

COVID-19 FAQs for Obstetrician-Gynecologists, Obstetrics

These FAQs are developed by a Work Group assembled of practicing obstetrician-gynecologists and ACOG members with expertise in obstetrics, maternal-fetal medicine, infectious disease, and hospital systems. They are based on expert opinion and are intended to supplement the Centers for Disease Control and Prevention (CDC) guidance.

FAQs will be added, modified, and removed on a regular basis.

Patients: Please refer to [this page](#) for information on coronavirus, pregnancy, and breastfeeding.”

Staffing, Personnel, and Hospital Resources

Q: When can an obstetric care professional with SARS-CoV-2 infection or exposure return to work? When they return to work, what personal protective equipment (PPE) do they need to wear on a regular basis? (REVISED)



The Centers for Disease Control and Prevention (CDC) has developed guidance outlining work restrictions for health care personnel (HCP) with SARS-CoV-2 *exposures* based on the risk level of the exposure, the PPE used at the time of exposure, and the vaccination status of the individual. Furthermore, the CDC provides recommended work restrictions for HCP with SARS-CoV-2 infection and exposures based on a facility's level of need to mitigate HCP and staffing shortages. Clinicians are encouraged to review these work restrictions and recommendations from the CDC regularly, as they are updated frequently. Additionally, clinicians are encouraged to work with their facilities, as situations may vary based on local circumstances.

After adhering to any applicable restrictions and returning to work, HCP should do the following:

- Always wear a face mask for source control (to contain respiratory secretions) while in the health care facility until all symptoms are completely resolved or at baseline. After this time period, HCP should revert to their facility's policy regarding universal source control during the pandemic.
- As with other respiratory illnesses, a residual nonproductive cough may persist for weeks after the illness has otherwise resolved. This is also the case for SARS-CoV-2 infection. Therefore, it is possible that an individual will meet the criteria for returning to work despite having lingering symptoms.
- A face mask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated (read **What personal protective equipment (PPE) should clinicians and patients wear for potential or confirmed COVID-19 cases?**).
- Self-monitor for symptoms and seek reevaluation from an occupational health specialist if respiratory symptoms recur or worsen.

Q: What personal protective equipment (PPE) should health care professionals wear to reduce their risk of COVID-19 infection?
(REVISED)



Last update July 1, 2021 at 7:00 a.m. EST

COVID-19 infection is highly contagious, and this must be taken into consideration when planning intrapartum care. Recommendations for personal protective equipment (PPE) from the Centers for Disease Control and Prevention (CDC) can be found on the [CDC's website](#). CDC also provides strategies for how to optimize the supply of PPE.

As vaccination rates increase, it is still critical to maintain general infection control strategies in health care settings. Regardless of vaccinations status, obstetric care clinicians should still wear adequate and appropriate PPE when caring for patients with suspected or confirmed COVID-19.

General Considerations

Q: What treatment options are available for pregnant individuals? (NEW)



Last updated October 4, 2023 at 1:55 p.m. EST

There are several treatment options for COVID-19, and many are available for use in pregnancy. The National Institutes of Health (NIH) and ACOG recommend against withholding treatment options for pregnant and lactating individuals specifically because of pregnancy and or lactation.

Outpatient treatment options

Currently the preferred treatment option for outpatient individuals with COVID-19 is Ritonavir-Boosted Nirmatrelvir (Paxlovid). Paxlovid can be administered to non-hospitalized pregnant and lactating patients. If a pregnant patient tests positive for COVID-19, obstetric care professionals should prescribe Paxlovid®. The dosage for Paxlovid is 300 mg nirmatrelvir (two 150 mg tablets) with 100 mg ritonavir (one 100 mg tablet), with all 3 tablets taken together twice daily for 5 days ([FDA package insert](#)). Treatment can be initiated in patients who are positive for COVID-19 or are highly suspected to be positive based on known exposure and symptoms.

Obstetrician-gynecologists and other obstetric care professionals should ensure the patient has no contraindications and should review any possible drug-drug interactions and how to handle them before prescribing Paxlovid. See [NIH](#) for more information on drug-drug interactions. If there is suspected or confirmed coinfection with influenza and COVID-19, both oseltamivir and Paxlovid® should be prescribed, and can be taken together. There are no clinically significant drug-drug interactions between the antiviral agents or immunomodulators that are used to prevent or treat COVID-19 and the antiviral agents that are used to treat influenza.

