Coronavirus and your maternity care

This information was last updated on 17th December 2020, and we will keep it under review as the situation develops. The links were checked at that time but webpages are sometimes moved. If a link appears to be broken please let us know by emailing enquiries@aims.org.uk. You should still be able to find the page by entering the title in your browser.

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 parent at this time. We hope this information helps you navigate the changes in the maternity services. 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 for pregnant women, and the guidance that has been given to the maternity services.

- [Coronavirus infection in pregnancy: information for healthcare professionals](https://www.aims.org.uk/pdfs/information/23) published 14 October 2020 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](https://www.aims.org.uk/pdfs/information/23) drawn from the clinical guidance.

- The RCM website has [Advice for pregnant women](https://www.aims.org.uk/pdfs/information/23).

- RCM and RCOG have jointly published "[Guidance for provision of midwife-led settings and home birth in the evolving coronavirus (COVID-19) pandemic]" Version 2.2 published 10 July.

- RCM and RCOG have jointly published [Guidance for antenatal and postnatal services in the evolving coronavirus pandemic Version 2.2 10th July](https://www.aims.org.uk/pdfs/information/23).
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” April Version


- The Welsh Government’s latest guidance Hospital visiting during the coronavirus outbreak: guidance was published on 30 November 2020

- The Scottish Government’s latest guidance was published on 02 November 2020 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 updated its guidance COVID-19: Regional Principles for Visiting in Care Settings in Northern Ireland on 13 November 2020

- The British Association of Perinatal Medicine has produced a document COVID-19: Frequently asked questions within neonatal services (updated on 04 November 2020) 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 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?

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, according to the latest RCM/RCOG guidance, pregnant women do not in general appear more likely to contract the infection than the rest of the population and most pregnant women who are infected will experience only mild or moderate symptoms. As many as three quarters of pregnant women who are infected may have no symptoms. Because many questions remain it is still considered ‘prudent’ for pregnant women to observe strict social distancing, especially from 28 weeks of pregnancy.

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 analysed 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, but we don’t know how many of those deaths were directly due to COVID-19. This is equivalent to 5.6 deaths for every 100,000 pregnant women who were admitted to hospital and tested positive for coronavirus, For comparison, the usual figure is that 9.2 out of every 100,000 pregnant women die from any cause during pregnancy.
Maternal COVID-19 infection is associated about a three times higher risk of premature birth but most of these are due to a decision to bring forward the birth by induction of labour or a caesarean because of concerns about the mother and/or baby’s wellbeing.

The UKOSS 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 four to five times more likely to be of black, Asian or minority ethnic heritage. Other risk factors were being overweight or obese, being over 35 years old or having pre-existing health problems such as diabetes.

As a result of these findings women of BAME heritage are being advised to seek to seek advice without delay if they have a concern about their health, and doctors are advised to apply a lower threshold for reviewing or admitting to hospital such women if they display symptoms of COVID-19. Remote consultations are generally favoured where appropriate, to reduce the risk of infection. However, Trusts are reminded that face-to-face consultations may be more effective especially if an interpreter is required. The RCOG Q&A for women and families has advice for women who are at higher risk of illness, including those of BAME heritage, and there is a video on the topic at the top of the webpage.

There is some evidence that people with Vitamin D deficiency may be at greater risk of severe breathing problems if they develop COVID-19. Pregnant women and individuals of BAME heritage are already advised to take a Vitamin D supplement, but this may be particularly important for those of BAME heritage who are pregnant.

What are the risks for my baby?

The RCM/RCOG guidance reports that the majority of babies born to mothers diagnosed with COVID-19 have been born in good condition. So far there is no evidence that a COVID-19 infection increases the risk of stillbirth, death of a baby shortly after birth or a birth defect. It’s considered possible that an infection could be associated with the baby’s growth being restricted, as that was the case with the similar SARS virus. However there is no evidence that this is happening with COVID-19.

