AIMS For a better birth...

Coronavirus and your maternity care

This information was last updated on 6 April 2022. The links were checked at that time but webpages are sometimes moved. If a link appears to be broken please let us know by emailingenquiries@aims.org.uk. If it hasn't been removed, you should still be able to find the page by entering the title in your browser.

For information about what AIMS has been campaigning for during the pandemic please seehere.

Although most Government restrictions introduced to control the spread of Covid-19 have now been lifted, it is possible that maternity services will continue to take a more cautious approach. We hope this information helps you to navigate your care at this time.

We try to answer some common questions about the current guidance below, but different Trusts and Boards may be taking different approaches, so you will need to check with your midwife about what is happening locally. There should also be information on your NHS Trust or Boards's website or Facebook page.

If there is any other general information that you would like to see on this page please let us know by emailing enquiries@aims.org.uk .

Latest Guidance

Here is the latest information about the implications of coronavirus during pregnancy, and the guidance that has been given to the maternity services.

- Coronavirus (COVID-19), infection in pregnancy Version 15.0: updated Monday 07 March 2022 by The Royal College of Obstetricians (RCOG), Royal College of Midwives (RCM), Royal College of Paediatrics and Child Health, Royal college of Anaesthetists and the Obstetric Anaesthetists Association. This is the guidance for healthcare professionals.
- There is an accompanying set of Coronavirus (COVID-19), infection and pregnancy FAQs drawn from the clinical guidance, and intended for the general public.
- RCM and RCOG have jointly published Guidance-for-provision-of-midwife-led-settings-and-home-birth-in-the-evolving-coronavirus-covid-19-pandemic.pdf
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NHS England published a set of recommendations early in the pandemic"Clinical guide for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic" 9 April Version

- NHS England published new guidance for NHS Trusts in EnglandSupporting-pregnant-women-maternity-services-access-for-parents-of-babies-in-neonatal-units.pdf Version 1 on 1 April 2022. This is an update of their previous guidance published on 14 December 2020
- The Welsh Government's latest guidance Hospital visiting during the coronavirus outbreak: guidance was updated on 18 June 2021
- The Scottish Government's latest guidance was published on 13 May 2021 and sets out minimum standards for visiting in maternity and neonatal settings during the COVID-19 pandemic. The document states that "These are minimum standards and Boards should consider whether additional visitors can be enabled throughout care, subject to local context, risk assessment and individual patient needs."
- In Northern Ireland the Department of Health COVID-19: Regional Principles for Visiting in Care Settings in Northern Ireland including a 'Pathway to Enhanced Visiting' was last updated on 23 February 2022. The decision then was to remain in the "Gradual Easing" phase of this Pathway. The next review is due by the end of April 2022.
- The British Association of Perinatal Medice has produced a documentCOVID-19: Frequently asked questions within neonatal services (updated September 2021) which offers advice about the care of babies in different situations.

Who can I speak to if I am concerned about my health?

You should have a contact number to contact your midwife, but you can also contact one of the following depending where you live.

- in England you can use the the NHS111 online tool 111.nhs.uk/covid-19
- in Scotland, use this tool www.nhsinform.scot/self-help-guides/self-help-guide-coronavirus-covid-19
- in Wales, use this tool www.nhsdirect .wales.nhs.uk/SelfAssessments/symptomcheckers/?ScName=CoronaVirusCOVID19&SCTId=175
- in Northern Ireland, call 111.

AIMS Helpline

The AIMS Helpline volunteers have experienced an increased workload during the pandemic but continue to offer information and support to maternity service users. Please contact us by email helpline@aims.org.uk. We will respond to all enquiries as soon as we can.

The AIMS Helpline does not offer medical advice, but we can provide information and support to help you navigate the maternity system, to know your rights and to listen to your concerns. We will be regularly reviewing the issues brought to us on the Helpline, so we offer the best information and most effective support that we can.

What are the risks for me if I am pregnant?

According to the latest RCM/RCOG guidance pregnant women do not appear to be more likely to contract the infection than the rest of the population unless they are unvaccinated and also have pre-existing diabetes, gestational diabetes requiring insulin, or are overweight or obese. However, as the Omicron variant is spreading very rapidly it is likely that your chances of catching it during pregnancy will be higher than with the previous variants.

Of women who became infected with the earlier variants during pregnancy, the majority had no symptoms and most of the others experienced only mild or moderate cold or flu-like symptoms. A review summarising 70 studies from 25 countries (the PregCOV-19 Living Systematic Review) reported that 73% (almost three quarters) of pregnant women who were admitted to hospital for any reason and tested positive for COVID-19 had no symptoms, but much of this data comes from before the emergence of the later variants.

