AIMS For a better birth...

Coronavirus and your maternity care

This information was last updated on 18 May 2020, and we will keep it under review as the situation develops. For information about what AIMS is doing to campaign for what women are telling us they want please see here.

We appreciate that it is going to be very stressful to be pregnant or a new mother at this time. It can help to be as clear as possible on ways to keep yourself and your family as safe as possible.

Latest Guidance

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

- Public Health England's guidance on social distancing: www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults
- "Coronavirus (COVID-19) infection in pregnancy version 9" published 13 May by The Royal College of Obstetricians (RCOG), Royal College of Midwives (RCM), Royal College of Paediatrics and Child Health, Public Health England and Health Protection Scotland. This is the guidance for healthcare professionals.
- There is an accompanying Q and A Factsheet for pregnant women and their families drawn from the above guidance
- The RCM website has Advice for pregnant women
- The NHS has published a set of recommendations "Clinical guide for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic" 9 April Version 1
- RCM and RCOG have jointly published "Guidance for provision of midwife-led settings and home birth in the evolving coronavirus (COVID-19) pandemic" Version 1.1 published 17 April
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RCM and RCOG have jointly published "Guidance for antenatal and postnatal services in the evolving coronavirus (COVID-19) pandemic" Version 1.2 published 24 April

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 maternity services are under huge stress with the Covid-19 pandemic. This is causing women to be given mixed messages about the services available, with different NHS Trusts making different decisions. The AIMS Helpline volunteers are working as normal to offer support to maternity service users. Please contact us by email helpline@aims.org.uk or by phone on 0300 365 0663.

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.

AIMS is receiving question from women about a variety of concerns and we try to answer some of those below. Different Trusts seem to be adopting different strategies, so you will need to check with your midwife about what is happening locally. There may also be information on your NHS Trust's website or Facebook page.

What are the risks for me if I am pregnant?

According to the latest RCOG guidance it is still expected that most pregnant women with a COVID-19 infection will only experience mild or moderate cold/flu like symptoms. Because many questions remain it is considered 'prudent' for pregnant women to observe strict social distancing, especially from 28 weeks of pregnancy.

There has been a concern that changes to the immune system which happen during pregnancy mean that in theory pregnant women could be more likely that other healthy women to be seriously affected by

COVID-19, but there is no evidence that this is happening. In fact the evidence so far suggests that pregnancy does not increase the risk of either catching or dying from coronavirus. A UK study (Docherty 2020) which looked at 16,749 people hospitalised with COVID-19 found that the percentage of pregnant women (6%) was no greater than in the general population, and that pregnant women did not have a higher risk of dying from the infection.

Another large study (the UKOSS study) is currently in progress in the UK and so far has collected data on 427 pregnant women admitted to hospital with a confirmed coronavirus infection between 1 March and 14 April 2020. This corresponds to 4.9 out of every 1000 pregnancies. Of those admitted to hospital 9% required admission to intensive care and 1.2% died, so only 5.6 out of every 100,000 women who were pregnant during the study period seems to have died of COVID-19

However, the study found that (in common with what seems to be the case for the general population) pregnant women admitted to hospital with COVID-19 are more likely to be of black, asian or minority ethnic heritage

What are the risks for my baby?

The RCOG guidance reports that so far there is no evidence of an increase in the risk of miscarriage or a birth defect if a mother has the disease.

There is some evidence which suggests that it 'probable' that the virus can be transmitted to babies in the womb but we don't yet know how commonly that happens or what effect this has on the baby if it occurs. There have been a couple of cases in China where newborn babies of infected mothers were found to have coronavirus antibodies in their blood at birth, although the babies showed no symptoms of the disease. A recent report from China Zeng et al March 2020 reviewed 33 babies born by caesarean to mothers in Wuhan who had COVID-19. Three of the babies (9%) tested positive for coronavirus after showing symptoms, but all made a full recovery. They were not tested until day 2 so we cannot be sure whether they were infected in the womb or after birth. Other studies have found no evidence of coronavirus in the cord blood, amniotic fluid or genital secretions of infected mothers. TheUK Obstetric Surveillance System (UKOSS) survey now underway found that between 1 March and 14 April out of 247 babies born to mothers who had been hospitalised with COVID-19 only 12 (5%) tested positive for coronavirus, and only one required admission to a neonatal unit.

On the evidence so far it seems that vertical transmission (infection in the womb) can occur but if so most babies are unaffected and any infection is likely to be mild.

Will I be able to have someone with me at my antenatal appointments?