For additional information on Paxlovid and other outpatient treatment options, see [NIH's Treatment Considerations for Pregnancy and Lactation](#).

Inpatient treatment options

Several treatment options are available for hospitalized pregnant patients. Recommendations for preferred treatment options for hospitalized individuals vary by disease severity and comorbidities. NIH outlines these options in their [Treatment Considerations for Pregnancy and Lactation](#).

Q: What are the criteria to discontinue transmission-based precautions for previously COVID-19 positive patients? (REVISED)



Last updated August 24, 2022 at 10:55 a.m. EST

According to [CDC's guidance](#), discontinuation of transmission-based precautions in the health care setting for an individual with confirmed COVID-19 should be made using a symptom-based strategy ([CDC](#)). The time period used depends on the patient's [severity of illness](#) and if they are severely immunocompromised. **Meeting criteria for discontinuation of transmission-based precautions is not a prerequisite for discharge from a healthcare facility.** Patients who are discharged home for required isolation or who are treated as outpatients with a diagnosis of COVID-19 should follow discontinuation of isolation precautions guidance from the [CDC](#). Recommendations regarding discontinuation of transmission-based precautions may continue to evolve. ACOG encourages members and patients to visit CDC's website for up to date information and details.

Detailed information on exposure, isolation, quarantine, and testing is available through the [CDC](#). Individuals are encouraged to review this information regularly.

Q: Does COVID-19 present an increased risk of severe morbidity and mortality for pregnant and recently pregnant individuals? (REVISED)



Last updated October 4, 2023 at 1:16 p.m. EST

Yes. Pregnant patients with symptomatic COVID-19 infection, when compared to uninfected pregnant patients, are at an increased risk of maternal death, admission to the ICU, requiring mechanical ventilation, cesarean delivery, preeclampsia or eclampsia, and thromboembolic disease ([Smith 2023](#)). In a retrospective cohort study of 14 104 pregnant and postpartum patients delivered between March 1, 2020, and December 31, 2020 at 17 US hospitals, pregnant patients with moderate or severe COVID-19 infection had an increased risk of a composite outcome of maternal mortality or serious morbidity from obstetric complications such as hypertensive disorders of pregnancy, postpartum hemorrhage, or infection other than SARS-CoV-2 when compared to pregnant individuals without COVID-19 infection ([Metz 2022](#)). Further symptomatic pregnant individuals with COVID-19 are at increased risk of more severe illness compared with nonpregnant peers ([Ellington MMWR 2020](#), [Collin 2020](#), [Delahoy MMWR 2020](#), [Khan 2021](#)). The CDC includes pregnant and recently pregnant individuals in its increased risk category for severe COVID-19 illness. Pregnant and recently pregnant patients with comorbidities such as obesity, diabetes, hypertension, and lung disease may be at an even higher risk of severe illness consistent with the general population with similar comorbidities ([Ellington MMWR 2020](#), [Panagiotakopoulos MMWR 2020](#), [Knight 2020](#), [Zambrano MMWR 2020](#), [Galang 2021](#)). Additionally, the risk of moderate-to-severe or critical illness during pregnancy appears to increase with increasing maternal age ([Metz 2021](#), [Galang 2021](#)). Black and Hispanic individuals who are pregnant appear to have disproportionate COVID-19 infection and death rates ([Ellington MMWR 2020](#), [Moore MMWR 2020](#), [Zambrano MMWR 2020](#)). Obstetrician-gynecologists and other obstetric care professionals should counsel pregnant individuals and those contemplating pregnancy about the potential risk of COVID-19, and measures to prevent infection with SARS-CoV-2 should be emphasized for these individuals and their families.

Q: What is the effect of COVID-19 on fetal and neonatal outcomes? (REVISED)



Last updated October 4, 2023, at 1:10 p.m. EST

Pregnant people with COVID-19 are at increased risk for preterm birth and some data suggest an increased risk for other adverse pregnancy complications and outcomes, such as preeclampsia, coagulopathy, and stillbirth, compared with pregnant people without COVID-19 ([Allotey 2020](#), [Jering 2021](#), [Ko 2021](#), [Villar 2021](#), [DeSisto 2021](#)). Data indicate that neonates born to people with COVID-19 are also at increased risk for admission to the neonatal intensive care unit ([Allotey 2020](#), [Villar 2021](#)). Although there are cases of reported vertical transmission of SARS-CoV-2, currently available data indicate that vertical transmission appears to be uncommon ([Dumitriu 2020](#)).