There is evidence that pregnant women infected with the wild-type, Alpha and Delta variants of COVID-19 were more at risk of severe illness and of being admitted to intensive care than those who were not pregnant (though it's possble that part of the difference in admissions may be because doctors are more cautious if someone is pregnant). We do not yet have the data to tell, but the Omicron variant may be associated with less severe disease. Severe illness appears to be more common with infections that occur in the third trimester.

This infographic shows the findings from the UK Obstetric Surveillance Survey (UKOSS), covering the period from 16th May 2021 to 31st October 2021 when the Delta variant accounted for most infections. Of the 1436 pregnant women admitted to hospital with symptoms during this time, 474 (33%) needed support to breathe, a similar number (32%) developed pneumonia, and 230 (16%) were admitted to intensive care.

It remains very rare for pregnant or postnatal women to die from COVID-19 though sadly it can happen. According to the RCOG/RCM guidance the UK maternal mortality rate from COVID-19 is 2.4/100 000

maternities.

COVID-19 infection is associated with a higher chance of giving birth prematurely (see also 'What are the risks for my baby?) with 19% of hospitalised mothers In the latest UKOSS study experiencing this. There is also a higher chance of having a caesarean (49% of those who had COVID-19 symptoms compared with 29% of a pre-COVID group). Both of these effects are, in the majority of cases, due to a decision to have the baby born early because of COVID-related concerns over the mother or baby's wellbeing.

The UKOSS study found that the main risk factors for being hospitalised with Covid-19 were being unvaccinated, being of a Black, Asian or minority ethnic background, having a body–mass index above 25 kg/m2 , having a pre-existing health condition such as diabeted or high blood pressure, being aged 35 years or older, living in increased socioeconomic deprivation, and working in healthcare or other public-facing occupations.

What are the risks for my baby?

The majority of babies born to mothers diagnosed with COVID-19 have been born healthy. So far the evidence is that a COVID-19 infection in early pregnancy does not seem to increase the risk of a birth defect or miscarriage.

Although it is possible for the virus to be transmitted to babies in the womb, theRCM/RCOG guidelines say evidence now suggests that it is uncommon. The risk of infection in the baby after birth appears to not be affected by whether the birth was vaginal or by caesarean, or by factors such as the timing of cord clamping, skin-to-skin contact, method of feeding or whether the mother and baby stay together. According to the Royal College of Paediatrics and Child Health "COVID-19 seems generally to be a fairly minor illness in young infants." However in the most recent period of theUKOSS study (16th May 2021 to 31st October 2021) sadly four babies in the UK died as a result of a COVID-19 infection after birth.

There is some evidence that COVID-19 infection is associated with an increased chance of a stillbirth, though the findings from different studies vary a lot and the actual numbers are small. Overall it looks as though the rate may be between 0.7% and 0.9% (seven to nine out of every 1000 births) for those with an infection compared to between 0.3% and 0.5% (three to five out of every 1000 births). However, the latest UKOSS survey found that of UK mothers who were ill enough to be hospitalised with a COVID-19 infection in the period when the Delta variant was dominant, 2% suffered a stillbirth. Having a severe COVID -19 infection may be associated with a slightly higher chance of having a very small baby, but the evidence on this is still unclear.

The greatest impact of COVID-19 on babies seems to arise not from any direct effect of the virus itself but because of births being deliberately brought forward due to concerns over mother or baby's well-being. This is leading to around two to three times more premature births in women with severe COVID-

19 symptoms compared to the normal rate and therefore to more babies being admitted to a neonatal uit and more experiencing the complications that can result from prematurity, such as breathing difficulties. Being born prematurely can also have long-term health consequences.

According to the most recent UKOSS study 19% of women admitted to hospital with COVID-19 symptoms gave birth before 37 weeks, compared with the usual figure of 7% of births in the UK being pre-term. There are similar findings from the British Pediatric Surveillance Unit which collected reports on all babies under 28 days old with a confirmed infection and receiving inpatient care, and all those babies born to mothers with a confirmed infection who were admitted to neonatal care, in the 13 months to September 2021. It looked at 111 babies of whom 11 (10%) were diagnosed with a COVID-19 infection. Most had no symptoms or were only mildly ill. Two-thirds of babies in the sample were born prematurely, almost three quarters of these deliberately so, and two thirds needed some kind of help with breathing. It appears that there is no increase in the risk of prematurity for babies of mothers who have tested positive but have no symptoms.

What about vaccinations?

Pregnant women have been classed as a 'vulnerable group' for whom vaccination is recommended. Guidance in the UK is for all pregnant women to be offered vaccination with the Pfizer-BioNTech or Moderna vaccines unless they have already had one dose of the Oxford-AstraZeneca vaccine, in which case their second dose should be the same. This is because most of the information on the safety of vaccines in pregnancy is from the USA, where these were the main vaccines used.

