefits of antenatal corticosteroids with the risks of potential harm to the pregnant patient.

- 34 07/–36 6/7 Weeks of Gestation (Late Preterm)

  The benefits of antenatal corticosteroids in the late preterm period are more modest (Committee Opinion 713, Practice Bulletin 171). As such, and weighing this against any potential harm to the pregnant patient, antenatal corticosteroids should not be offered to pregnant patients with suspected or confirmed COVID-19 who are between 34 0/7 weeks and 36 6/7 weeks of gestation and at risk of preterm birth within 7 days. Modifications to care for these patients may be individualized, weighing the neonatal benefits of antenatal corticosteroids with the risks of potential harm to the pregnant patient.

In the setting of critical maternal illness, the risk and benefits should be considered at any gestational age prior to administration but is not routinely recommended in the late preterm period (Practice Bulletin 211). Indicated delivery should not be delayed for administration of steroids in the late preterm period (Practice Bulletin 211, Committee Opinion 713, Practice Bulletin 171)

Q: Are there any special considerations regarding GBS collection?

Last updated March 26, 2020 at 8:00 a.m. EST.

Group B streptococcus (GBS) screening should occur as indicated during the recommended time period, 36 0/7–37 6/7 weeks of gestation (Committee Opinion 797). Consideration may be given to grouping other components of care during the GBS screen at 36 0/7–37 6/7-week window to reduce

the number of in-person prenatal visits needed. Alternatively, patients can self-collect with proper instruction on how to collect a vaginal-rectal swab if the resources and infrastructure are in place to do so.

Q: How should I counsel patients who are considering home birth because of concerns about COVID-19?

Last updated April 29, 2020 at 4:00 p.m. EST.

Although recognizing that many patients are experiencing new concerns because of the COVID-19 pandemic, hospitals and accredited birth centers remain the safest settings for birth (Committee Opinion 697), even during COVID-19 and especially for individuals with suspected or confirmed COVID-19. Patients concerned that delivering in a hospital or accredited birth center setting will increase their risk of exposure to COVID-19 should be assured that hospitals and accredited birth centers continue to be safe with strict infection control procedures. ACOG, AAFP, ACNM, and SMFM have released a statement with additional information.

Please see:

- Committee Opinion 697, *Planned Home Birth*, for additional guidance, including counseling regarding risk and benefits and absolute contraindications.
- **How should visitation rules be modified in the setting of the COVID-19 pandemic?** FAQ for information about visitors.
- Coronavirus (COVID-19), Pregnancy, and Breastfeeding Patient FAQs.
- ACOG's Practice Advisory for key postpartum points, including the importance of shared decision making between the mother and the clinical team.

Q: Are there additional components to prenatal care that should be considered?

Last updated March 23, 2020 at 11:30 p.m. EST.

Yes. It may be necessary to:

- Offer mental health or social work services or referrals to provide additional resources, particularly for patients who are experiencing anxiety regarding the COVID-19 pandemic or are at an increased risk of intimate partner violence (Committee Opinion 518).
- Provide enhanced anticipatory counseling to patients regarding:
  - Any potential changes to length of hospital stay and postpartum care.
  - How to best communicate with their obstetric care team, especially in the case of an emergency.
  - Signs and symptoms of labor and when to call their obstetric care clinician.
  - Any special considerations for infant feeding.
  - Checking with their pediatric clinician or family physician regarding newborn visits because pediatric clinicians or family physicians also may be altering their procedures and routine appointments (American Academy of Pediatrics).
  - Postpartum contraception. Ideally, all methods of contraception should be discussed in context of how provision of contraception may change within the limitations of decreased postpartum in-person visits. For patients who express interest in postpartum contraception, clinicians should discuss the additional benefit of immediate postpartum long-acting reversible contraception (LARC): an additional visit for placement is not needed (Committee Opinion 670) and placement is not resource intensive. (For information on tubal sterilization, please see **How can elective procedures be managed to optimize personnel and resources?**)
  - Any potential changes to their postpartum care team and support system. Most patients will likely have had changes to expected care support resources at home (eg, family who can no longer travel, childcare providers who are no longer available). To the extent possible, patients should be connected to community support resources.