The UK Obstetric Surveillance System (UKOSS) survey now underway to look at the impact of COVID-19 in pregnancy found that 27% of those admitted to hospital gave birth prematurely. Two thirds of these were deliberate early births due to concerns over mother or baby’s well-being.
There is some evidence which suggests it is possible for the virus to be transmitted to babies in the womb but that it is uncommon for this to happen. A summary of the findings of 49 studies, with a total of 666 babies born to mothers with a confirmed infection found that only 4% tested positive (Walker et al 2020). There was no difference in the risk whether the baby was born vaginally or by caesarean. The UKOSS study found that between 1 March and 14 April out of 247 babies born to mothers who had been hospitalised with COVID-19 only six (2.5%) tested positive for coronavirus in the first 12 hours after birth, and only one required admission to a neonatal unit.

On the evidence so far it seems that the infection can be passed to babies in the womb, but most babies are unaffected and any infection is likely to be mild.

According to the Royal College of Paediatrics and Child Health "COVID-19 seems generally to be a fairly minor illness in young infants."

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

The latest guidance from the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists (RCM/RCOG) suggests that the normal schedule of antenatal appointments should be offered in full wherever possible. Ideally these should be carried out face to face, especially for "those from BAME communities, those with communication difficulties or those living with medical, social or psychological conditions that put them at higher risk of complications, or adverse outcomes, during pregnancy." In cases where it is thought necessary to offer 'virtual' appointments (e.g. during a local lockdown) they recommend the use of teleconferencing and videoconferencing - which would have the advantage of allowing your partner or supporter to be present and participate if you wish.

The guidance on partners/supporters attending in-person antenatal appointments and scans 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 guidance based on local risk assessments, so check the current local situation too.

The guidance in all four nations encourages Trusts/Boards to accommodate the support for those with communication or care needs, so if you feel this applies to you it is worth asking, even if restrictions are generally in place. AIMS has drafted a template letter which you can adapt to your own situation if your Trust/Board is not currently allowing partners or other supporters to be present at antenatal appointments or scans and you want to request them to allow it in your case.

If you attend any medical appointment you are legally entitled to make an audio or visual recording for your own use, and share it with your partner or other supporters, as this article from the British Medical Association confirms. In the article it says "Information disclosed during a consultation is confidential to the patient. Therefore, patients do not need doctors’ permission to make an audio or visual recording of a consultation"
AIMS believes that the same legal principle would apply to appointments with other healthcare staff and therefore to all antenatal appointments and scans. You might, as a courtesy, like to explain that you are making a recording and why, but you do not have to do so.

Although the article does not cover phone or video calls specifically, AIMS believes that you should also be able to have a 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 at your appointment or scan.

Some Trusts are stating that recordings or calls are “not permitted” during scans so you might want to ask them what the legal basis is for placing this restriction on your use of your own personal data. If a healthcare professional were to refuse to continue with an appointment or scan unless you ended the recording or call, they could be considered to have breached their duty of care to you, as this article from the Medical Defense Union indicates would be the case for a doctor who refused to continue to treat a patient who was recording the consultation.

In England the latest guidance from NHS England Coronavirus » Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers asks all NHS Trusts “to urgently complete any further action needed so that partners can accompany women to all appointments and throughout birth” by undertaking risk assessments, making changes to their use of space and infection control measures, and using testing, including rapid testing. It says that “Women should therefore have access to support at all times during their maternity journey and trusts should facilitate this” while as far as possible reducing the risk of COVID-19 infections for both service users and staff. In particular it recommends “making sure that women can safely take a support person to the early pregnancy unit, all antenatal scans, and other antenatal appointments where the woman considers it important to have support.” The guidance lists a number of solutions which some Trusts have already implemented. AIMS hopes that all Trusts will now be looking urgently at these solutions and identifying what they can do to enable women to be accompanied to antenatal appointments and scans by their chosen supporter.

