Pregnancy and COVID-19 FAQ

SEIU Healthcare

The following FAQ has been developed by SEIU Healthcare from a comprehensive review of the current scientific research on pregnancy and COVID-19. All recommendations are informed by the most up-to-date research; however, the dynamic nature of the COVID-19 outbreak means new research and recommendations are constantly being updated and released. This research represents our best data at the time of publishing.

Am I at higher risk for contracting COVID-19 if I am pregnant?

Unlike its predecessor's H1N1, MERs, and SARS, COVID-19 does not appear to target pregnant women at a higher rate than the rest of the population. Or in other words, "pregnant women do not appear more likely to contract the infection than the general population" (1).

In previous respiratory illness outbreaks, there were disproportionately more negative health outcomes recorded for pregnant women. "Pregnant women were more than four times more likely to be admitted to the hospital for 2009 swine-origin influenza A (H1N1) than the general population" (14). The study continued, "approximately 50% of pregnant women with SARS were sent to the ICU, approximately 33% of pregnant women with SARS needed mechanical ventilation, and the death rate of pregnant women with SARS was as high as 25%" (14).

While pregnant women are not at a higher risk of contracting COVID-19, the evidence does suggest that for a small proportion of women, pregnancy can alter the body's response to viral infections in a way that could enhance COVID-19 symptoms if contracted (1).

Am I at higher risk of severe COVID-19 symptoms if I am pregnant?

Pregnancy is known to alter the body's immune system, to varying degrees for different women, which affects the body's response to a viral infection, including COVID-19. This can mean that for some pregnant women, contracting COVID-19 could mean experiencing more severe symptoms. This potential is enhanced in later stages of pregnancy. However, some pregnant women who are infected will likely have no or mild symptoms from which they are likely to make a full recovery (1).

Pregnant women who contract COVID-19 and develop more severe systems can see their recovery delayed and may develop more significant chest infections that require enhanced care. In these cases, it is important to contact your physician and your maternity team right away for advice and to develop a care plan (1). While the potential for developing more severe symptoms exists, the data indicates that with proper care, full recovery is still expected. In one study, there was no link between pregnancy and worse symptoms, "pregnancy and delivery did not aggravate the severity of COVID-19 pneumonia" (14).

What affects will COVID-19 have on my pregnancy?

There have been a handful of studies now completed on the experience of pregnant women in China during the COVID-19 pandemic. All the women involved in these studies contracted COVID-19 within their third trimester. The data from these studies displayed that some pregnant women who contracted COVID-19 developed influenza, hypertension, anemia, preeclampsia, and there were four cases of preterm labour. We also know that stress plays a large role in health and health outcomes, which can affect the experience and severity of symptoms.

However, at this point in our knowledge and the data available, none of the above complications can be confirmed as being caused by the contraction of COVID-19. Additionally, it is important to note that none of the women studied developed severe pneumonia, there were no maternal deaths reported (1, 2, 3). As well, "there are currently no data suggesting an increased risk of miscarriage or early pregnancy loss in relation to COVID-19" (1).

Can I pass COVID-19 to my baby?

The data that is currently available suggests that while vertical transmission of the COVID-19 virus from mother to child is not impossible, the majority of pregnancies have not resulted in vertical transmission (1, 2, 3, 4, 5, 6). One study conducted at the Hospital of Wuhan University involving six mothers with confirmed COVID-19 status had their newborn babies' serum and throat swab tested. None of the infants presented any symptoms and all tests were returned with negative COVID-19 results (4).

There are only two potential cases in all the data that has come available beginning from the first outbreak in Wuhan, China, that lead medical experts to question whether the virus was transmitted vertically. However, in these cases, the babies were not tested immediately and there was confirmed contact with infected persons post-delivery, thus vertical transmission cannot be confirmed. There is only one documented possible case of a baby contracting an inutero infection (5).

The vast majority of testing has shown no evidence of the COVID-19 virus in amniotic fluid, cord blood, neonatal throat swabs, placenta swabs, genital fluid, and breastmilk samples from COVID-19 infected mothers (1, 2, 6). Furthermore, the data that has been produced so far have, while there have been a handful of newborns that have tested positive for COVID-19, they have all had mild symptoms (shortness of breath, coughing, fever). Importantly, "to date no severe cases of COVID-19 have been reported in newborns" (8). There is also no evidence that the virus is teratogenic, or in other words, that the virus has the ability to disturb the development of the embryo or fetus, or cause birth defects (1).

It is reassuring that within the data so far, all breastmilk has tested negative for COVID-19. A research study in the Journal of Human Lactation reported that there have been no reports of COVID-19 in human milk. The World Health Organization (WHO) has provided guidance, stating that infants born to mothers with suspected, probable or confirmed COVID-19 infection should continue to breastfeed. The main risk with breastfeeding is the close contact between the infant and the mother, who is likely to share infective droplets (9).

In light of the current evidence, we advise that the benefits of breastfeeding outweigh any potential risks of transmission of the virus (1). To address this risk, while breastfeeding, mothers should ensure that they wash hands before touching the baby, breast pump, or bottles, and avoid coughing or sneezing on the baby while feeding.

This guidance from the WHO may be helpful:

> Considering the benefits of breastfeeding and the insignificant role of breastmilk in the transmission of other respiratory viruses, the mother can continue breastfeeding, while applying all the necessary precautions…symptomatic mothers who are breastfeeding or practicing skin-to-skin contact or kangaroo mother care should practice respiratory hygiene, including during feeding, perform hand hygiene, before and after contact with the child, and routinely clean and disinfect surfaces which the symptomatic mother has been in contact with.

Should I go to work if I am a pregnant health care worker?

SEIU Healthcare agrees with the UK Royal College of Obstetricians and Gynecologists, the Society of Obstetricians and Gynecologists of Canada, and the Canadian Federation of Nursing Unions, that pregnant women, particularly those who are more than 28 weeks pregnant, should avoid unnecessary exposure that would come from working in areas with suspected or confirmed COVID-19 patients [1, 10]. This includes direct patient care for COVID-19 presumptive or positive patients or clients. This is especially important for pregnant healthcare workers with comorbidities, which could impact the severity of symptoms if COVID-19 is contracted and could further impact pregnancy experiences and complications. For example, cardiac disease, hypertension, and pulmonary disease [11].

If choosing to remain at work, accommodations should be sought to avoid high-risk areas and direct care of patients or clients with presumptive or positive COVID-19 status. We recommend, following the Canadian Federation of Nurses Unions, "that pregnant health care workers who are concerned about their health – especially those with co-morbidities – seek an accommodation from their employer if they are asked to care for presumed or confirmed COVID-19 patients in COVID-19 'hot zones' (such as intensive care units, emergency rooms, operating rooms, post-anaesthetic care units, negative pressure rooms, single-patient rooms used to isolate patients in absence of negative pressure rooms, and trauma centres), and accommodation be readily granted based on language in collective agreements and provincial human rights legislation" [10]. The Ontario Human Rights Code names pregnancy as a protected category from discrimination (to the point of undue hardship on employers). If a pregnant healthcare worker wishes to seek an accommodation, they should consult their union representative.

Should Pregnant Health Care Workers wear N95 Masks?

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