It should be noted that it may be necessary to provide these services or other enhanced resources by phone or electronically where possible. If telehealth visits are anticipated, patients should be provided with any necessary equipment (eg, blood pressure cuffs) if available and as appropriate.

Q: Should pregnant women continue to receive maternal immunizations during the COVID-19 pandemic?

Last updated April 29, 2020 at 4:00 p.m. EST.

Yes. Maternal immunizations continue to be an essential component of prenatal care during the COVID-19 pandemic. Adhering to the recommended timing of maternal immunization as much as possible is encouraged to maximize maternal and fetal benefits. If a practice decides to modify or reduce the number of prenatal care visits, clinicians are encouraged to include recommended maternal immunizations (influenza and Tdap) during remaining in-person appointments, even if that means immunizations will be administered outside of the typically recommended weeks of gestation. Modified prenatal care schedules during COVID-19 may make it disproportionately more difficult for some to receive preventive care such as maternal immunizations. This reality underscores the importance of clinicians integrating social determinants of health screening into practice, and maximizing and facilitating referrals to social services (Committee Opinion 729).

Importantly, there is no evidence that vaccination with either the influenza vaccine or Tdap vaccine increases a pregnant woman's or fetus' risk of infection with or complications from the virus that causes COVID-19.

Similar to other infectious diseases, if a postpartum individual has suspected or confirmed COVID-19 and did not receive indicated immunizations prior to (e.g. MMR) or during (influenza & Tdap) pregnancy, those immunizations should be delayed until the patient has fully recovered from illness.

Intrapartum Care

When a pregnant patient with suspected or confirmed COVID-19 is admitted and birth is anticipated, the obstetric, pediatric or family medicine, and anesthesia teams should be notified in order to facilitate care.

Q: Is timing of delivery affected by COVID-19?

Last updated March 23, 2020 at 11:30 p.m. EST.

Timing of delivery, in most cases, should not be dictated by maternal COVID-19 infection. For women with suspected or confirmed COVID-19 early in pregnancy who recover, no alteration to the usual timing of delivery is indicated. For women with suspected or confirmed COVID-19 in the third trimester who recover, it is reasonable to attempt to postpone delivery (if no other medical indications arise) until a negative testing result is obtained or quarantine status is lifted in an attempt to avoid transmission to the neonate. In general, COVID-19 infection itself is not an indication for delivery.

Q: Is COVID-19 considered an indication for cesarean delivery for patients with suspected or confirmed COVID-19 infection?

Last updated March 23, 2020 at 11:30 p.m. EST.

No. Currently, based on very limited data based on primarily cesarean deliveries, there does not appear to be a risk of vertical transmission via the transplacental route. Additionally, based on limited data, outcomes for individuals appear to be similar between pregnant and nonpregnant patients. Cesarean delivery should therefore be based on obstetric (fetal or maternal) indications and not COVID-19 status alone.

In the event that an individual should request a cesarean delivery because of COVID-19 concerns, obstetrician–gynecologists and other obstetric care clinicians should follow ACOG's guidance provided in Committee Opinion 761, *Cesarean Delivery on Maternal Request*.

Q: How can scheduled inductions of labor or cesarean deliveries be managed to optimize personnel and resources?

Last updated March 23, 2020 at 11:30 p.m. EST.

Inductions of labor and cesarean deliveries should continue to be performed as indicated. Decisions on how to schedule these procedures in the time of the COVID-19 pandemic are best made at the local facility and systems level, with input from obstetric care professionals and based on health care personnel availability, geography, access to readily available local resources, and coordination with other centers. (For information on elective procedures, please see **How can elective procedures be managed to optimize personnel and resources?**)

Q: Is operative vaginal delivery indicated in a patient with suspected or confirmed COVID-19?

Last update March 26, 2020 at 8:00 a.m. EST.

No, operative vaginal delivery is not indicated for suspected or confirmed COVID-19 alone. Practitioners should follow usual clinical indications for operative vaginal delivery, in the setting of appropriate personal protective equipment (Practice Bulletin 154 on Operative Vaginal Delivery).

Q: Is delayed cord clamping still appropriate in a patient who has suspected or confirmed COVID-19?

Last updated March 23, 2020 at 11:30 p.m. EST.