As with any medical treatment it is up to you whether you wish to accept the offer of vaccination. The previous sections 'What are the risks for me if I am pregnant?' and 'What are the risks for my baby?' explain what the latest research evidence shows about the risks of catching COVID-19 during pregnancy. For more about making decisions about vaccination see out webageVaccination During Pregnancy

The original clinical trials of the available vaccines did not include pregnant women, but there is now extensive real-world data . The RCM/RCOG guidance says that more than 347 150 women in the UK and USA have had a COVID-19 vaccine in pregnancy with "no concerning safety signals". A number of studies are now in progress to look at the safety and effectiveness of COVID-19 vaccines in pregnancy.

The real-world data has so far shown no signs of an increase in miscarriages, birth defects or any other pregnancy-related concerns after vaccination, and it appears that the level of minor side-effects is similar to that in the general population . The most common side-effects are soreness at the injection site, headache and fatigue, and studies so far have found that rates of these are similar for pregnant women, with perhaps fewer experiencing fever but more reporting nausea and vomiting after a second dose of the Pfizer-BioNTech or Moderna vaccines compared to non-pregnant women. The very rare risk of blood clots found with the Oxford-AstraZeneca vaccine has not been observed with the Pfizer-BioNTech or

Moderna vaccines.

In the UK, data published by the UK Health Security Agency (UKHSA) shows that for the 355 thousand women who gave birth between January and August 2021 there was "a similar very low risk of still birth, prematurity and low birth weight in vaccinated and unvaccinated women."

In the USA the Centers for Disease Control (CDC) has safety monitoring systems which have gathered information on over 212,000 pregnant women and people who have received vaccinations (mainly with the Pfizer-BioNTech and Moderna vaccines). Their website says that the preliminary analyses "did not identify any safety concerns for pregnant people who were vaccinated or for their babies. Additional follow-up is needed, particularly among those vaccinated in the first or second trimesters of pregnancy; however, these preliminary findings are reassuring."

If you are fully vaccinated and catch COVID-19 during your pregnancy, your chances of being hospitalised or admitted to intensive care appear to be greatly reduced. According to the RCM/RCOG guidance those who have had two doses and a booster (or three doses) of vaccine (combined data on Pfizer-BioNTech, Oxford-AstraZeneca and Moderna) are 88% less likely to be admitted to hospital with the Omicron variant than those who have not been vaccinated. 96% of pregnant women admitted to hospital with symptomatic COVID-19, and 98% of those admitted to intensive care, were unvaccinated.

Will I be able to have someone to support me during my maternity care?

The guidance on partners/supporters attending in-person antenatal appointments and scans, during labour and any postnatal stay is now different in the four nations of the UK. Please follow the links below to check details of the guidance for your country, but be aware that this may change at short notice. Trusts/Boards still have discretion about how far to implement the national guidance based on local risk assessments, and the position could change if there is a rise in cases either locally or nationally. Please check the current local rules, which should be available in your hospital's website.

AIMS hopes that all Trusts and Boards will at the very least to consider on a case-by-case basis requests for support beyond these minimum levels, which may be critical to some people's mental well-being or other needs e.g. due to disability or being non-English speakers. We know that some Trusts/Boards are being flexible about allowing a second birth partner at least for people with a particular need for extra support. If yours is limiting you to one birth partner you may want to challenge this, especially if there are exceptional circumstances which mean that you need more than one person for support. You may want to ask them to give you their justification for the decision.

AIMS has drafted a set of template letters which you can adapt to your own situation if you feel that your Trust/Board is not meeting your support needs.

In **England** the latest guidance from NHS England Supporting-pregnant-women-maternity-services-access-for-parents-of-babies-in-neonatal-units

asks "all trusts to continue enabling women to have asupport person of their choice at every point throughout their maternity journey." The guidance makes clear that "Within maternity and neonatal services, support people and parents of babies on neonatal units are not considered to be visitors and should not be treated as such." Therefore any visiting restrictions in force elsewhere in the hospital should not apply.

In line with changes to Government policy on testing, the guidance says that maternity settings should no longer expect evidence of a negative test before allowing supporters in. However, if a support person has received a positive test, or has symptoms of COVID-19, they should be advised not to attend. You may therefore want to identify an alternative support person in case your chosen supporter is affected.

The guidance also makes clear that if you personally have symptoms of Covid or have tested positive you should still be able to have a supporter with you.

There is no mention of second birth supporters, but it is worth noting that the guidance onInfection prevention and control for seasonal respiratory infections in health and care settingsnow recommends "that physical distancing should be at least 1 metre, increasing whenever feasible to 2 metres across all health and care settings" unless someone has a "suspected or confirmed respiratory infection." Since restrictions on second birth supporters were often explained by the need to maintain 2 metres' distancing this is something which those Trusts should be reviewing.

