

Beleid andere landen werk en corona en kinderen

[https://oshwiki.eu/wiki/COVID-19: Back to the workplace - Adapting workplaces and protecting workers](https://oshwiki.eu/wiki/COVID-19:_Back_to_the_workplace_-_Adapting_workplaces_and_protecting_workers)

UK: Q. Can I still go to work? What if I work in a public-facing role?

We understand that it must be an anxious time if you are pregnant and you work in a public-facing role.

Despite the easing of restrictions from 4 July 2020, the advice remains that pregnant women who can work from home should continue to do so. If you can't work from home, but your work in a public-facing role can be modified appropriately to minimise your exposure, this should be considered and discussed with your occupational health team or employer.

If you are in your first or second trimester (less than 28 weeks' pregnant), with no underlying health conditions, you should practise [social distancing](#) but can choose to continue to work in a public-facing role, provided the necessary precautions are taken - these include the use of personal protective equipment (PPE) and an individualised risk assessment.

If you are in your third trimester (more than 28 weeks' pregnant), or have an underlying health condition – such as heart or lung disease – you should work from home where possible, avoid contact with anyone with symptoms of coronavirus and significantly reduce unnecessary social contact. Read the government guidance on [social distancing](#).

In response to feedback from individuals and charities supporting pregnant women, the latest version of the [guidance](#) (updated on 22 May 2020 - Version 3.2) clarifies that the responsibility for risk assessment in the workplace lies with the employer. The guidance clearly places the emphasis on employers undertaking a risk assessment and involving occupational health, to determine whether women who are under 28 weeks' pregnant can continue working in public-facing roles.

Pregnant women can only continue working where the risk assessment supports this. The evidence underpinning this guidance and the fundamentals agreed with the UK Chief Medical Officers remains unchanged.

Q. What is the advice for pregnant women with older children attending school/nursery/external childcare?

Pregnant women were placed in the vulnerable category as a precaution during the coronavirus pandemic. The government's [guidance on schools and early years settings](#) advises that: children and young people who live with someone who is pregnant (vulnerable) can attend school and early years settings. See the next

question for information about pregnant women who are classed as extremely vulnerable.

All pregnant women are advised to follow government guidance on staying alert and safe ([social distancing](#)). Pregnant women are at no greater risk of contracting coronavirus or becoming seriously unwell than other healthy adults. However, there are additional concerns for pregnant women in the third trimester. This is based on the challenges in caring for women who are heavily pregnant, and the risk of the baby needing to be born early for the woman's wellbeing.

A recent report from a UK study showed that so far the majority of pregnant women who became seriously unwell with coronavirus were in the third trimester. This emphasises the importance of stringently adhering to [social distancing](#) from 28 weeks of pregnancy.

If you choose to take your children to school/nursery/external childcare, you should ensure you practice [social distancing](#)– stay two metres away from teachers/carers and other parents and do not go inside the building. If this is difficult, then consider staggering your child's drop off and pick up times. Remember to wash your hands when you return home and ensure that your children wash their hands when they leave the childcare setting. Alcohol gel can be used if they cannot wash their hands with soap and water.

If you are concerned about the choice of returning to school or other childcare settings based on the risk to children attending, helpful information is available from the [RCPCH](#).

Pregnancy - <https://www.rcpch.ac.uk/resources/covid-19-guidance-paediatric-services#pregnancy>

Information for the vulnerable workforce, including pregnant staff members, is available from the [RCPCH COVID-19 guidance for planning paediatric staffing and rotas](#).

Guidance from the Royal College of Obstetricians, Royal College of Midwives, RCPCH, Public Health England and Health Protection Scotland covers COVID-19 infection and pregnancy, information for pregnant women and their families, and occupational health advice for employers and pregnant women.

Public Health England has [guidance on PPE that should be worn on the labour ward](#) (section 8.7). This is adopted by all UK countries.