Most Trusts are requiring women to attend antenatal appointments on their own to reduce the risk of

transmission of coronavirus. The latest guidance from RCM/RCOG suggests "A minimum of six face-to-face (physical) antenatal consultations" but that maternity services should " aim to maximise the use of remote means to provide additional antenatal consultations. Remote consulting enables greater compliance with social distancing measures recommended for pregnant women and maternity staff, while enabling a pregnant woman to have a partner, family member or friend join the appointment for support." It also suggests "Home visits may be preferable, provided the woman and everyone in her household is well." You might want to ask whether your Trust is arranging telephone or video consultations for some routine appointments, and whether it has considered offering home visits for those where you need to physically see a midwife.

You could also ask whether for appointments you attend you could have a video call in progress with your partner or other supporter using your own smartphone or tablet, so that at least they can hear and take part in any discussions.

Will I be able to have my Birth Partner(s) with me when my baby is born?

We are aware that some hospitals are restricting the number of people who can accompany you in labour because of concern over transmission of coronavirus, insisting that a birth partner must be someone from the woman's household or even preventing women from having a birth supporter at all.

The latest guidance from RCM/RCOG says " Women should be **permitted and encouraged to have a birth partner present** with them in their labour and during birth. Having a trusted birth partner present throughout labour is known to make a significant difference to the safety and well-being of women in childbirth. A single, asymptomatic birth partner should be permitted to stay with the woman, at a minimum, through pregnancy and birth, unless the birth occurs under general anaesthetic. Additional restrictions, such as limiting the number of birth partners to one, restricting any visitors to antenatal or postnatal wards, and preventing swapping and postnatal visitors, should follow hospital policy." The latest version of the Q&A for pregnant women and their families says that if a woman's intended birth partner is unwell they should not attend and "To prepare for this, women and their current birth partner are being encouraged to think about an alternative birth partner, if required.**This person does not need to be from the same household as you**."

Similarly, the NHS guidance to Trusts says "While it may be necessary to restrict numbers for reasons of infection control, women should have access to one birth partner during labour (from the point of admission to labour ward or birth centre) and birth in line with World Health Organization advice. The birth partner will often be able to support midwives in caring for the woman and her baby, as well as being important for the wellbeing of the woman in labour. Birth partners must be asymptomatic; if they are not, the woman must be asked to nominate another person."

AIMS believes that this means that where a woman does not have a suitable and asymptomatic birth

partner who shares her home, she should be able to choose another trusted person as her birth partner. We have suggested that the NHS guidance should be amended to clarify this. We would also like the guidance to encourage Trusts to consider on a case-by-case basis requests for a second birth partner, which may be critical to some women's mental well-being or other needs e.g. due to disability or being non-English speakers.

Birth partners won't be admitted if they have had symptoms within the last seven days which suggest COVID-19, so you may want to have someone else on stand-by to support you. One option for this would be to employ a doula (paid birth supporter). You can find out more about this and look for doulas in your area on the website of Doula UK. Not all doulas are members of this organisation, so try social media, word of mouth and search online as well.

Even for women with suspected or confirmed COVID-19, the RCM/RCOG guidance is that "Asymptomatic birth partners should be asked to wash their hands frequently. If symptomatic, birth partners should remain in self-isolation and not attend the unit. Women should be advised when making plans about birth to identify potential alternative birth partners, should the need arise." The guidance seems clear that even women with a suspected or confirmed infection should be allowed a birth partner.

Birthrights have expressed the view in their statement www.birthrights.org.uk/2020/03/12/coronovirus-how-will-it-affect-my-rights-to-maternity-care/that "Trusts that restrict a woman's right to choose who will be present at her birth, for example by restricting birth partners to one, will need to be very clear that this response is proportionate to the additional threat of infection, and be prepared to look at exceptions on an individual basis. Birthrights does not believe that banning all birth partners can be justified as a proportionate response to the current pandemic."

If your Trust is refusing to permit any birth companions you may want to challenge this and refer them to the NHS and RCM/RCOG guidelines.

If your hospital Trust is restricting people to one birth companion, you could try 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.

Birth partners may wish to discuss whether they should be wearing personal protective equipment (PPE) such as gloves and masks, in order to help to reduce potential transmission of Covid-19 between them and the medical staff.

Can I have a birth partner with me for an induction or caesarean?