In **Scotland** the guidance sets out minimum standards for both for the situation in which there is "no current active outbreak on ward" or if there is "an active outbreak management scenario". However, "A birth partner supporting a women during hospital visits continues to be categorised as an essential visitor." This means that even during an active outbreak one birth supporter should be allowed to accompany you to the booking scan, 20 week scan and any emergency appointments "subject to local risk assessments and physical distancing." They should also be able to stay with you throughout induction, labour and birth (except during a general anaesthetic), and during any stay on the antenatal or postnatal ward, again "subject to risk assessments and physical distancing."

If there is no current active outbreak then an additional visitor/second birth partner should be allowed "subject to local risk assessments and physical distancing" and plans should also be in place "for return to person-centred visiting" during labour and in inpatient wards.

All visitors are asked to take a lateral flow test before attending, but staff won't be asked to check these.

In Wales the guidance makes recommendations for the support that should be available at four different "Risk Ratings": Very High, High, Medium and Low. It appears that these will be determined by a local risk assessment, so AIMS hopes that Boards and hospital managements will be transparent about both what their current Risk Rating is, and the basis on which the judgement has been made, as well as providing detailed information about any current restrictions.

We have attempted to summarise the guidance, but suggest you check the relevant document for the full

details.

Health Boards are encouraged "be innovative in the way that visiting access is enabled." In addition, they are told to give consideration to reasonable adjustments for those with specific needs leading them to require extra support, such as mental health issues, learning disabilities, communication needs and "Where the treatment/procedure is likely to cause the woman distress and the partner/nominated other can provide support." It may therefore be possible to negotiate for additional support if you can demonstrate a specific need.

If the Risk Rating is Very High the recommendation is for women to attend all appointments and scans alone and for no visiting in antenatal or postnatal in-patient settings. However they can be accompanied by"essential support assistants" (defined as someone required "for specific additional support eg a support worker, BSL or foreign language interpreter", but who could be a partner or family member in some circumstances.) In addition "One nominated adult may accompany the woman attending where she requires familiar support for consultations which may cause her distress." In active labour only either a birth partner or an 'essental support assistant' is allowed.

The rules are the same if the rating is High, except that a supporter can attend an early pregnancy assessment unit scan, early pregnancy dating scan and the 18-20 week anomaly scan, or visits to the Fetal Medicine Department.

If the Risk Rating is Medium, essential support assistants and/or up to one support partner are allowed for all antenatal appointments, and one supporter is allowed at the above list of scans, all subject to social distancing rules being possible. The limitation that a supporter is allowed in 'active' labour is not mentioned, so it seems they can be present from the time of admission "if national guidance on social distancing can be achieved in the local setting."

If the Risk Rating is Low, there should be a "phased reintroduction of usual visiting policies" if different to the medium risk level.

In Northern Ireland while in the Gradual Easing phase the maternity services should allow for a birth partner to "be facilitated to accompany the pregnant woman to any pregnancy related appointments and ultrasound scans with particular effort made to keep the environment COVID secure." A COVID-19 secure envirment is defined as: a social distance of 2 metres wherever possible, optimal hand hygiene and personal hygiene measures, good ventilation, use of PPE when required and all visitors to wear appropriate face coverings.

A chosen birth partner should also "be facilitated to accompany the pregnant woman for induction of labour, duration of labour and birth and, for up to three hours after the birth." Postnatally "One daily visit from one of two nominated individuals (from up to two households) can be permitted, with particular effort made to keep the environment COVID secure."

Will I be able to birth my baby at home?

The evidence about the safety of homebirth can be found in the "Your Choice - where to have your baby" leaflets for first time mothers and for those having a subsequent baby which your midwife should already have given you at antenatal appointment early in your pregnancy. You will also need to take into account any specific issues that might affect your birth, as well as the chance of catching Covid-19.

Article 8 of the Human Rights Act protects your right to birth where you choose. In normal circumstances if you made the decision to birth at home, you should be able to expect NHS care for the birth. However in the current circumstances there may be situations where this in not possible. This does not mean that you can be legally **required** to birth in hospital, but that you may not be guaranteed medical support if you decide to birth at home.

RCM/RCOG's Guidance for provision of midwife-led settings and home-birth in the evolving coronavirus pandemic recognises that "Continuation of as near normal care for women should be supported, as it is recognised to prevent poor outcomes." It also says that "The positive impact of midwife-led birth settings is well documented, including reductions in the need for a range of medical interventions. These positive impacts remain of significant importance to prevent avoidable harm, and availability of midwife-led care settings for birth should therefore be continued as far as is possible during the pandemic." The guidance notes that "Emerging evidence from European settings supports continuing to strengthen community services in order to enable social distancing and minimise spread in healthcare settings."

Although many NHS Trusts/Boards have reinstated support for home births, there may still be restrictions in some areas, often justified as being due to local staffing shortages.

