

# Novel Coronavirus 2019 (COVID-19)

Practice Advisory ⓘ | July 2020

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*Last updated July 1, 2020*

## Summary of Key Updates (July 1, 2020)

Below is a summary of recent critical updates to this Practice Advisory.

- The section "General Information Regarding Pregnant Individuals and COVID-19" has been updated to reflect a new data analysis of women of reproductive age with laboratory-confirmed SARS-CoV-2 infection published by the CDC on June 26, 2020.

## General Information Regarding Pregnant Individuals and COVID-19

**The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine (SMFM) have developed an [algorithm](#) to aid practitioners in assessing and managing pregnant women with suspected or confirmed COVID-19. [View the algorithm \(Spanish version\)](#).**

Historically, respiratory infections in pregnant individuals have been thought to increase their risk for severe morbidity and mortality. With regard to COVID-19, early available data did not indicate that pregnant individuals were at an increased risk of infection or severe

morbidity compared with nonpregnant individuals in the general population. However, a recent [data analysis](#) from the Centers for Disease Control and Prevention (CDC) COVID-19 surveillance suggest that in women with COVID-19, pregnant women (n = 8,207) appear to be at increased risk for certain manifestations of severe illness compared to non-pregnant peers (n = 83,205). Specifically, these data indicate an increased risk of ICU admissions (1 in 68 of pregnant versus 1 in 110 non-pregnant women, crude risk ratio 1.6, 95% CI 1.3-1.9) and mechanical ventilation (1 in 195 of pregnant versus 1 in 370 non-pregnant women, crude risk ratio 1.9, 95% CI 1.4-2.6). Yet no increase was noted in the rate of mortality (1 in 513 of pregnant versus 1 in 400 of non-pregnant women, crude risk ratio 0.8, 95% CI 0.5-1.3). Consistent with previously reported data regarding non-pregnant individuals, this analysis suggests that pregnant patients who are Black or Hispanic may be disproportionately affected by SARS-CoV-2 infection. Of note, when stratified by race/ethnicity, ICU admission was more common among non-Hispanic Asians (3.5%) than among all pregnant women (1.5%). Further, while this report suggests an increase in risk of severe outcomes in pregnant women with SARS-CoV-2 infection, it is important to highlight that the overall risk to pregnant women is still low, and consider this risk compared to risks from other upper respiratory illnesses, especially while counseling patients. For example, based on data currently available, the absolute risk is still substantially lower than that of pandemic H1N1 influenza infection during pregnancy. During the H1N1 influenza pandemic, pregnant women made up 5% of deaths, despite only making up 1% of the population and pregnancy risk of ICU admission was reported as high as a 7-fold increase ([Rasmussen et al 2012](#); [Mosby et al 2011](#)). ACOG recognizes the need for further data, analysis, and peer review literature on SARS-CoV-2 infection during pregnancy.

Importantly, these new data have several key limitations including missing pregnancy status for 72% of women included in the surveillance. Moreover, among COVID-19 cases in female patients with known pregnancy status, data was unavailable for race/ethnicity in 20%, symptoms in 35%, and underlying medical conditions in 77%. Information on gestational age at the time of infection and whether the hospitalization, ICU admission, or mechanical ventilation was related to delivery or other pregnancy conditions rather than for COVID-19 illness are not available, which limits the interpretation ([CDC](#)).

Pregnant patients with comorbidities such as obesity are likely at increased risk for severe illness consistent with the general population with similar comorbidities. However, given that pregnancy itself is now identified as a risk factor for certain outcomes, the magnitude of further increase from such comorbidities will need to be further delineated. Although there are cases of reported vertical transmission of SARS-CoV-2, the data are reassuring that vertical transmission appears to be uncommon. Finally, the surveillance data analyzed in this report do not capture pregnancy or birth outcomes. ACOG continues to monitor the emerging literature on these topics.