PHE guidance for households with possible coronavirus infection would indicate that if a mother and baby leave hospital and return to share a home with someone with symptoms of COVID-19 infection they should self-isolate.

The Scottish Government has infant feeding guidance for us by all NHS staff working in maternity, community and Health and Social Care Partnerships during the COVID-19 outbreak. For guidance regarding COVID-19 suspected and positive mothers, see 'Breastfeeding by COVID-19 suspected or confirmed mothers' in the 'Working in neonatal settings' section, below.

<https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-24-coronavirus-covid-19-infection-in-pregnancy.pdf>

1.3 Transmission

Most global cases of COVID-19 have evidence of human-to-human transmission. This virus can be readily isolated from respiratory droplets or secretions, faeces and fomites (objects). Transmission of the virus is known to occur most often through close contact with an infected person (within 2 metres) or from contaminated surfaces.

Pregnant women do not appear more likely to contract the infection than the general population.^{5 6 7} Pregnancy itself alters the body's immune system and response to viral infections in general, which can occasionally cause more severe symptoms. This may be the same for COVID-19 but there is currently no evidence that pregnant women are more likely to be severely unwell, need admission to intensive care, or die from the illness than non-pregnant adults.⁸

With regard to vertical transmission (transmission from woman to her baby antenatally or intrapartum), evidence suggests that vertical transmission might be possible.⁹ Two reports have published evidence of immunoglobulin M (IgM) for SARS-CoV-2 in neonatal serum at birth.^{10 11} A recent report has demonstrated a high SARS-CoV-2 viral load in the placenta, associated with a maternal viraemia and followed by a neonatal infection, including neurological manifestations with inflammatory changes in the neonatal cerebrospinal fluid.¹⁴ In the interim report from the UK Obstetric Surveillance System (UKOSS), six babies (2.5%) had a positive nasopharyngeal swab within 12 hours of birth.¹⁵ In a systematic review of 24 pregnant women with COVID-19, there was no evidence of SARS-CoV-2 on polymerase chain reaction (PCR) testing of placenta, amniotic fluid, cord blood or breastmilk samples.¹⁶ In a larger systematic review of 666 neonates born to women with confirmed COVID-19, 28 out of 666 (4%) neonates had confirmed COVID-19 infection postnatally. On comparing mode of birth, eight out of 292 (2.7%) neonates were born vaginally and 20 out of 374 (5.3%) were born via caesarean birth. Seven were breast fed, three formula fed, one was given expressed breast milk and in 17 neonates the method of infant feeding was not reported, showing that neonatal COVID-19 infection is uncommon and the rate of infection is no greater when the baby is born vaginally, breastfed or stays with the woman after birth.¹⁷

Further investigation around vertical transmission is required and is underway.

1.4 Effect of COVID-19 on pregnant women

There is evolving evidence within the general population that there could be a cohort of asymptomatic individuals or those with very minor symptoms who are carrying the virus, although the prevalence is unknown. A prospective study of 675 pregnant women consecutively admitted to three New York City hospitals for birth, all tested for SARS-CoV-2, found 10% of women were positive for the virus; 79% of those infected women were asymptomatic for COVID-19.⁷

Most pregnant women will experience only mild or moderate cold/flu-like symptoms. Cough, fever, shortness of breath, headache and anosmia are other relevant symptoms.¹⁹ More severe symptoms which suggest pneumonia and marked hypoxia are widely described with COVID-19 in older people, the immunosuppressed and those with chronic conditions such as diabetes, cancer or chronic lung disease.²⁰ The symptoms of severe infection are no different in pregnant women and early identification and assessment for prompt supportive treatment is key.