This article Homebirthing in the United Kingdom during COVID-19 includes a discussion of the legal position and states that "we argue that it is illogical to assert that the blanket removal of homebirthing service meets the test of 'necessity' when two-thirds of Trusts have continued to offer some form of homebirth service throughout the pandemic. The blanket removal of homebirthing services is neither necessary nor proportionate, therefore these policies amount to a violation of the Article 8 rights of birthing people."

In fact, the RCM/RCOG guidance recommends that Trusts take a phased approach based on levels of midwifery shortage and how the ambulance service is running. They indicate that if the midwifery shortage is under 20% and the ambulance service is running as usual, all places of birth should continue to be available. The calculation of available midwifery resources should include " additional midwives from the NMC emergency register, independent midwives, those previously in non-clinical roles or year-3 student midwives."

Before moving to restrict homebirths this guidance says that Trusts should consider adapting the usual policy of having two midwives at a homebirth "to include senior student midwives, returning registered

non-clinical midwives, returning recently retired midwives or appropriately prepared maternity support workers to attend as the second member of the team for low-risk home births." They should also consider a combined rota for community midwives and those at freestanding birth centres "so as to maximise the spread of resources and maintain the full range of maternity settings for as long as sustainable staffing allows."

Even with a midwifery shortage of over 30% and/or ambulance service experiencing severe delays either an alongside midwife-led unit or allocated midwife-led rooms on obstetric units should still be available, if Trusts feel unable to offer support for homebirths.

Trusts should review the constraints on a daily basis and follow a corresponding 'de-escalation plan', reinstating services as midwifery shortages reduce.

If you are planning a homebirth, you will need to check the situation in your local area, and be aware that this can change at short notice. You may want to check whether your Trust has followed the escalation/de-escalation plan which RCM/RCOG recommend, and the current state of midwifery staffing levels and ambulance services.

If your local Trust is one of those that has said that they will not support homebirths, you could try writing to your local Head/Director of Midwifery asking them to consider the solutions adopted elsewhere to enable support to be provided for homebirths. AIMS has drafted a template letter which you may like to adapt to your own situation. You can find it here www.aims.org.uk/information/item/booking-a-home-birth.

In some areas, Trusts/Boards are asking people to sign a "Homebirth Contract" before they will agree to provide midwifery support. The article by Romanis and Nelson states "These documents do not carry any legal weight when it comes to decisions during birth – the fact that a pregnant person preparing to birth has signed cannot compel them to have any intervention during their birth, such as transfer to hospital, to which they do not consent."

You may also want to find out whether you could go to a birth centre or a midwife-led room in the hospital instead, as in line with the RCM/RCOG guidance at least one of these should be an option. Another option for some families could be to hire an independent midwife. Independent midwives work separately to the NHS and so can offer support for a homebirth even when the NHS will not, or there is a threat of withdrawal. Some Independent Midwives can be found on the IMUK website but not all midwives are part of IMUK so try social media, word of mouth and search online.

If neither of these is an option for you, and your Trust continues to decline support for a homebirth, you will need to decide whether to go to hospital or birth at home without medical support. If you are considering remaining at home for the birth even if a midwife may not be available please see the section "Can I birth at home without a midwife?" below.

Will I be able to go to a birth centre?

See "What are my birth choices if I have tested positive or have symptoms of coronavirus?"for how this might affect your ability to access a birth centre.

You should have already been given information about birth outside an obstetric unit, but you can also find it here: "Your Choice - where to have your baby" leaflet forfirst time mothers and for those having a subsequent baby. Your midwives should be able to answer any questions that you have. You will also need to take into account any specific issues that might affect your birth, as well as the chance of catching Covid-19.

Please see the section "Will I be able to have my baby at home?" for details of guidance from RCM/RCOG on maintaining midwife-led care settings for birth, depending on the levels of midwifery shortage and how the ambulance service is running. If there are problems with these, the guidelines say that Alongside Midwifery units (AMUs) may be prioritised over Freestanding Midwifery units (FMUs) where a Trust has both. If a Trust decides that it needs to close an FMU, then an AMU should still be available. If there is no AMU then they should arrange for "allocated midwife-led rooms on obstetric units".

Can I birth at home without a midwife?

We are receiving increasing numbers of contacts from women who tell us that they are now considering remaining at home to give birth even though a midwife may not be available to come out to them. A planned birth without the presence of a health professional is known as a**freebirth**. It is your right to birth without a midwife or doctor present.

We would hope that if you are planning a homebirth and want a midwife present you will not be forced into a choice between leaving home to birth elsewhere or having to birth without that support, but in the current situation we know this is happening. If you are in this position you will need to weigh up the risks and benefits of remaining at home without medical support compared to going into hospital.

Guidance from the RCM suggests that maternity services should seek to build a dialogue with women considering a freebirth. This should include a chance to "share what is important to her in relation to her psychological and physical safety", time to "explore why she wants to have an unassisted birth" and the offer of support for previous birth trauma. AIMS hopes that this means that midwives will listen to such women with empathy.