However, although this guidance goes further than the previous guidance issued by NHS England, it will still be up to individual NHS Trusts to decide how far they go in implementing it. It’s likely to take some time for Trusts to carry out risk assessments and make any necessary changes, especially where this requires reorganisation of the available space. The guidance says that “Communications plans should be clear about the timescale for these actions, and information should be readily accessible to women, support people and their families, digitally and in accessible formats” - so if this information is not available to you we suggest you write to the Chief Executive of your Trust and ask them to publish their plans.

NHS England says that “Trusts should especially prioritise the need for continuous support for women with particular needs, such as those with a disability, significant communication challenges or complex medical, mental health or social factors” and should carry out an “equality impact assessment” to make sure that “their approach does not have a disproportionate impact on women with protected
characteristics as described in the Equality Act 2010." (A list of protected characteristics is [here](https://www.aims.org.uk/pdfs/information/23).) So even if your Trust has not yet enabled partners/supporters to be present in all cases, they really should be doing so for people who have these particular needs.

The guidance points out that if both a woman and her support person test negative for COVID-19 on arrival for an antenatal appointment or scan, and provided guidelines such as the use of personal protective equipment are followed, the additional risk of infection is likely to be small. This might allow some relaxation of the 2-metre social distancing rule. NHS England is therefore "now asking trusts to offer all women and their support people lateral flow [rapid] testing ahead of specifically 12 and 20 week scans and fetal medicine appointments" so that a partner/supporter can be present at least for these.

In **Scotland** the guidance sets out minimum standards according to which Tier the hospital's local authority area is in. Even in Tiers 3 and 4 (the highest risk areas) the minimum standard is "One supportive person to accompany to the booking scan, 20 week scan and any emergency appointments subject to local risk assessments and physical distancing" - which of course still means it is up to the Board/Hospital to decide about local risk and whether sufficient social distancing is possible. For Tier 2 the minimum standard is "One supportive person to accompany to all [antenatal] appointments subject to local risk assessments and physical distancing" and for Tiers 0 and 1 as well as this "One additional visitor (adult or child) may attend subject to local risk assessments and physical distancing."

Regardless of the Tier, the guidance says that "every effort should be made to ensure that women who have previously suffered a loss have one supportive person accompany her to all appointments and scans subject to local risk assessments and physical distancing."

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 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 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."

If the Risk Rating is Low, there should be a "phased reintroduction of usual birth policies" in all areas of maternity care.

If the Risk Rating is Very High the recommendation is for women to attend all inpatient and outpatient appointments and scans alone. However they can be accompanied by "essential support assistants" (defined as someone required "for specific additional support eg a support worker or 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."

If the Risk Rating is High, in addition to the above support, one nominated adult can accompany a woman to an early pregnancy assessment unit scan, the (12-14 week) dating scan, the (18-20 week) anomaly scan, and for any attendance at the Fetal Medicine Department.

If the Risk Rating is Medium, essential support assistants and/or up to one designated /nominated visitor are allowed for all antenatal appointments, and one designated supporter is allowed at the above list of scans, all subject to social distancing rules being possible.

In Northern Ireland the guidance varies according to the "Regional Surge Level Position" with different guidance for pre/low surge (level 3), medium surge (level 4) and high/extreme surge (level 5). The general principle is that except in high/extreme surge, women can be accompanied by their partner or nominated other to any of the 10-12 week dating scan, early pregnancy clinic, 19-20 week anomaly scan, if attending the Fetal Medicine Department, or should they suffer a pregnancy loss or bereavement. Trusts can apply greater restrictions e.g. for social distancing but if so "clear explanations will be given to women and their partner/nominated other." However, the guidance recognises the need to address the fact that "some individuals may have specific support and assistance requirements to ensure that their communication or other health and social care needs are met due to a pre-existing condition" and the aim should be "as far as possible facilitate their needs."