Another cases series published by clinicians in New York, suggests possible patterns of disease in pregnant women. It describes 43 pregnant women who tested positive for SARS-CoV-2 and reported a similar pattern of disease severity to non-pregnant adults: 86% mild, 9% severe and 5% critical, although the sample size was too small to draw a definitive conclusion and no comparison was made for age, sex or co-morbidity-matched individuals.²¹

On 20 March 2020, UKOSS launched a registry for all women admitted to UK hospitals with confirmed COVID-19 in pregnancy. Further information can be found here. An interim report, was published on 08 June 2020.¹⁵ The UKOSS study is the largest published population-based cohort of pregnant women admitted to hospital with COVID-19 to date. At the time of the interim report, complete data were available for 427 pregnant women admitted to UK hospitals with confirmed SARS-CoV-2 infection between 1 March and 14 April 2020; this represents an admission rate of 4.9 (95% confidence interval [CI] 4.5–5.4) per 1,000 maternities. The women included in the report may have required admission to hospital for many reasons, including severe symptoms of COVID-19 or other obstetric indications (e.g. labour and birth) where COVID-19 was co-existent; it is not known what proportion of the admissions were because of COVID-19, rather than with COVID-19. Of the 427 pregnant women reported in the UKOSS study, 38 women (9%) required level-3 critical care; four women (<1%) received extracorporeal membrane oxygenation (ECMO). Five women included in the study died, suggesting a SARS-CoV-2-associated maternal mortality rate of 5.6 (95% CI 1.8–13.1) per 100,000 maternities compared to the overall maternal mortality rate in the UK of 9.2 per

100,000 from 2015–2017 data.²³ Whether these deaths are a direct result of COVID-19 infection is currently unclear. These data are expected to be updated in the future.

In data from the UKOSS study, most women were hospitalised in the third trimester or peripartum (n=342, 81%). The median gestational age at hospital admission was 34 completed weeks (interquartile range [IQR] 29–38). Of those admitted, 42% did not require iatrogenic birth of the baby; these women were discharged whilst still pregnant. Of those who did give birth during the data collection period, 59% had caesarean births; approximately half of these were because of maternal or fetal compromise. The remainder were for obstetric reasons (e.g. progress in labour; previous caesarean birth) or maternal request (6%). Of the women having a caesarean birth, 20% required general anaesthesia (GA) because of severe COVID-19 symptoms or urgency of birth.¹⁵

The UK Intensive Care National Audit and Research Centre (ICNARC) weekly report of the admissions to critical care with COVID-19, last updated on 17 July 2020, describing the first 10,492 admissions.⁸ Only 28 were currently pregnant and 39 recently pregnant (within the last 6 weeks).

1.6 Effect of COVID-19 on the fetus

There are currently no data suggesting an increased risk of miscarriage in relation to COVID-19. Case reports from early pregnancy studies with SARS-CoV and MERS-CoV have not demonstrated a significant relationship between infection and increased risk of miscarriage or second trimester loss.⁴³

There is no evidence that fetal growth restriction (FGR) is a consequence of COVID-19; however, at present, this is considered possible as two-thirds of pregnancies with SARS were affected by FGR.^{44 45}

In the UKOSS cohort, the median gestational age at birth was 38 weeks (IQR 36–39 weeks). Of women who gave birth, 27% had preterm births: 47% of these were iatrogenic for maternal compromise and 15% were iatrogenic for fetal compromise, with 10% of term babies requiring admission to the neonatal unit. Six (2.5%) babies had a positive test for SARS-CoV-2 during the first 12 hours after birth; three of these were in babies born by pre-labour caesarean birth. One of these babies required admission to the neonatal unit. It was unclear from the report whether two perinatal deaths were related to co-existing maternal COVID-19.¹⁵

A review of 71 neonates born to women with COVID-19 in the third trimester reported that neonatal infection was diagnosed in 4 cases (5.6%) within 48 hours of birth by PCR tests of cord and neonatal blood samples.⁹

<https://www.rcog.org.uk/globalassets/documents/guidelines/2020-05-22-occupational-health-advice-for-employers-and-pregnant-women-during-the-covid-19-pandemic.pdf>

3.1 Protection of all pregnant healthcare workers

Every pregnant worker should have a risk assessment with their manager, which may involve occupational health. Employers should modify the working environment to limit contact with suspected or confirmed COVID-19 patients to minimise the risk of infection as far as possible.