It is important for midwives to give objective, factual evidence about the risks of all of a mother's birthplace options in order to enable her to make an informed decision. However, mothers have the right to decline further discussion for any reason, including if they feel that they are being subjected to unwanted repetition of the risks of freebirth.

The RCM guidance suggests asking the woman “what plan for the birth would feel safe and acceptable to her” and that “The senior midwifery management team should then assess what individualised, flexibility of service provision might be possible to avoid an unassisted birth as far as possible.” AIMS hopes that this would include the option of providing support for a homebirth if this is the only way in which a woman can feel safe and/or able to protect her mental well-being.

It is not acceptable, and could be illegal, for anyone to coerce you, or threaten to refer you to Child Services if you decide to remain at home to birth your baby unattended by a midwife. Anyone who tries to do so should be reminded that this is not a valid reason for referral and that it goes against the code of practice for both doctors and midwives, and could lead to a complaint not only to their employer, but to the General Medical Council (GMC) or Nursing and Midwifery Council (NMC). The RCM guidance reminds midwives that “It is not illegal for a woman to give birth unattended by a midwife or healthcare professional” and that “It is not appropriate for healthcare professionals to refer a woman to social services with concerns about the unborn baby, solely on the basis that she has declined medical support, as she is legally entitled to do."

If you are considering a freebirth we would suggest gathering as much information and emotional and practical support as possible in order to prepare for a birth without a doctor or midwife present. There is more information about Freebirth on the following AIMS Birth information pageFreebirth, Unassisted Childbirth and Unassisted Pregnancy which addresses rights and other things you need to know and where you can find support.

What are my birth choices if I tested positive or have symptoms of COVID-19?

The RCM/RCOG guidelines say that **if you have tested positive at the time or within 10 days before going into labour, but have no symptoms** and wish to give birth at home or in a birth centre it is recommended that you "should have an informed discussion around place of birth with {your} clinician." Note, however, that the decision whether to birth at home is yours - you do not need 'permission' to do this.

Offering continuous monitoring of your baby's heartrate "is not recommended" just because of a positive test though you should be offered a discussion of monitoring options (see our Birth Information page "Monitoring your baby's heartbeat during labour".) This is because there is no evidence that an infection without symptoms puts your baby at any increased risk of problems during labour. Consequently, you should not be denied access to a birth centre on the grounds that you need continuous monitoring if you would decline this anyway.

After the birth you should as normal be offered delayed cord clamping (waiting for the blood from the cord to finish passing to your baby before it is clamped and cut) and immediate skin-to-skin contact with

your baby. There is no evidence that these practices increase the risk of a baby becoming infected.

If you have **mild COVID-19 symptoms** the guidelines say you should be encouraged to remain at home (self-isolating) in early labour, and if you do go to the maternity unit in early labour but all is well with you and your baby you should be encouraged to go home again until your labour is more established (assuming you have your own transport to do so). The guidelines recommend that if you have symptoms you should give birth in a hospital obstetric unit rather than at home or in a birth centre because "there may be an increased risk" of a baby becoming distressed in active labour (though they don't say how great the risk is) and because women with COVID symptoms are more likely to have a caesarean. You still have the right to birth at home if you choose.

The guidelines also say you should be offered continuous monitoring of your baby's heartrate, because "While further data is required in women with symptomatic confirmed or suspected COVID-19, it appears prudent to use" it. In other words, there isn't any evidence to say whether continuous monitoring helps in this situation, but the guideline authors feel it's better to be on the safe side. You have the right to decline continuous monitoring if you do not want it.

There is no evidence to favour either a caesarean or a vaginal birth for people with COVID-19, unless their condition is worsening and they need urgent treatment and you should be free to choose which you want to plan for. You might be recommended to have an epidural put in during early labour, so that if you were to need a caesarean very urgently you would not need to be put under a general anaesthetic. However this is just being recommended as a precaution. So far there is no evidence to show whether women with suspected/confirmed COVID-19 are significantly more likely to need a very urgent caesarean where there would not be enough time to set up an epidural or spinal block. It is up to you whether you want to have an epidural for this reason, if you were not otherwise intending to use it to manage your labour, and your doctor or midwife should discuss the benefits and risks so that you can make an informed decision.

The guideline admits that there is no evidence on which to base recommendations about your care if you have recovered from COVID-19, so the following are "based on expert consensus" - which means what those writing the guideline thought made sense.

If you have recovered from COVID-19 but did not need to be admitted to hospital with it, "there should be no change to planned care during labour and birth."

If you were admitted to hospital with severe COVID-19 and have recovered "healthcare professionals should discuss and plan place of birth with the woman" taking into consideration your baby's growth and your choices. This does not affect your right to choose a homebirth, and if all is now well with you and your baby there would appear to be no reason for you not to go to a birth centre.