Population level changes in preterm birth and stillbirth rates have also been noted when comparing periods of COVID-19 lockdown to a time period prior to COVID. In Europe, decreases in rates of preterm delivery have been reported along with increased number of stillbirths, but initial evidence in the United States suggests preterm delivery and stillbirth rates are unchanged ([Handley 2020](#), [Hedermann 2020](#), [Kahlil 2020](#), [Yang 2022](#)).

Q: Should pregnant patients wear a mask? (REVISED)



Last updated October 4, 2023 at 3:36 p.m. EST.

With regard to wearing a mask, pregnant patients should follow the same recommendations as the general population as outlined by the [CDC](#).

Pregnant individuals are at increased risk for severe disease; therefore, it is extremely important that pregnant individuals in high COVID-19 hospital admission level areas use masks. Even in low COVID-19 hospital admission level areas, pregnant individuals may wish to wear masks and should be supported if they decide to do so. There are currently no known risks related to mask use during pregnancy.

Clinicians and patients should be aware that CDC recommendations regarding mask wearing may change frequently and CDC and/or state officials may reinstate mask mandates, as needed.

Q: Should routine screening testing continue to occur in labor and delivery units? (REVISED)



Last updated January 10, 2023 at 4:46 p.m. EST.

Pregnant individuals admitted for labor and delivery with suspected COVID-19 or who develop symptoms suggestive of COVID-19 during admission should be tested ([CDC, AMA statement](#)). Performance of SARS-CoV-2 viral testing upon admission to labor and delivery is at the discretion of the facility. For asymptomatic patients, the yield of screening testing for identifying infection is likely lower when performed on those in counties with lower levels of SARS-CoV-2 community transmission. However, these results might continue to be useful in some situations (e.g., when performing higher-risk procedures or for HCP caring for patients who are moderately to severely immunocompromised) to inform the type of infection control precautions used and prevent unprotected exposures.

Regardless of vaccination status, individuals may decline testing for a variety of reasons including stigma, mistrust, and fear of possible mother–baby separation. Facilities that continue to practice routine screening testing in labor and delivery should have a plan for the care of individuals who decline COVID-19 testing.

Q: How should thromboprophylaxis be managed for pregnant and postpartum patients with suspected or confirmed COVID-19 infection? (REVISED)



Last updated July 1, 2021 at 7:22 a.m. EST

Pregnancy is a hypercoagulable state, and women who are pregnant or in the postpartum period have a fourfold to fivefold increased risk of thromboembolism compared with nonpregnant women ([Practice Bulletin 196, Thromboembolism in Pregnancy](#)). [Data](#) indicate that COVID-19 infection may lead to increased coagulopathy. Although not yet known, it is possible that pregnancy and COVID-19 infection may be additive for risk of thrombosis. The [National Institutes of Health COVID-19 Treatment Guidelines](#) recommends that pregnant patients hospitalized for severe COVID-19 receive prophylactic dose anticoagulation unless contraindicated.

Additional resources:

- [American Society of Hematology. COVID-19 and VTE/Anticoagulation: Frequently Asked Questions](#)
- [National Institutes of Health. COVID-19 Treatment Guidelines. Antithrombotic Therapy in Patients with COVID-19](#)
- [COVID-19 resources on coagulation and anticoagulation \(International Society on Thrombosis and Haemostasis\)](#)

(These links are for resource purposes only and should not be considered developed or endorsed by the American College of Obstetricians and Gynecologists.)

Prenatal Care

Q: Do patients with suspected or confirmed COVID-19 need additional antenatal fetal surveillance?



Last updated November 4, 2020 at 1:54 p.m. EST.

During acute illness, fetal management should be similar to that provided to any critically ill pregnant person. Continuous fetal monitoring in the setting of severe illness should be considered only after fetal viability, when delivery would not compromise maternal health or as another noninvasive measure of maternal status.

Very little is known about the natural history of pregnancy after a patient recovers from COVID-19. In the setting of a mild infection, management similar to that for a patient recovering from influenza is reasonable. It should be emphasized that patients can decompensate after several days of apparently mild illness, and thus should be instructed to call or be seen for care if symptoms, particularly shortness of breath, worsen. Given how little is known about this infection, a detailed mid-trimester anatomy ultrasound examination may be considered following pre-pregnancy or first-trimester maternal infection. Interval growth assessments could be considered depending on the timing and severity of infection, with the timing and frequency informed by other maternal risk factors. Antenatal testing is reserved for routine obstetrical indications ([SMFM Coronavirus COVID-19 and Pregnancy](#)).