The guidance from NHS says "women should have access to one birth partner during labour (from the point of admission to labour ward or birth centre) and birth" and the RCM/RCOG information for pregnant women says "A birth partner without symptoms should be able to attend your induction of

labour where that is in a single room (e.g. on the Labour Ward) but not if the induction takes place in a bay on a main ward, as it would not be possible to achieve the necessary social distancing measures. Please be assured that if your partner is unable to be with you on a ward during your induction, this will not impact on your birth partner's presence during labour and the birth, unless they are unwell. At the point you go into active labour, you will be moved to your own room and your birth partner will be able to join you."

This guidance makes it acceptable for hospitals to restrict access for a birthing partner until women are on the labour ward. You may therefore not be able to have a birth partner with you in the early stages of induction, if this is being done in a ward shared with other women. AIMS has suggested that the guidance should encourage local Trusts to explore options to enable birth partners to be present throughout an induction. It may be worth asking whether your hospital has facilities for you to be in a separate room from the start of the induction, especially if your circumstances mean that you have a particular need to have the support of a birth partner throughout.

Some doulas are offering virtual support for women in early labour, including the early stages of an induction. You may be able to find someone offering this service heredoula.org.uk/find-a-doula but not all doulas are members of this organisation, so try social media, word of mouth and search online as well.

RCM/RCOG have also suggested that hospitals "improve outpatient provision of induction of labour, depending on availability of transport to hospital." They haven't explained what this means, but it's probably about encouraging women in the early stages of an induction to go home once a slow-release pessary has been inserted. They would then return to hospital 24 hours later, or sooner if labour has started. If you are planning an induction you may want to ask your midwife or doctor about doing this.

If you are having a caesarean, unless this is being done under general anaesthetic, the RCM/RCOG information says "everything will be done by the clinical staff – midwives, obstetricians and anaesthetists – to keep your birth partner with you" but "there will be some occasions when there is a need for an urgent emergency birth with epidural or spinal anaesthetic, and it is not possible for your partner to be present. " However "your maternity team will explain this to you and will do everything they can to ensure that your partner can see you and your baby as soon as possible after the birth." This is a clear expectation that staff should be enabling birth partners to be present during a caesarean unless it really is an emergency.

Will I be able to have my baby at home?

Many women are asking about whether they and their babies would be safer if they stayed at home for the birth. 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 (COVID-19) 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."

Many Trusts seem to be justifying withdrawing support for all home-births on the grounds that they have insufficient midwifery staff and/or that local ambulance services cannot guarantee timely transfer in the event of an emergency. However, many others have put arrangements in place to ensure that women wishing to have a homebirth can be supported to do so.

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. 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.

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 theIMUK 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?

Many women feel that this would be the option they would prefer because they feel it would be safer for them, their baby and their family. 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 new 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".

Confusingly, Trusts around the country seem to be taking different approaches to the use of birth centres. We are aware that in some areas efforts are being made to support more birth centre births, as this may help to reduce the transmission of coronavirus and relieve pressure on staff in the obstetric unit. You may even find that you are encouraged to consider this option even if you were previously planning to have your baby in hospital. In other areas, birth centres are being closed for birth, in order to concentrate staff in the obstetric unit or so they can be used for providing other care. If this is the case in your area and you had planned to birth there, you may want to discuss the option of a homebirth.

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 women who are planning a homebirth and want a midwife present will not be forced into a choice between leaving their 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.

Recent 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.

Will I be able to use Gas & Air during my birth?

AIMS has heard that some women have been told that they will not or may not be able to use Gas and Air (Entonox) during their birth because of a concern about transmission of Coronavirus. However, the latest RCOG guidance (www.rcog.org.uk/globalassets/documents/guidelines/2020-03-28-covid19-pregnancy-guidance.pdf) states "There is no evidence that the use of Entonox is an aerosol-generating procedure. Entonox should be used with a single-patient microbiological filter. This is standard issue throughout maternity units in the UK ". RCOG's information for women says "there is no reason you cannot use this in labour." This means you should not be denied access to Gas and Air because of concerns about you contracting Coronavirus or because you might pass it on to others.

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.

If homebirth is an option for you then you can hire your own birth-pool.

Some Trusts have decided to suspend the use of birth-pools even though these are available in an obstetric unit and/or in a midwife-led unit which remains open. The justification for this is concern over the transmission of coronavirus to babies or staff, as the virus has been detected in the faeces of some COVID-19 patients.

Because of this possibility, the RCM/RCOG guidance says that for women with **suspected or confirmed COVID-19** the use of birth-pools should be avoided. However, the authors of the study (Barth 2020) point out that their test is unable to tell the difference between active virus and "non-viable, and therefore non-infectious, viral material" so it seems that the guidance is erring on the side of caution and there isn't any real evidence to show whether waterbirth increases the risk of infection if a woman has COVID-19 symptoms.