Clinicians should counsel pregnant women and those contemplating pregnancy about the potential risk for severe illness from COVID-19, and measures to prevent infection with SARS-CoV-2 should be emphasized for pregnant women and their families. Pregnant individuals in particular are encouraged to take all available precautions to optimize health and avoid exposure to COVID-19 including:

- maintaining prenatal care appointments
- wearing a mask and other recommended PPE, if applicable, at work and in public
- washing hands frequently
- maintaining physical distancing
- limiting contact with other individuals as much as practicable
- maintain an adequate supply of preparedness resources including medications

The findings in this report underscore the need to advocate for protection measures such as appropriate PPE for individuals with increased risk of exposure and infection due to occupation or other circumstances.

ACOG understands that many pregnant individuals are experiencing increased stress due to COVID-19. When counseling pregnant individuals about COVID-19, it is important to acknowledge that these are unsettling times (see [How can I help my pregnant and postpartum patients manage stress, anxiety, and depression?](#)) and to encourage patients to communicate regularly with the health care team. Clinicians are encouraged to share ACOG's [patient resources](#) as appropriate.

ACOG is working to address the concerns that have been raised about the effect of COVID-19 in pregnant individuals. While this data analysis from CDC increases our knowledge of the impact of COVID-19 on pregnant women, more robust and complete data, including data on race/ethnicity, are needed to truly understand the impact of COVID-19 on pregnancy. ACOG encourages our members and all clinicians who care for pregnant patients with known or suspected COVID-19 to submit information to an appropriate COVID-19 registry to augment the collective knowledge about the effect of COVID-19 during pregnancy.

Obstetrician–gynecologists and other health care professionals should be vigilant in counseling pregnant women and in screening for exposure as well as symptoms of COVID-19 for pregnant patients. This can be done via phone or telehealth before a visit to allow facilities to appropriately prepare and optimize care coordination needs. For any patient with fever or acute respiratory illness, clinicians should follow the [CDC’s Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease \(COVID-19\)](#) and guidance for [Overview of Testing for SARS-CoV-2](#). Of note, health care professionals should follow their health care facility’s policies and their local and state health department policies for notification of a person under investigation for COVID-19.

ACOG will continue to work with CDC and diligently monitor the literature for any COVID-19 risk signals in pregnancy.

## Testing

Testing is critical for risk mitigation, data collection, and directing critical resources, including PPE. CDC has published guidance for who should be tested, but decisions about testing are at the discretion of state and local health departments and individual clinicians. Clinicians should work with their state and local health departments to coordinate testing through public health laboratories, or to work with clinical or commercial laboratories.

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

## Community Mitigation Efforts

Community mitigation efforts to control the spread of COVID-19 have been implemented across the United States. Although these efforts are important, ob-gyns and other health care professionals should be aware of the unintended effect they may have, including limiting access to routine prenatal care. Ob-gyns and other obstetric care professionals should continue to provide medically necessary prenatal care, referrals, and consultations, although modifications to health care delivery approaches may be necessary. Ob-gyns and other prenatal care professionals also should consider creating a plan to address the possibility of a decreased health care workforce, potential shortage of personal protective equipment, and limited isolation rooms, and should maximize the use of [telehealth](#) across as many aspects of prenatal care as possible.

## Addressing Inequities in Racial and Ethnic Minority Populations

Obstetrician–gynecologists and other women’s health care professionals can work toward addressing inequities in the health care system by confronting individual and structural biases. Emerging data indicate disproportionate rates of COVID-19 infection, severe morbidity, and mortality in some communities of color, particularly among Black, Latinx, and Native American people. Social determinants of health, current and historic inequities in access to health care and other resources, and structural racism contribute to these disparate outcomes. These inequities also contribute to disproportionate rates of comorbidities in these communities that place individuals at higher risk of severe illness from COVID-19. Access to COVID-19 testing and health care resources for those testing positive or who would be considered as persons under investigation also may be limited in these communities. Additional data are needed to understand the full extent of these disparities and to guide equitable allocation of health care resources and other public health interventions.

