



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Interim Coronavirus Disease 2019 (COVID-19) Guidance for Maternal Health and Pregnancy

Updated September 22, 2020

The COVID-19 pandemic poses unique challenges for pregnant individuals, their families, and the health care providers who care for them.

Pregnant people with COVID-19 are considered a group that [might be at high-risk for severe disease due to COVID-19](#). In the absence of COVID-19 specific data, this designation was due to the fact that other similar viruses (MERS, SARS and influenza) are known to result in higher rates of morbidity and mortality during pregnancy. [Recent data of US women infected with COVID-19](#) reveals small increased risks of ICU admission and intubation but no increased mortality from COVID-19 among pregnant compared with non-pregnant individuals of the same age.

There also have been concerns about possible vertical transmission of COVID-19 to fetuses and neonates from mothers infected with COVID-19. It is still unclear whether COVID-19 can cross the placenta and cause infections in fetuses prior to delivery but [this is likely not the case in the majority of situations](#). However, neonates who have close exposure to a COVID-19 positive mother are at high risk to contract the virus soon after delivery. [Among pediatric cases](#), hospitalization was most common among pediatric patients aged <1 year and those with underlying conditions. To date, no recently published reports have identified an infant who died during the initial birth hospitalization as a direct result of COVID-19 infection. Additionally, the likelihood of an infant testing positive for COVID-19 is similar for those who room-in as for those who are separated from their infected parents as long as preventive measures are used, showing that the risk of newborn infection during birth hospitalization is low with safety precautions. For these reasons, [guidance from the American Academy of Pediatrics \(AAP\)](#) and [the American College of Obstetricians and Gynecologist \(ACOG\)](#) no longer recommends routine separation of neonates from COVID-19 infected mothers and encourages breastfeeding as the best choice for infant feeding. SARS-CoV-2 nucleic acids in breast milk have been reported in several studies but it is unknown whether viable, infected virus is present in and can be transmitted via breastmilk. Therefore, breastfeeding is not contraindicated and confers other health benefits for mothers and their babies.

Another challenge is that families must continue to have safe access to high quality prenatal and obstetric care throughout the COVID-19 pandemic. In this context, attention must be paid both to preventing the spread of disease and to preventing a rise in adverse maternal and infant health outcomes as an unintended consequence of pandemic measures. [A recent research study documented that in-person prenatal visits do not appear to raise COVID-19 risk](#).

Additionally, the COVID-19 pandemic is adding to the documented inequities in maternal and infant health outcomes. [Recent CDC data](#) revealed that pregnant women who are Hispanic and Black may be more likely to be infected with COVID-19 than white women.

Given the data and evidence available to date, guidance from professional organizations and shared best practices, NCDHHS provides the following recommendations around maternal health related to the COVID-19 pandemic:

1. When formulating new policies to care for pregnant individuals and families during the COVID-19 pandemic, health care providers and systems should engage members of potentially vulnerable or historically marginalized communities to ensure that disparities and inequities are not worsened by proposed policies.