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

We are aware that some Trusts/Boards have been restricting the number of people who can accompany pregnant women and people in labour. It is also still common for birth partners not to be admitted to the hospital or birth centre until the pregnant woman or person is considered to be in 'active labour'. Support for those staying in antenatal or postnatal wards is usually very limited, if permitted at all.

The guidance on this 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 guidance based on their own risk assessment, so check the current local situation too.

In England the latest guidance from NHS England [Coronavirus » Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers](https://www.aims.org.uk/pdfs/information/23) asks all NHS Trusts "to urgently complete any further action needed so that partners can accompany women to all appointments and throughout birth" by undertaking risk assessments, making changes to their use of space and infection control measures, and using testing, including rapid testing. It says that "Women should
therefore have access to support at all times during their maternity journey and trusts should facilitate this" while as far as possible reducing the risk of COVID-19 infections for both service users and staff. In particular, it recommends making sure that a woman can safely have a support person with her throughout "labour and birth from the point of attendance at the hospital or midwifery unit." This is a welcome change from the previous guidance which only spoke of allowing birth supporters to be present during active labour and birth.

NHS England also states that "Women should also have access to support people while admitted for early pregnancy loss or on the antenatal or postnatal ward in line with pre-COVID trust policies."

The guidance lists a number of solutions which some Trusts have already implemented. AIMS hopes that all Trusts will now be looking urgently at these solutions and identifying what they can do to enable women to be be supported by their chosen person throughout labour and during any postnatal stay.

However, although this guidance goes further than the previous guidance issued by NHS England, it will still be up to individual NHS Trusts to decide how far they go in implementing it. It’s likely to take some time for Trusts to carry out risk assessments and make any necessary changes, especially where this requires reorganisation of the available space. The guidance says that "Communications plans should be clear about the timescale for these actions, and information should be readily accessible to women, support people and their families, digitally and in accessible formats" - so if this information is not available to you we suggest you write to the Chief Executive of your Trust and ask them to publish their plans.

NHS England says that "Trusts should especially prioritise the need for continuous support for women with particular needs, such as those with a disability, significant communication challenges or complex medical, mental health or social factors" and should carry out an "equality impact assessment" to make sure that "their approach does not have a disproportionate impact on women with protected characteristics as described in the Equality Act 2010." (A list of protected characteristics is here.) So even if your Trust has not yet enabled partners/supporters to be present in all cases, they really should be doing so for people who have these particular needs.

In Scotland the guidance sets out minimum standards according to which Tier the hospital's local authority area is in. We have attempted to summarise this, but suggest you check the guidance for the full details.

A birth partner "supporting a women during hospital visits is categorised as an essential visitor and is permitted at all of the five COVID levels." This means that even in Tiers 3 and 4 (the highest risk areas) the minimum standard is "One birth partner throughout induction, labour and birth (except during a general anaesthetic)."
For Tiers 0-2 people can have a second birth partner though this is "subject to local risk assessments and physical distancing" which means it is up to the Board/hospital to decide whether to accommodate such requests.

The guidance also states that "In addition, in line with national visiting guidance, a carer or interpreter – or someone else fulfilling a similar necessary function – should not be considered as a visitor." - which should mean that these support people should be allowed in addition to a birth partner, in all Tiers.

People who are staying in maternity wards (presumably both antenatal and postnatal wards) are allowed "One birth partner only (as essential) with time restrictions and subject to risk assessments and physical distancing" if in Tiers 3 and 4. In Tier 2 they can have one additional "designated visitor" and in Tiers 0 and 1 they can have two additional "designated visitors", subject to local risk assessments and physical distancing. Again, carers, interpreters or other people fulfilling "a similar necessary function" should not be counted as visitors.

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.

Health Boards are encouraged to "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 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."

If the Risk Rating is Low, there should be a "phased reintroduction of usual birth policies” in all areas of maternity care.