Yes, delayed cord clamping is still appropriate in the setting of appropriate clinician personal protective equipment. Although some experts have recommended against delayed cord clamping, the evidence is based on opinion; a single report later confirmed COVID-19 transmission most likely occurred from the obstetric care clinician to the neonate. Current evidence-based guidelines for delayed cord clamping should continue to be followed until emerging evidence suggests a change in practice. See Committee Opinion 684, *Delayed Umbilical Clamping After Birth*, for more information.

Q: How should umbilical cord blood banking be managed during the COVID-19 pandemic?

Last updated March 23, 2020 at 11:30 p.m. EST.

Respiratory diseases are typically not transmitted by the transfer of human cells. Currently, there are no reported cases of transmission of COVID-19 by blood products (FDA); therefore, umbilical cord blood banking can continue to be managed according to clinical guidance (Committee Opinion 771), in the setting of appropriate clinician personal protective equipment. A variety of circumstances may arise during the process of labor and delivery that may preclude adequate cord blood collection. Umbilical cord blood collection should not compromise obstetric or neonatal care or alter routine practice of delayed umbilical cord clamping with the rare exception of medical indications for directed donation (Committee Opinion 771).

Q: How can doulas support maternal care and delivery during the COVID-19 pandemic?

Last updated May 1, 2020 at 8:50 a.m. EST.

Evidence suggests that, in addition to regular nursing care, continuous one-to-one emotional support provided by support personnel, such as a doula, is associated with improved outcomes for women in labor (Committee Opinion No. 766). The presence of doulas during the COVID-19 pandemic should be considered in the context of the institutional visitor policy. If doulas are considered by the facility to be health care personnel, they should adhere to infection prevention and control recommendations, including the correct and consistent use of proper personal protective equipment. If doulas are not designated as health care personnel by the facility, they would be considered visitors and included in that facility's visitor count for the patient.

Labor, delivery, and postpartum support may be especially important to improve outcomes for individuals from communities traditionally underserved or mistreated or harmed within the health care system. In considering visitation policies, institutions should be mindful of how restrictions might differentially and negatively affect these communities, which in many areas are also disproportionately affected by COVID-19.

Q: Should nitrous oxide continue to be used during labor?

Last updated April 20, 2020 at 4:00 p.m. EST.

There is currently insufficient information about the cleaning, filtering, and potential aerosolization when using nitrous oxide in labor analgesia systems in the setting of COVID-19. As such and considering the risk of viral shedding from asymptomatic individuals, individual labor and delivery units should consider suspending use of nitrous oxide during the COVID-19 pandemic.

Q: Should intrapartum oxygen continue to be used in the setting of COVID-19?

Last updated April 29, 2020 at 4:00 p.m. EST.

Oxygen should continue to be considered if maternal hypoxia is noted (Practice Bulletin 116). Based on limited data, high-flow oxygen use is not considered an aerosol-generating procedure (CDC). Still,

there is insufficient evidence about the cleaning and filtering when using oxygen. As such, facilities should consider suspending routine use of intrapartum oxygen for indications where benefits of use are not well-established (eg., category II and III fetal heart rate tracings).

Q: Should intrapartum fever be considered as a possible sign of COVID-19 infection?

Last updated April 29, 2020 at 4:00 p.m. EST.

Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Fever is the most commonly reported sign; most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (cough, difficulty breathing). However, other causes of intrapartum fever should not be overlooked.

Data regarding COVID-19 in pregnancy are limited; according to current information, presenting signs and symptoms are expected to be similar to those for non-pregnant patients, including the presence of fever.

Other considerations that may guide testing are epidemiologic factors such as the occurrence of local community transmission of COVID-19 infections. As part of evaluation, clinicians are strongly encouraged to test for other causes of respiratory illness and peripartum fever. For more information please see: Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19).

Postpartum Care

Q: Should expedited discharge be considered during the COVID-19 pandemic?

Last updated March 23, 2020 at 11:30 p.m. EST.

Yes. To limit the risk of inadvertent exposure and infection, it may be appropriate to expedite discharge when both the mother and the infant are healthy (Committee Opinion 726). For example, discharge may be considered after 1 day for women with uncomplicated vaginal births and after 2 days for women with cesarean births depending on their status. Early discharge will require discussion with the facility's pediatric care team and should be linked to home telehealth visits for the mother and infant.

Q: Are there additional components to postpartum care that should be considered?