ACOG will continue to carefully monitor the literature to provide our members with the best available and most current guidance. Should new literature indicate any need for additional antenatal fetal surveillance for pregnant patients with suspected or confirmed COVID-19, ACOG will update our recommendations accordingly.

Postpartum Care

Q: How should lactating individuals be counseled about special considerations for infant feeding with breastmilk in the setting of suspected or confirmed maternal COVID-19 infection? (REVISED)



Last updated February 11, 2022 at 3:15 p.m. EST.

Breastmilk provides protection against many illnesses and there are few contraindications to breastfeeding ([Committee Opinion 756](#), [CDC's Pregnancy and Breastfeeding](#)). Current evidence suggests that breastmilk is not a source of COVID-19 infection ([Walker 2020](#), [CDC](#)). A recent cohort of 110 lactating women found no SARS-CoV-2 infectious material in breastmilk samples ([Krogstad 2022](#)). Therefore, suspected or confirmed maternal COVID-19 is not considered a contraindication to infant feeding with breastmilk.

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 patients 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 birthing 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 patient's informed decision about whether to initiate or continue breastfeeding, recognizing that the patient is uniquely qualified to decide whether exclusive breastfeeding, mixed feeding, or formula feeding is optimal ([Committee Opinion 756](#)).

A child being breastfed by someone with suspected or confirmed COVID-19 should be considered as a close contact of a person with COVID-19, and should be quarantined for the duration of the lactating parent's recommended period of isolation and during their own quarantine thereafter ([CDC](#)).

ACOG will continue to review emerging literature on this topic.

**Q: Should a mother-infant dyad be separated in the hospital?
(REVISED)**



Last updated October 4, 2023 at 1:31 p.m. EST.

No. Early and close contact between the mother and neonate has many well-established benefits including increased success with breastfeeding, facilitation of mother-infant bonding, and promotion of family-centered care. Given the available evidence on this topic, mother-infant dyads where the mother has suspected or confirmed SARS-CoV-2 infection should ideally room-in according to usual facility policy. Although data is still emerging and long-term effects are not yet fully understood, data suggests that there is no difference in risk of SARS-CoV-2 infection to the neonate whether a neonate is cared for in a separate room or remains in the mother's room.

For additional information on the management of newborns to COVID-19 positive mothers, see the American Academy of Pediatrics recommendations:

<https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/faqs-management-of-infants-born-to-covid-19-mothers/>

Special Populations

Q: Are there special considerations for incarcerated pregnant people? (REVISED)



Last updated July 1, 2021 at 7:16 a.m. EST.

Prisons, jails, and detention facilities are high-risk environments for COVID-19 transmission, and ACOG has provided [recommendations](#) for addressing the needs of pregnant and postpartum individuals who are incarcerated during the pandemic. For pregnant people who must remain in custody, prisons, jails, and detention facilities should implement measures for social distancing, hygiene, screening, testing, medical care [including COVID-19 vaccination](#), safe housing arrangements, and other interventions as outlined by the CDC's [Interim Guidance on Management of COVID-19 in Correctional and Detention Facilities](#) and as recommended by guidance from the [National Commission on Correctional Health Care](#). As institutions of incarceration adapt operations in response to the pandemic, they must ensure that pregnant people continue to have access to comprehensive health care, including prenatal care, abortion care, postpartum care and breastmilk expression, and timely assessment of pregnancy-related or COVID-19 symptoms, in accordance with [ACOG guidance](#).

If you have unanswered COVID-19 questions or comments, please send them to covid@acog.org.

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COVID-19 FAQs

Clinical Information

Find related FAQs regarding Ethics, Telehealth, and Gynecology.



This document has been developed to respond to some of the questions facing clinicians providing care during the rapidly evolving COVID-19 situation. As the situation evolves, this document may be updated or supplemented to incorporate new data and relevant information. This information is designed as an educational resource to aid clinicians in providing obstetric and gynecologic care, and use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology. The American College of Obstetricians and Gynecologists reviews its publications regularly; however, its publications may not reflect the most recent evidence. Any updates to this document can be found on [acog.org](https://www.acog.org) or by calling the [ACOG Resource Center](#).

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