## Infection Prevention and Control in Inpatient Obstetric Care Settings

The CDC has published [Considerations for Inpatient Obstetric Healthcare Settings](#). These considerations apply to health care facilities providing obstetric care for pregnant individuals with confirmed COVID-19 or pregnant persons under investigation in inpatient obstetric health

care settings including obstetric triage, labor and delivery, recovery, and inpatient postpartum settings.

ACOG encourages physicians and other obstetric care professionals to read and familiarize themselves with the complete list of recommendations.

Key highlights from the recommendations include:

- Health care professionals should follow their health care facility's policies and their local and state health department policies for notification of a person under investigation for COVID-19. Patients with known or suspected COVID-19 should be cared for in a single-person room with the door closed. Airborne Infection Isolation Rooms may be reserved for patients undergoing aerosol-generating procedures.
- Infants born to patients with known COVID-19 at the time of delivery should be considered infants with suspected COVID-19. As such, infants with suspected COVID-19 should be tested, isolated from other healthy infants, and cared for according to the [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\)](#).
- Infants born to a pregnant individual with suspected COVID-19 for whom testing is unknown (either pending results or not tested) are not considered to be infants with suspected COVID-19.
- Discharge for postpartum individuals with suspected or confirmed COVID-19 should follow recommendations described in CDC's [Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings \(Interim Guidance\)](#) in conjunction with guidance from the local and state health department and health system.

## Precautions for Health Care Personnel: Personal Protective Equipment

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

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

CDC Recommended Personal Protective Equipment:

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

Eye Protection

- Put on eye protection (ie, goggles or a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
- Remove eye protection before leaving the patient room or care area.

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

During N95 respirator shortages, facilities might need to prioritize N95 respirator use for aerosol-generating procedures\*, and use face masks for other types of health care. Even during a shortage, it is important that medical staff use appropriate forms of personal protective equipment, including surgical masks. During shortages, facilities are encouraged to take steps that facilitate the protection of medical staff and enable personnel to protect themselves. Although there has been an understandable emphasis on facial protection, data from the SARS outbreak suggest that the comprehensive array of recommended personal protective equipment (listed above) used alongside hand hygiene and environmental cleaning leads to the optimal decreased risk of transmission of respiratory viruses, and this is likely true for COVID-19. Finally, although individual physicians, after careful consideration, may opt to provide care without adequate personal protective equipment, physicians are not ethically obligated to provide care to high-risk patients without protections in place.

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

For more information on Staffing, Personnel, and Hospital Resources, see ACOG's [COVID-19 Physician FAQs webpage.](#)

## Location of the Mother-Infant Dyad

Whether to separate a woman with suspected or confirmed COVID-19 from her newborn is a challenging topic; available evidence on which to base firm recommendations is limited. Several organizations recommend allowing the mother and infant to remain together with enhanced precautions in place when the mother has suspected or confirmed COVID-19 emphasizing the well-documented benefits of keeping the mother with her newborn, breastfeeding, and skin-to-skin contact ([WHO](#), [SOGC](#), [Canadian Paediatric Society](#), [RCOG](#), [Royal Australian and New Zealand College of Obstetricians and Gynaecologists](#)). However, the CDC and AAP strongly encourage temporary separation of a newborn from a mother with suspected or confirmed COVID-19, emphasizing the rare but grave risk of severe neonatal COVID-19 infection ([CDC](#)).

Given the limited evidence on this topic, the determination of whether to keep patients with known or suspected COVID-19 and their infants together or to separate after birth should be made on a case-by-case basis, using shared decision-making between the patient and the clinical team. In the counseling process, it is important to include a discussion of the risks and benefits, including the benefits of keeping the mother with the newborn and the risk of uncommon but potentially severe infection. Although separation in the hospital setting temporarily reduces the risk of neonatal infection, separation of patients from their newborns may be linked to additional risks including, but not limited to, undue stress on the patient and disruption of breastfeeding. In addition, available infection control measures and options for accommodations, including feasibility of temporary separation in both the hospital setting and upon discharge, should be discussed.