Even at the Very High and High risk ratings those in active labour should be able to have an essential support assistant and/or a single birth partner. (An essential support assistant is defined as someone required “for specific additional support eg a support worker or interpreter”, who could be a partner or family member in some circumstances.) At the Medium risk rating this is extended to an essential support assistant and/or a single birth partner at all stages of labour, as long as social distancing can be achieved.

Support on the postnatal ward in Very High/High risk areas appears to be limited to essential support assistants, plus "One nominated adult may accompany the woman attending where she requires familiar support for consultations which may cause her distress." In Medium risk areas "essential support assistants and/or up to one designated/nominated visitor" are allowed subject to social distancing.

In Northern Ireland the guidance varies according to the "Regional Surge Level Position" with different guidance for pre/low surge (level 3), medium surge (level 4) and high/extreme surge (level 5). At level 1
birth partners are admitted "for induction of labour, duration of labour and birth and, to visit in antenatal and postnatal wards for up to one hour once a week." At level 2 support in labour is limited to "when admitted to individual room for active labour (to be determined by midwife)" and the birth partner can visit the postnatal ward for up to one hour once a week. At level 3 a birth partner "will be facilitated to accompany the pregnant woman to labour ward for active labour (to be determined by midwife) and birth only", with no support on the postnatal ward.

Trusts can apply greater restrictions e.g. for social distancing but if so "clear explanations will be given to women and their partner/nominated other." However, the guidance recognises the need to address the fact that "some individuals may have specific support and assistance requirements to ensure that their communication or other health and social care needs are met due to a pre-existing condition" and the aim should be "as far as possible facilitate their needs."

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.

Birth partners won’t be admitted if they have had symptoms within the last ten 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.

Some Trusts and Boards have been refusing to allow birth partners who are from a different household. However, the latest version of the RCM/RCOG Q&A for pregnant women and their families says that "We know that for some women, their chosen birth partner may be from a different household due to their individual circumstances. You should be supported to have them with you unless they are unwell with coronavirus symptoms or have tested positive for coronavirus." This means that single parents, or those whose partners are unable for any reason to support them in labour and birth, should be able to have a birth supporter of their choice, as long as that person has no signs of having COVID-19.

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 or Board is refusing to permit any birth partners, limiting you to one or insisting that they must be from your household you may want to challenge this and refer them to the relevant national and RCM/RCOG guidelines, 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 to request the support you want for your birth.

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

As with the general guidance on birth partners in labour, there are now differences between the four nations of the UK on access for partners/supporters in the antenatal ward. The rules remain subject to local discretion by trusts and other NHS bodies so please check with your maternity team for their policy.

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. AIMS has drafted a template letter which you can adapt to your own situation to request the support you want for your birth.

On 14 December 2020 NHS England published new guidance for NHS Trusts in England [Coronavirus » Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers](https://www.aims.org.uk/pdfs/information/23). [see the previous section for details of what this says]. This recommends making sure that a woman can safely have a support person with her throughout "labour and birth from the point of attendance at the hospital or midwifery unit" - which should include during induction of labour. It also says that "Women should also have access to support people while admitted... on the antenatal or postnatal ward in line with pre-COVID trust policies." So if birth supporters were previously allowed to be with someone undergoing the early stages of induction on the antenatal ward, the Trust should be looking to reinstate this.

In Scotland the guidance sets out minimum standards according to which Tier the hospital's local authority area is in. It states that "A birth partner supporting a women during hospital visits is categorised as an essential visitor and is permitted at all of the five COVID levels." This means that even in Tiers 3 and 4 (the highest risk areas) the minimum standard is "One birth partner throughout induction , labour and birth (except during a general anaesthetic)."
See above for details of the guidance on birth supporters in Wales. It appears from this that a birth supporter would only be admitted once a woman is in active labour in areas that have been given a Very High/High Risk rating, but if the Risk rating is Medium a partner should be able to be present at all stages of labour (so including the early stages of induction), as long as social distancing can be achieved. At a Low Risk rating there should be a phased return to the usual local practice. However, the guidance talks about the need to give consideration to reasonable adjustments for those with specific needs 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 support during the early stages of induction if you can demonstrate a specific need.