In the light of the limited evidence, pregnant women can only continue to work in direct patient-facing roles if they are under 28 weeks' gestation and if this follows a risk assessment that recommends they can continue working, subject to modification of the working environment and deployment to suitable alternative duties. Pregnant women of any gestation should not be required to continue working if this is not supported by the risk assessment, as per the Management of Health and Safety at Work Regulations 1999 (MHSW). If a risk assessment indicates that a pregnant woman under 28 weeks' gestation can continue to work in a patient facing role, and the woman chooses to do so, she should be supported by her employer.

Suitable alternative duties might include remote triage, telephone consultations, governance or administrative roles. This is in line with the national guidance that workers, including healthcare professionals, who are also identified by the government as vulnerable to COVID-19 should participate in their own risk assessment.

3.2 Choices for pregnant healthcare workers prior to 28 weeks' gestation

Following a risk assessment with their employer and occupational health, pregnant women should only be supported to continue working if the risk assessment advises that it is safe for them to do so. This means that employers must remove any risks (that are greater in the workplace than to what they would be exposed to outside of the workplace), or else they should be offered suitable alternative work. Issues about pay and remuneration are beyond the remit of this guidance. If alternative work cannot be found, advice on suspension and pay should be sought from the relevant trade union and/or staff representative. There is some further guidance available from the [BMA](#), [RCM](#) and [Maternity Action](#).

Some working environments (e.g. operating theatres, respiratory wards and intensive care/high dependency units) carry a higher risk of exposure to the virus for all healthcare staff, including pregnant women, through the greater number of aerosol-generating procedures (AGPs) performed. These procedures are summarised in the PHE publication '[Guidance on Infection Prevention and Control](#)'. When caring for suspected or confirmed COVID-19 patients, all healthcare workers in these settings are recommended to use appropriate PPE. Where possible, pregnant women are advised to avoid working in these areas with patients with suspected or confirmed COVID-19 infection.

3.3 Healthcare workers after 28 weeks' gestation or with underlying health conditions

For pregnant women from 28 weeks' gestation, or with [underlying health conditions](#) such as heart or lung disease at any gestation, a more precautionary approach is advised. Women in this category should be recommended to stay at home. For many healthcare workers, this may present opportunities to work flexibly from home in a different capacity, for example by undertaking telephone or videoconference consultations, or taking on administrative duties.

All NHS employers should consider both how to redeploy these staff and how to maximise the potential for homeworking given current relaxation of [NHS Information Governance](#) requirements, wherever possible.

The RCM provides advice for pregnant healthcare workers who cannot be redeployed or work from home. Staff in this risk group who have chosen not to follow government advice and attend the workplace must not be deployed in roles where they are working with patients. Services may want to consider deploying these staff to support other activities such as education or training needs (e.g. in IPC or simulation).

These measures will allow many pregnant healthcare workers to choose to continue to make an active and valuable contribution to the huge challenge facing us, whether at home or in the workplace, until the commencement of their maternity leave.

Update registratie COVID-19 positieve zwangeren in NethOSS

Geplaatst op 24 juli 2020

Onderstaande tekst wordt frequent geüpdatet, afhankelijk van de ontwikkelingen in Nederland. (datum 24 juli 2020).

Per 1 maart 2020 is NethOSS gestart met de registratie van COVID-19 positieve zwangeren in Nederland.

Tot **24-7-2020** zijn in totaal **268 meldingen** gedaan van zwangeren met een bewezen COVID-19 infectie. *Grafiek 1* en *Grafiek 2* geven een overzicht van het type meldingen en een overzicht per week. *Grafiek 3* geeft een overzicht van het aantal meldingen per provincie. De meldingen van de afgelopen vier weken bevatten ook de resultaten van bloedtesten naar positieve antistoffen, waarbij zwangeren al eerder klachten hadden.