Will I be able to have a waterbirth?

The availability of birth-pools varies. In some NHS Trusts there are one or more pool rooms within the main hospital obstetric unit, but in others they are only available in midwife-led units (birth centres). In that case, if the midwife-led units have been suspended, then there probably won't be a birth-pool available unless the Trust has, for example, installed a portable birth-pool in the obstetric unit. Unfortunately, you do not have a right to insist on a water-birth so you may need to negotiate for this. If homebirth is an option for you then you can hire your own birth-pool.

The RCM/RCOG guidance guidance recognises that labour and birth in water "may confer benefits" and makes it clear that those who have **no symptoms or who have tested negative** for COVID-19 should be able to use a birth-pool "providing adequate PPE can be worn by those providing care."

The guidelines note that for those who have **tested positive but have no symptoms** there is a lack of evidence to show whether the virus can be transmitted in water, so they make no recommendation for or against the use of birthpools in this case. In fact, while there is evidence that coronavirus may be present in faeces (poo) there is no direct evidence that it can be caught from a birthpool, so there seems no good reason to prevent someone without symptoms from using one, even if they have tested positive. However, hospitals may decide against it in order to protect staff.

The guidelines note that it is not usually recommended for those with **fever** to labour in water, and that those with **symptoms** such as coughing or breathing difficulties, or who feel unwell, need careful monitoring so their care is better managed on land.

This briefing from the Royal College of Midwives (RCM) concludes that "The current evidence does not suggest that there should be a blanket cessation on the use of water in labour or waterbirth for all women." It does go on to say that "Individualised risk assessment about the appropriateness of providing labour or birth care in the pool room should be undertaken for each woman by the midwifery team providing care, based on the woman's individual presentation and the pool environment within the labour setting." This would still allow a Trust to say that their pool room is not suitable.

A paper from Oxford Brookes University water immersion during labour and waterbirth - COVID-19 context makes the case for waterbirth being a potentially safer option for women who do not have suspected or confirmed symptoms of COVID-19 "because it promotes the use of social distancing without interrupting normal midwifery care" and that the water should dilute any potential contamination from respiratory droplets or faeces.

Will I still be offered an induction or planned caesarean?

The RCM/RCOG guidelines suggest having a discussion with your doctor about the timing and mode of birth but it is (as always) up to you whether to accept an offer of induction or a caesarean, and you should also be able to request a caesarean if that is what you want and it is not being offered.

If you are self-isolating because you or someone in your household has suspected COVID-19 they

suggest a"personalised assessment should take place" to decide whether it is better overall to delay a planned caesarean or induction. This should include consideration of how urgent it is for your baby to be born, and the risks of infection to others and to your baby after birth. You can ask for a second opinion if you are unhappy with the decision.

Can my baby stay with me after birth if I have suspected or confirmed COVID-19?

There is little evidence about the risk of a baby catching COVID-19 from an infected mother but according to Advice from the British Association of Perinatal Medicine (BAPM) "it now appears unlikely" that a baby will become infected around the time of birth "if correct hygiene precautions are undertaken." The recommended approach differs according to whether the baby is well at birth, or needs to spend time in a neonatal unit.

The RCM/RCOG guidance says that, as long as your baby is healthy they should remain with you and you should be supported to breastfeed and to practice skin-to-skin/kangaroo care if you wish, even if you have a suspected or confirmed COVID-19 infection. However, if your baby needs to be cared for in a neonatal unit then you will probably not be admitted to the unit, in order to protect the other babies and adults in there, except in some specific circumstances. The guidance confirms that parents should still be involved in decisions about their baby's care and that those who wish to breastfeed should be supported to do so. (See "Will I be able to be with my baby if s/he is being cared for in a neonatal unit (NNU)?" for more about this situation.)

Will I be able to be with my baby if s/he is being cared for in a neonatal unit (NNU)?

Advice from the British Association of Perinatal Medicine (BAPM) makes it clear that there should be no restriction on parents being with their baby in a neonatal unit unless they have tested positive or are required to self-isolate. They state that "it is essential that the mother and her partner are never considered to be visitors within the neonatal unit – they are partners in their baby's care, and their presence should be encouraged." NNUs are advised to identify how to admit parents safely at all times of day, including during ward rounds, so that they can be properly involved in discussions of their baby's care. It notes that "The benefits of extended parental contact, including skin to skin care and active involvement in their baby's care are well documented, as are the long established advantages of breast feeding. At such a stressful time it is important for both parents to be able to be present together, at least for part of the day, unless such practice would be clearly detrimental to other babies and/or staff in the NNU or TCU." BAPM also encourages hospitals to offer testing to parents on the same basis as to staff, in order to minimise unnecessary separation from their baby.