In Northern Ireland the guidance varies according to the “Regional Surge Level Position” with different guidance for pre/low surge (level 3), medium surge (level 4) and high/extreme surge (level 5). At level 1 birth partners are admitted “for induction of labour, duration of labour and birth and, to visit in antenatal and postnatal wards for up to one hour once a week.” However, for level 2 and 3 they are only admitted during “active labour (to be determined by midwife).”

Trusts can apply greater restrictions e.g. for social distancing but if so “clear explanations will be given to women and their partner/nominated other.” However, the guidance recognises the need to address the fact that “some individuals may have specific support and assistance requirements to ensure that their communication or other health and social care needs are met due to a pre-existing condition” and the aim should be “as far as possible facilitate their needs.”

The RCM/RCOG Q&A for pregnant women and their families says “At least one birth partner without symptoms should be able to attend your induction of labour where that is in a single room (e.g. on the maternity suite). Whether a partner can visit you if the induction takes place in a bay on a main ward, will be dependent on the local NHS Trust/Board assessment of safety, including whether it is possible to maintain the necessary social distancing measures.” Some hospitals will only allow your birth partners in once you have been admitted to a birth room in active labour. However, some are willing to be flexible about this for those who have a specific need to have a supporter with them during the early stages of induction or while waiting to be admitted to a birth room. It is worth seeing if you can negotiate to have your needs met.

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 here doula.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.

The RCM/RCOG guidelines for antenatal care suggest that Trusts “Consider offering outpatient induction of labour for low-risk women.” This means going home in early stages of an induction once a slow-release pessary or mechanical dilation device has been inserted, after waiting a short period to check that there are no problems. You 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 birth 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 is 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.

This article Homebirthing in the United Kingdom during COVID-19 - Elizabeth Chloe Romanis, Anna Nelson https://www.aims.org.uk/pdfs/information/23
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. 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.

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 for first 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”.

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.

If you wish to use a Birth centre and have tested positive but have no symptoms of COVID-19 the RCM/RCOG guidelines say "it is recommended that an informed discussion takes place with the midwife, consistent with local policies." It also says that continuous monitoring should not be recommened if the only factor is that someone has tested positive. This means that if a birth centre is available in your area, you should not be prevented from using it on the grounds that you need continuous monitoring, if there is no other reason why you might choose to have it.

**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 page Freebirth, 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 recovered from COVID-19 but did not require hospital treatment and have completed the necessary period of self-isolation there should be no change to your planned care or birth choices. You should therefore be able to have midwifery support for a homebirth, go to a birth centre or use a birth pool as long as these options are available in your area.

If you were admitted to hospital with severe COVID-19 and have recovered the guidelines say “place of birth should be discussed and planned with the woman, her family, if she wishes.” The plan should take account of your baby’s growth and your choices.

If you have tested positive within 10 days of going into labour but have no symptoms and wish to give birth at home or in a birth centre “it is recommended that an informed discussion around place of birth takes place with the midwife.” Note, however, that the decision whether to birth at home is yours - you do not need ‘permission’ to do this. It also says that continuous monitoring of your baby’s heart rate “is not recommended” just because of the positive test. This means that you should not be offered this unless there is some other reason for suggesting it (but see our Birth Information page “Monitoring your baby’s heartbeat during labour.”) This is because there is no evidence that a mother having an infection without symptoms puts her baby at any increased risk of problems.