Van de **268 meldingen**, hebben we van **251 casus** korte aanvullende informatie ontvangen en van **217 casus** uitgebreide aanvullende informatie.

Zwangerschap:

Van deze binnengekomen casus zijn **152 vrouwen** op dit moment zwanger. Er is helaas één casus gemeld waarbij er maternale sterfte heeft plaatsgevonden ten gevolge van covid-19. Er heeft geen neonatale sterfte plaatsgevonden. Er zijn in totaal **175 vrouwen** in thuisisolatie (geweest) met milde klachten, verder hebben 5 vrouwen opgenomen gelegen op de intensive care en 7 op de obstetrische 'high care'. Er zijn 105 patiënten opgenomen (geweest) op een obstetrische of interne afdeling in het ziekenhuis. Daarvan hebben 50 antepartum opgenomen gelegen, 82 tijdens de bevalling en 11 postpartum. Bij 33 vrouwen is beschreven dat er radiologische afwijkingen waren die passen bij een virale pneumonie. De meest voorkomende beschreven klachten zijn hoesten (45,8%), koorts (37,6%) en kortademigheid (26,6%). Het percentage vrouwen met koorts lijkt hierbij af te nemen, dit kan mogelijk verklaard worden vanwege de versoepelde testmogelijkheden.

Therapie:

In **40 casus** werd medicamenteuze therapie gestart. In 36 van deze casus is gestart met antibiotica. Er werd in 3 casus beschreven dat werd gestart met een antiviraal middel. In één casus werd tamiflu gestart en twee keer remdesevir. Er is bij **27 vrouwen** beschreven dat zij tijdelijke behandeling met zuurstof hebben ontvangen. Van deze vrouwen hebben 20 een O2 masker gekregen en zijn 3 patiënten geïntubeerd (geweest), waarvan twee ook op de buik beademd zijn. In een aantal casus wordt beschreven dat een neusbril voldoende was.

Partus:

Van de **98 vrouwen** die niet meer zwanger zijn, is van 91 vrouwen aanvullende informatie bekend. Er zijn hierbij twee casus gemeld waarbij er sprake is geweest van een miskraam voor 12 weken, één late miskraam bij 14 weken en één casus van een mola zwangerschap. Negenentwintig van de overige **87 vrouwen** zijn bevallen middels sectio. Bij 12 van deze sectio's gaat het om een primaire sectio. Van de 17 secundaire sectio's was in 7 casus sprake van niet vorderende ontsluiting of uitdrijving en in 7 casus van verdenking foetale nood. Van de overige sectio's is nog niet duidelijk wat de indicatie was. Er zijn 13 casus gemeld waarbij sprake is geweest van vroeggeboorte (8 casus met een termijn <36 weken en 5 >36 weken), en 10 casus van dreigende vroeggeboorte waarbij 4 vrouwen nog zwanger zijn. In totaal is bij 10 vrouwen gestart met corticosteroiden in de zwangerschap. De bevalling werd bij 44 vrouwen ingeleid en 44 vrouwen kregen durante partu pijnstilling middels epidurale analgesie (23 vrouwen), remifentanyl (15 vrouwen), epidurale analgesie en remifentanyl (5 vrouwen), pethidine of morfine (1 vrouw). In 27 casus werd aanvullend microbiologisch onderzoek gedaan door middel van vaginale kweken, kweken van het vruchtwater of van de placenta. In één van deze casus was de vaginale kweek positief voor COVID-19 en één keer de kweek van het vruchtwater.

Neonataal:

Van de **90 pasgeborenen** (er is in drie casus sprake geweest van een gemelli-zwangerschap) werden 20 neonaten postpartum opgenomen op de afdeling neonatologie. Geen van de neonaten werd positief getest op COVID-19. Bij 61 neonaten werd gestart met borstvoeding. Daarbij werden geen problemen beschreven.