Most Trusts/Boards appear to be allowing both parents to visit together, for all or a large part of the day,

but some still have restrictions e.g. only allowing one parent to visit at a time, or limiting visiting to daytime. AIMS has a template letter which parents can use to request access to a baby in a neonatal unit, if this is being restricted without good reason.

BAPM recognises that "It would generally not be appropriate" for parents who have tested positive or are self-isolating to visit a neonatal unit but every effort should be made to facilitate remote contact by use of video technology and/or social media. If a baby is critically ill or receiving palliative or end-of-life care then "everything possible should be done to achieve parental presence and participation in cares" even if the parents have tested positive.

If parents are not able to visit their baby, it remains their right to receive information and be supported to make decisions about their baby's care, and mothers should be supported to express breastmilk if they wish (see "Can I breastfeed my baby if I have suspected or confirmed COVID-19?")

All four nations of the UK have issued their own , which in most cases is in line with the BAPM advice.

In **England** the latest guidance from NHS England Supporting-pregnant-women-maternity-services-access-for-parents-of-babies-in-neonatal-units asks "all trusts to continue enabling parents of babies on neonatal units having access to their babies." The guidance makes clear that "Within maternity and neonatal services, support people and parents of babies on neonatal units are not considered to be visitors and should not be treated as such." Therefore any visiting restrictions in force elsewhere in the hospital should not apply.

The guidance advises that parents should not attend neonatal units if they are symptomatic of COVID-19, but should be offered video access to their baby.

Welsh Government guidance is for "Up to two parents, guardians, or carers at the bedside at a time for paediatric inpatients and neonates subject to local determination, and following a risk assessment including the ability to maintain social distancing."

In **Scotland** the guidance sets out minimum standards for both for the situation in which there is "no current active outbreak on ward" or if there is "an active outbreak management scenario". In all cases "Parents/primary care givers are partners in neonatal care, and as such should never be considered as visitors to neonatal units and are also considered essential." If there is a current outbreak, both parents should still be able to visit "Both parents subject to local risk assessments and physical distancing." If there is no current outbreak then an additional visitor may be allowed "subject to local risk assessments and physical distancing" and for long-stay patients, siblings are permitted to visit, subject to local risk assessment.

In Northern Ireland the guidance states that in the current 'Gradual Easing' phase any child admitted to a neonatal unit "can be accompanied by two persons (either/both parents or two nominated caregivers from up to two households) at all times for the duration of the stay."

Can I breastfeed my baby if I have suspected or confirmed COVID-19?

The best way to protect your baby from infection is to breastfeed and maintain close contact/skin to skin contact with your baby even if you are ill. You may choose to wear a mask when you are in close contact with your baby, or when you are feeding them.

The latest Advice from the British Association of Perinatal Medicine (BAPM) confirms that even a woman with a suspected or confirmed COVID-19 infection should be enabled to have skin-to-skin contact and breastfeed her baby if that is her choice and the baby is well. They say " To date viral RNA has been reported only very rarely in fresh breast milk of COVID-19 confirmed mothers" and so, though the sample is small, the current advice for "well babies of COVID-19 suspected or confirmed mothers is that the benefits of breast feeding outweigh any theoretical risks."

For a baby being cared for in a neonatal unit (NNU) it suggests that carers and parents should discuss the pros and cons of a mother with a suspected or confirmed infection expressing breastmilk for her baby, taking into account the baby's age and state of health, and whether donor breastmilk is available as an alternative. However, it would be the mother's right to provide expressed breastmilk if she wishes, and the RCM/RCOG guidance says that if you are unwell or otherwise unable to breastfeed your baby directly, you should be supported to express your breastmilk, or be offered donor milk for your baby.

If your baby is receiving donor breastmilk, you may wish to continue expressing and discarding your own milk until you are no longer infectious, in order to maintain your supply.

The following breastfeeding helplines offer information and support:

- **National Breastfeeding Helpline:** 0300 100 0212
  www.nationalbreastfeedinghelpline.org.uk
- NCT Helpline: 0300 330 0700 (Choose option 1 for NCT infant feeding line)
- La Leche League GB Helpline: 0345 120 2918
- Association of Breastfeeding Mothers: 0300 330 5453

Breastfeeding Support organisations

- www.laleche.org.uk/get-support
- abm.me.uk
- www.nct.org.uk/parenting/feeding
- www.breastfeedingnetwork.org.uk
- www.lcgb.org

What if you are giving your baby formula?

If you are formula feeding your baby it is even more important than usual to make sure you are carefully

sterilising all the equipment you use and minimising the number of people who hold and feed the baby.

Many parents worry about their baby not taking the recommended amount of milk, and during this time where they may be a lack of support you may be concerned about this. In which case you may find the 'Paced Bottle-Feeding' method may be useful and information can be found here https://feedsleepbond.com/lactation-consultants-guide-bottle-feeding