Last updated March 23, 2020 at 11:30 p.m. EST.

Yes. It may be necessary to:

- Offer mental health or social work services or referrals to provide additional resources, particularly for patients who are experiencing anxiety regarding the COVID-19 pandemic or are at an increased risk of intimate partner violence (Committee Opinion 518).
- Offer modified postpartum counseling regarding:
  - Any potential changes to the length of hospital stay and postpartum care.
  - How to best communicate with their postpartum care team, especially in the case of an emergency.
  - When and how to contact their postpartum care clinician.
  - Any special considerations for infant feeding.
  - Checking with their pediatric clinician or family physician regarding newborn visits because pediatric clinicians or family physicians also may be altering their procedures and routine appointments (American Academy of Pediatrics).
  - Postpartum contraception. Ideally, all methods of contraception should be discussed in context of how provision of contraception may change within the limitations of decreased postpartum in-person visits.
  - Any potential changes to their postpartum care team and support system. Most patients will likely have had changes to expected care support resources at home (eg, family who can no longer travel, childcare providers who are no longer available). To the extent possible, patients should be connected to community support resources.

It should be noted that it may be necessary to provide these services or enhanced resources by phone or electronically where possible. If telehealth visits are anticipated, patients should be provided with any necessary equipment (eg, blood pressure cuffs) if available and as appropriate.

Q: Is it appropriate to modify postpartum care delivery approaches to decrease the risk of COVID-19 exposure?

Last updated March 23, 2020 at 11:30 p.m. EST.

As with prenatal care, yes (see **Is it appropriate to modify prenatal care delivery to decrease the risk of COVID-19 spread and exposure?** for important considerations). However, modifying or reducing care is only appropriate because the risk of inadvertent exposure from receiving or delivering care can be high at this time; normal care approaches and schedules should resume when this risk subsides. Plans for modified care are best made at the local level with consideration of patient populations and available resources. Some examples of approaches to modifying postpartum care that may be considered are listed below.

- Perform the initial three week (or sooner) assessment (Committee Opinion 736), wound checks, and blood pressure checks by phone or telehealth visits, if possible.
- Delay the comprehensive postpartum visit to 12 weeks, with the intention of seeing the patient for the comprehensive assessment in person and using telehealth visits as needed before 12 weeks. However, it should be noted that some patients may lose insurance before 12 weeks postpartum; in this case, the comprehensive postpartum visit should be prioritized and scheduled before the patient loses insurance and also can be completed by telehealth visit.

Q: How should newborn male circumcisions be managed during the COVID-19 pandemic?

Last updated April 29, 2020 at 4:00 p.m. EST.

If requested, well newborn male circumcision is considered indicated care (American Academy of Pediatrics). However, given the current demands on medical personnel, it may not always be possible to provide this service. Facilities are encouraged to consult with their obstetric, pediatric, and family medicine teams and temporarily modify their policies based on COVID-19 community spread, health care personnel availability, and access to readily available local resources.

Special Populations (NEW)

Q: Are there special considerations for incarcerated pregnant people?

Last updated April 29, 2020 at 4:00 p.m. EST.

Prisons, jails, and detention facilities are high-risk environments for COVID-19 transmission. For pregnant people who must remain in custody, prisons, jails, and detention facilities should implement measures for social distancing, hygiene, screening, testing, medical care, safe housing arrangements, and other interventions as outlined by the CDC's Interim Guidance on Management of COVID-19 in Correctional and Detention Facilities and as recommended by guidance from the National Commission on Correctional Health Care. As institutions of incarceration adapt operations in response to the pandemic, they must ensure that pregnant people continue to have access to comprehensive health care, including prenatal care, abortion, postpartum care and breastmilk expression, and timely assessment of pregnancy-related or COVID-19 symptoms, in accordance with ACOG guidance. Barriers to accessing care within institutions, such as co-pays for incarcerated individuals, should be removed.

If you have unanswered COVID-19 questions or comments, please send them to covid@acog.org.

COVID-19 FAQs

Clinical Information

Find related FAQs regarding Ethics, Telehealth, and Gynecology.

This document has been developed to respond to some of the questions facing clinicians providing care during the rapidly evolving COVID-19 situation. As the situation evolves, this document may be updated or supplemented to incorporate new data and relevant information.

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