There seems to be no good reason for denying the use of a birth-pool to a mother who does**not** have any symptoms of COVID-19. Unfortunately, you do not have a right to insist on a water-birth so would need to try to negotiate for this. The following documents may help you to make the case.

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 Bookes 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?

RCOG has suggested that Trusts should identify areas where services could be 'rationalised' giving as an example "reducing induction of labour for indications where this is not 'medically indicated'." This means that you may not be offered an induction if your doctor thinks the risk of continuing your pregnancy is low. You should be able to discuss this with your doctor, and if you are not happy with the recommendation you can ask for a second opinion. Although they do not mention it, it's possible that some hospitals will also try to reduce or delay planned caesareans.

For women with suspected or confirmed COVID-19 he RCOG guidance is that "an individual assessment should be made to determine whether it is safe to delay" a planned caesarean or induction. Again, you can ask for a second opinion if you are unhappy with the decision.

What are my options if I have a suspected or confirmed COVID-19 infection?

The latest RCOG guidance is still to encourage, rather than require, women with current

suspected/confirmed COVID-19 to birth in hospital. It says ”If birth at home or in a midwifery-led unit is planned, a discussion should be initiated with the woman regarding the potentially increased risk of fetal compromise in women infected with COVID-19. The woman should be advised to attend an obstetric unit for birth, where the baby can be monitored using continuous electronic fetal monitoring. This guidance may change as more evidence becomes available.”

The recommendation to have continuous monitoring is based on two very small Chinese case series, including a total of 18 pregnant women infected with COVID-19 and 19 babies (one set of twins), in which there were 8 reported cases of concern over a baby's well-being. Though this appears to be a high level of problems, we do not know how severely ill the mothers in these cases were, how serious the concerns over the baby were or how typical the findings are of all pregnant women infected with COVID-19. It remains your right to decline continuous monitoring if you do not want it.

Similarly, RCOG is recommending epidural analgesia in labour to women with suspected/confirmed COVID-19 "to minimise the need for general anaesthesia if urgent delivery is needed." 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 your choice whether you would want to have an epidural for this reason, if you were not otherwise intending to use it to manage your labour.

There is lots of useful information in the guidance from the RCOG herewww.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/covid-19-virus-infection-and-pregnancy

If you need support regarding any aspect of your pregnancy or birth, please do contact the AIMS Helpline (details above).

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

RCOG says that there is little evidence about the risk of a baby catching coronavirus from an infected mother. For now they advise that "that women and healthy infants, not otherwise requiring neonatal care, are kept together" due to the benefits this has for breastfeeding and bonding.

What about support with feeding my baby?

If you have given birth and have questions about infant feeding, it is important to know that 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 guidance from RCOG confirms that even women with a suspected or confirmed COVID-19

infection should be enabled to have skin-to-skin contact and breastfeed their baby if that is their choice, as "the well-recognised benefits of breastfeeding outweigh any potential risks of transmission of coronavirus through breastmilk." They suggest the following precautions:

- Wash your hands before touching your baby, breast pump or bottles
- Try to avoid coughing or sneezing on your baby while feeding at the breast
- Consider wearing a face mask while breastfeeding, if available
- Follow recommendations for pump cleaning after each use
- Consider asking someone who is well to feed your expressed breast milk to your baby.

Getting breastfeeding support may be more difficult right now due to the closures of face to face breastfeeding drop ins, however, most of those groups will have moved online and be offering video call support to parents. Search Facebook for your local group.

Breastfeeding Counsellors, Lactation Consultants and doulas are making themselves available for video consultations so do reach out if you need support.

All the breastfeeding helplines are still open:

- **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.

Should you encounter any issues obtaining formula for your baby please do not ring the 'careline' number on the packaging - the rumour that the companies are sending out free supplies to mothers is not true. If you are running short of formula and unable to find any in the shops, please inform your pharmacy or GP surgery, who can order in stocks for you.

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

For information about what AIMS is campaigning for during this crisis please seehere.

AIMS Helpline Team 28 March 2020

AIMS supports all maternity service users to navigate the system as it exists, and campaigns for a system which truly meets the needs of all. AIMS does not give medical advice, but instead we focus on helping women to find the information that they need to make informed decisions about what is right for them, and support them to have their decisions respected by their health care providers. The AIMS Helpline volunteers will be happy to provide further information and support. Please emailhelpline@aims.org.uk or ring 0300 365 0663.