If you have mild COVID-19 symptom 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 any mother with symptoms should give birth in a hospital obstetric unit rather than at home or in a birth centre, and be offered continuous monitoring of her baby’s heart rate. The guidelines say “Although the data in this area
are poor, it appears prudent to use fetal monitoring for maternal systemic infection including COVID-19."
In other words, there isn’t any evidence to say whether a baby whose mother has mild symptoms is at
increased risk, or that continuous monitoring would help if they are, but the guideline authors feel it’s
better to be on the safe side. However, you still have the right to birth at home if you choose and to
decline continuous monitoring if you do not want it.

There is no evidence to favour a caesarean over a vaginal birth for women with COVID-19, unless the
mother’s condition is worsening and she needs urgent treatment. Of the small number of babies found to
be infected within 12 hours of birth in the UKOSS study of pregnant women with COVID-19, two had
been born vaginally and four by caesarean. 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.

**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
[RCM/RCOG guidance](https://www.aims.org.uk/pdfs/information/23) states "Entonox can be used with a single-patient microbiological filter. There is no
evidence that the use of Entonox is an aerosol-generating procedure." The use of single-patient filters is
standard practice. 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.
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.

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 [RCM/RCOG guidance](https://www.aims.org.uk/pdfs/information/23) guidance
recognises that labour and birth in water "may confer benefits" and makes it clear that those who have
**no symptoms and have tested negative** or can be presumed not to be infected with COVID-19 should be
able to use a birth-pool "providing adequate PPE can be worn by those providing care." AIMS hopes that this will mean that Trusts cease to impose blanket bans on waterbirths.

The guidance goes on to say that 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. It notes that there is a "small theoretical risk" of the virus being transmitted to a baby or the staff caring for a woman in water but "this risk also applies when caring for a woman during labour out of water." Despite the fact that there is no evidence of a higher risk of transmission when birthing in water compared with birthing on land, the UK Infection Prevention and Control Cell have decided to recommend that women who, within 10 days of birth, test positive for, or have symptoms of, COVID-19 "should not be offered to birth in water".

**RCM/RCOG** feel that those with symptoms such as fever, coughing or breathing difficulties, or who feel on well, need careful monitoring so their care is better managed on land. For those who have tested positive but have no symptoms they simply say "there is inadequate evidence" about the risk - which leaves the situation rather confused.

The guidance no longer quotes the research on the potential risk of disease transmission through faeces [poo], but previously they gave two references. One (Wang 2020) is a report of live virus being detected in stool samples from some COVID-19 patients in China, but the number of patients tested was very small so we don't know how common that is. The other (Amirian 2020) is a review of published reports where viral RNA (the genetic material of the coronavirus) has been detected in the faeces of some COVID-19 patients. The authors of this review point out that the presence of viral genetic material in a stool does not necessarily mean that it contains infectious virus particles, nor prove that the virus can be spread by this route, but it is possible that it is. They recommend that "additional precautions for preventing potential fecal transmission should be strongly considered until future studies can establish whether this is a plausible (and if so, frequent) mode of transmission for SARS-CoV-2" (the scientific name for this strain of coronavirus). They are mainly talking about things like sewage exposure, food preparation or infections in care homes and do not mention birthpools.

The guidance is therefore erring on the side of caution in recommending against the use of birthpools for women with suspected or confirmed COVID-19.

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?

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 who are self-isolating because they or someone in their household has suspected COVID-19 the RCM/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.

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 "Support women with suspected or confirmed COVID-19 to remain together with their baby and to practice skin-to-skin/kangaroo care, if the newborn does not require additional medical care at this time" but to "Adopt a precautionary approach" if the baby needs to be cared for in the neonatal unit. However, the guidance confirms that even if a baby is in the neonatal unit parents should still be involved in decisions about their baby’s care and that mothers 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) takes the view that "visitor" restrictions should not apply to the parents of babies in neonatal care as “they are partners in their baby’s care, and their presence should be encouraged. The mother and her newborn are a biological
entity and should have unrestricted contact when admission to a NNU is unavoidable. In order properly to involve parents in decision making about their baby’s care, NNUs should identify how to facilitate parental presence at all times of day, including on ward rounds, while maintaining social distancing within the NNU. 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.”