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2. Pregnant individuals and those contemplating pregnancy should be educated about the potential risks of COVID-19 in pregnancy. Providers may need to be prepared for discussions related to out of hospital deliveries.
3. Discussion of contraceptive methods of choice prenatally, with postpartum access at hospital discharge, should be prioritized. Individuals in the preconception/postpartum/interconception period should have access to contraceptive methods of choice, preferably on the same day they are requested, and should be prioritized for all women of reproductive age.
4. Access to time-sensitive women's health services should not be delayed due to COVID-19 concerns.
5. Pregnant individuals should take [measures to prevent COVID-19 exposure](#), including:
 - a. Wearing a mask or face covering outside of one's home.
 - b. Washing hands frequently.
 - c. Maintaining physical distancing.
 - d. Limiting contact with other individuals outside of household contacts as much as practicable.
 - e. Maintaining an adequate supply of preparedness resources including medications, medical supplies and vitamins.
6. Employers of pregnant individuals should allow them to work remotely as much as possible, limit opportunities for exposure to COVID-19 on the job by implementing safety measures, and ensure PPE access as indicated for those who must have close contact with other individuals outside of household contacts as part of their job duties.
7. To the extent possible, health care facilities who care for pregnant individuals with COVID-19 should participate in data collection (e.g. [the PRIORITY study](#)) so that more information is gathered including information about racial and ethnic inequities.
8. Health care systems and providers should investigate and provide alternative methods of providing prenatal care to limit in-person appointments while still providing high quality care. This may include use of [telehealth](#), home visiting, and [drive through visits](#) when applicable.
9. When telehealth appointments are used, providers should appropriately screen patients for access to telehealth (including Internet access). They should also provide information about [local broadband access](#) such as school or library parking lots.
10. Health care systems and facilities should have a policy limiting visitors during inpatient and outpatient encounters that considers:
 - a. Infection risks specific to their geographic area and their population.
 - b. Availability of PPE and space for social distancing in the facility.
 - c. The need for an individual in labor to have a support person.
 - d. The health benefits of including doulas in the childbirth team.
 - e. Compassionate exceptions in the outpatient setting for fetal loss, miscarriage and/or serious fetal anomalies.
 - f. Compassionate exceptions in the outpatient setting for pregnant individuals with serious mental health conditions or disabilities or who are under the age of 18.
11. Providers and facilities should inform pregnant individuals covered by Medicaid that their Medicaid for Pregnant Women (MPW) coverage postpartum is extended during this COVID-19 pandemic. MPW continues to cover services that were caused or worsened by the pregnancy and/or complicate their postpartum status. Individuals are strongly encouraged to check with their local Department of Social Services to determine if they qualify for full Medicaid services beyond the immediate postpartum period. This may provide coverage for additional services beyond the immediate postpartum period than MPW alone. Some individuals qualify for full Medicaid after the pregnancy is completed and others may qualify for the [Family Planning Be Smart Program](#) after postpartum coverage.
12. Families should continue to have access to interventions that are known to improve maternal outcomes and health inequities including access to trained doulas during labor, access to group prenatal care in a virtual format when possible, lactation support, and access to home visiting programs and care management services.
13. Ensure access to COVID-19 testing for pregnant individuals. Providers should be aware of local testing sites for patients.
 - a. In areas and populations with high COVID-19 infection rates and access to testing, [universal testing for pregnant women prior to delivery should be considered](#).
 - b. Considerations should be made for pregnant individuals who have tested negative for COVID-19 and/or are at low risk of COVID-19 to remove their mask during active labor.

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14. [AAP](#) currently recommends that mothers with confirmed or suspected COVID-19 room-in with their well newborns with safety measures. Providers should use individualized shared decision-making about rooming-in and infant feeding decisions with pregnant individuals who have active COVID-19 infection during their admission for delivery.
15. For COVID-19 positive parents who room-in with their infants and/or directly breastfeed their infants, [precautions to prevent transmission to the neonate](#) should be followed, including:
 - a. All family members should use a mask or cloth face covering (masks should not be placed on infants).
 - b. All family members should practice hand hygiene during all contact with the infant.
 - c. Use physical barriers (e.g. placing the infant in a temperature-controlled isolette and keeping the infant 6 feet or more away from the mother) as often as possible. Skin-to-skin care has proven benefits for infants but would add additional risk for COVID-19 transmission when a parent has tested positive. If COVID-19 positive parents desire to provide skin-to-skin care, they should be informed of the potential risks and be encouraged to use face coverings and practice hand hygiene as above.
 - d. Health care workers should use gowns, gloves, standard procedural masks and eye protection (face shields or goggles) when providing care for well infants.
 - e. Parents of NICU infants may express breast milk for their infants during any time that their infection status prohibits their presence in the NICU. Centers should make arrangements to receive this milk until the parent is able to enter the NICU.

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