Possible options for accommodations include:

**Co-isolation or rooming-in.** This occurs in accordance with the mother's wishes or can be unavoidable because of space limitations within the facility. When this approach is taken, it should be combined with safety measures to minimize the risk of transmission, including:

- Mother using a mask or cloth face covering and practicing hand hygiene during all contact with the neonate. Masks or cloth face coverings should not be placed on neonates or children younger than 2 years of age.
- Engineering controls such as using physical barriers (eg, placing the neonate in a temperature-controlled isolette) and keeping the neonate 6 feet or more away from the mother as often as possible.

**Temporary separation (separate rooms).** Decisions about temporary separation should be made in accordance with the mother's wishes. Additional considerations include:

- Clinical conditions of the mother and neonate
  - Separation may be necessary for infants at higher risk of severe illness (eg, preterm infants and infants with medical conditions) or whose mothers are severely ill
- Availability of testing, staffing, space, and PPE in the healthcare facility

- Results of neonatal testing
  - If the neonate tests positive for SARS-CoV-2, separation is not necessary
- The pregnant individual's home situation and ability to adhere to physical distancing and hygiene upon discharge

If temporary separation is undertaken, mothers who intend to breastfeed should be supported and encouraged to express their breastmilk to establish and maintain the milk supply. If possible, a dedicated breast pump should be provided.

## Infant Feeding with Breastmilk

Breastmilk provides protection against many illnesses and there are few contraindications to breastfeeding ([Committee Opinion 756](#), [CDC's Pregnancy and Breastfeeding](#)). It is not known whether COVID-19 can be transmitted through breastmilk, or if any potential viral components, if transmitted, are infectious. Although a recent case report detected SARS-CoV-2 RNA in the breastmilk ([Lancet Groß 2020](#)), the majority of the data has not demonstrated the presence of SARS-CoV-2 virus in breastmilk. Therefore, suspected or confirmed maternal COVID-19 is not considered a contraindication to infant feeding with breastmilk at this time.

However, individuals with suspected or confirmed COVID-19 can transmit the virus through respiratory droplets while in close contact with the infant, including while breastfeeding. Therefore, obstetrician-gynecologists and other maternal care practitioners should counsel women with suspected or confirmed COVID-19 who intend to infant feed with breastmilk on how to minimize the risk of transmission, including:

- Breastmilk expression with a manual or electric breast pump. This includes the importance of proper hand hygiene before touching any pump or bottle parts and following recommendations for proper pump cleaning after each use. If possible, individuals should consider having someone who does not have suspected or confirmed COVID-19 infection and is not sick feed the expressed breastmilk to the infant. Additionally, individuals should be counseled on whether the facility is able to provide a dedicated breast pump.

- Safety measures if breastfeeding. A mother with suspected or confirmed COVID-19 who wishes to breastfeed her infant directly should take all possible precautions to avoid spreading the virus to her infant, including hand hygiene and wearing a mask or cloth face covering, if possible, while breastfeeding. Even in the setting of the COVID-19 pandemic, obstetrician–gynecologists and other maternal care practitioners should support each woman's informed decision about whether to initiate or continue breastfeeding, recognizing that she is uniquely qualified to decide whether exclusive breastfeeding, mixed feeding, or formula feeding is optimal for her and her infant ([Committee Opinion 756](#)).

ACOG will continue to review emerging literature on this topic.

## Additional Information

The American College of Obstetricians and Gynecologists will continue to closely monitor the evolution of the 2019 novel coronavirus (COVID-19) in collaboration with the CDC. New and updated information will be shared as it becomes available. Obstetrician-gynecologists and other health care practitioners are encouraged to check ACOG's COVID-19 webpage and CDC's COVID-19 webpage regularly for updated information.

This Practice Advisory was developed by the American College of Obstetricians and Gynecologists' Immunization, Infectious Disease, and Public Health Preparedness Expert Work Group in collaboration with Laura E. Riley, MD; Richard Beigi, MD; Denise J. Jamieson, MD, and Brenna L. Hughes MD.

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