This means that, other than when a mother has tested positive for COVID-19 or is required to self-isolate, the unit should be making every effort to enable her to be with her baby for as much of the time as she wishes. Similarly, the father/other parent should be able to visit, either together with the mother or alone, for at least part of the time.

BAPM also encourages hospitals to offer testing to parents in order to minimise unnecessary separation from their baby.

BAPM recognises that "It would generally not be appropriate" parents who have tested positive or are self-isolating to visit a neonatal unit. The advice is that a mother who tested positive before the birth should not attend the NNU until 14 days after she developed symptoms and is symptom free. Somewhat confusingly, it says that a mother who tests positive after being discharged from the maternity unit only needs to self-isolate for 10 days. Fathers or other partners will need to self-isolate for 14 days from when the mother developed symptoms, and so cannot go into the NNU even if they have no symptoms themselves.

However, for these parents "every effort should be made to facilitate remote contact by use of video technology and/or social media." Further, in the case of a baby who is critically ill or not expected to survive "everything possible should be done to achieve parental presence and participation in care” even for parents who 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.
NHS England reaffirms that “Parents of babies in neonatal critical care also need to be involved in their baby’s care as much as possible. Integral to this is ensuring parents have access to their baby, while complying with legislation and government guidance on managing transmission risks.” It is therefore asking neonatal critical care providers “to maximise opportunities for parents to be with their babies and to identify how to facilitate parental presence at all times of day” by carrying out a risk assessment and implementing changes to reduce the risk. In particular it recommends routinely testing parents of babies in the NNU, using rapid testing where available, and that if parents test positive they “should be offered video access to their baby for the duration of their self-isolation.”

The Wales Maternity and Neonatal Network says that “If you are both well, one parent at a time can visit your baby.” However, visiting is not allowed if either parent has a confirmed infection, or if anyone in the household has a suspected infection until they have been confirmed negative. It confirms that “will still be able to give you updates on your baby and involve you in decisions and may be able to arrange video contact for you.” It provides guidance on expressing and delivering breastmilk if a mother is positive, suspected positive or self-isolating.

In Scotland the Government’s minimum standards for visiting say that “Both parents/primary care givers must be supported to have maximum access to their baby together, across all protection levels, subject to the need to maintain physical distancing in neonatal units. This includes supporting both parents to be present to care for their baby if they are critically ill or receiving end of life care. Where space makes maintaining physical distancing challenging, we expect neonatal units to undertake and document risk assessments, including an assessment of the impact on babies and families if access is limited, to maximise all possible opportunities for parents to be with their babies” and any decision to limit access must be “reviewed by the unit management team at least weekly, with a view to improving access as soon as possible.”

In Northern Ireland the guidance states “Evidence supports that Parents/Caregivers are an integral part of the baby or child’s care team, and should not be considered visitors in the traditional sense. This is in line with the principles for family integrated care.” In neonatal units “Families will be asked to nominate a maximum of two parents/caregivers who will be permitted access together throughout the baby’s stay.” However, the guidance varies according to the “Regional Surge Level Position” with different guidance for pre/low surge (level 3), medium surge (level 4) and high/extreme surge (level 5). At Level 4 or 5 a baby can be “accompanied by one of two nominated parents/caregivers at any given time for the duration of the stay” - which seems to mean that either parent/carer can attend the NNU alone. At level 3, two parents/carers can be admitted together.

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.

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](http://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](http://www.laleche.org.uk/get-support)
- [abm.me.uk](http://abm.me.uk)
- [www.nct.org.uk/parenting/feeding](http://www.nct.org.uk/parenting/feeding)
- [www.breastfeedingnetwork.org.uk](http://www.breastfeedingnetwork.org.uk)
- [www.lcgb.org](http://www.lcgb.org)

https://www.aims.org.uk/pdfs/information/23
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 see here.