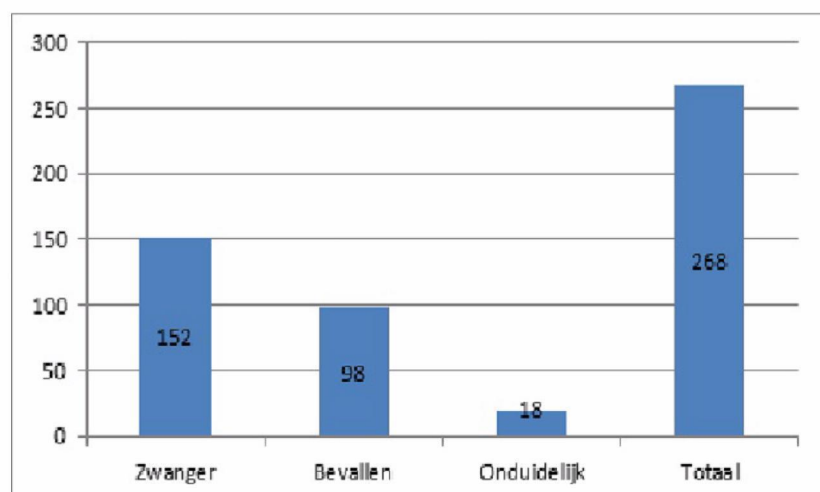
Hoe werkt de registratie?

De registratie verloopt via een contactpersoon in elk ziekenhuis. We hebben de verloskundigen uit de eerste lijn ook gevraagd om casus via de contactpersonen te melden. De contactpersonen ontvangen elke week een mail met een link naar een vragenlijst. Als er een melding gedaan is, wordt vervolgens een case report form verzonden met aanvullende vragen.

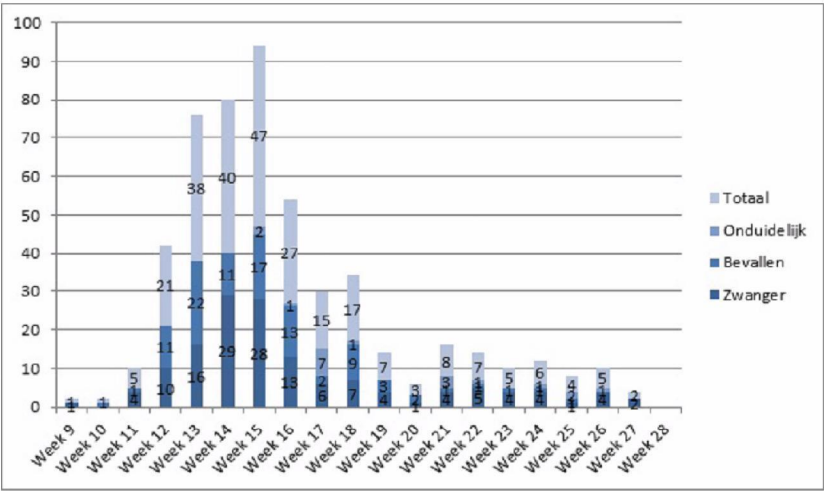
Tot nu toe gaat het melden van de casus goed en wordt het case report form snel ingevuld en teruggestuurd, waarvoor veel dank!

Aangezien er via NethOSS wekelijks geregistreerd wordt, lopen we iets achter op de informatie die via het RIVM beschikbaar is. We zijn inmiddels over op het nieuwe datamanagement programma, dus iedere NethOSS contactpersoon heeft weer een link ontvangen voor meldingen van de afgelopen weken. De volgende link zult u 27 juli ontvangen en zal gaan over meldingen van de afgelopen week dus tussen **20 en 26 juli**. Voor vragen en opmerkingen kunt u contact met ons opnemen via info@nethoss-perined.nl

Grafiek 1: Status aantal gemelde zwangere vrouwen met COVID-19



Grafiek 2: aantal gemelde casus per week



Grafiek 3: Aantal meldingen per provincie



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