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Effect of COVID-19 on maternal and neonatal services

I congratulate Ashish KC and colleagues¹ for their efforts to highlight the lesser-known effects of COVID-19. The pandemic abruptly disrupted efforts towards almost all Sustainable Development Goals and, in many cases, turned back decades of progress.² The increased stillbirths and neonatal mortality during COVID-19 will also be a major setback for the Every Newborn action plan by WHO.^{1,3} The study by KC and colleagues focused on hospital deliveries and the effect at the community level is likely to be worse. Due to strict lockdown measures, many pregnant women did not reach hospitals and some of these pregnancies ended with adverse outcomes (stillbirth or neonatal mortality). Strategies to prevent stillbirths and neonatal deaths during the COVID-19 pandemic will require further clarification on some of the findings.

Reasons for the increased stillbirths shown by KC and colleagues might include reduced intrapartum care and delay in transport;⁴ however, the reason for increased neonatal mortality despite fewer admissions (suggesting less overcrowding and reduced health-care worker to patient ratio) is unclear. During the COVID-19 pandemic, hand-hygiene compliance and demand for personal protective equipment (PPE) increased substantially. The sudden increase in the demand for PPE in designated COVID-19 wards led to the diversion of supplies from so-called non-COVID-19 areas (leading to a decrease in PPE availability in these areas), accompanied by fear among health-care workers of contracting severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) from undiagnosed patients (as no asymptomatic patients admitted to hospital, including pregnant women,

were tested), might have led to decreased intrapartum surveillance.⁵

Initially, in India and Nepal, SARS-CoV-2 testing was reserved for pregnant women presenting with an influenza-like illness. However, many asymptomatic pregnant women became symptomatic after delivery and ultimately tested positive for SARS-CoV-2, thereby exposing a large number of health-care workers to the virus. This led to fear among staff and resulted in reduced contact with patients (and therefore reduced intrapartum monitoring) because the PPE supply was poor. Later, adopting a policy of universal SARS-CoV-2 testing for pregnant women entering hospitals for delivery, segregating them into different areas, and ensuring adequate PPE supply led to a reduction in fear and apprehension among health-care workers, resulting in better intrapartum monitoring.

The increased number of caesarean sections shown by KC and colleagues, despite no COVID-19 cases being diagnosed before delivery, and the decreased number of women breastfeeding at 1 h despite doubled skin to skin contact rates warrant further exploration. The hypothesis of the misunderstanding of breastfeeding protocol by health-care workers in the absence of any confirmed cases does not seem logical.

The effect of fewer admissions (and therefore an improved doctor or nurse to patient ratio) accompanied by fewer interventions for puerperal and neonatal sepsis should be investigated. Universal SARS-CoV-2 testing before delivery, availability of PPE, use of standardised protocols, sensitisation of the community to institutional delivery using multimedia platforms, improved transport services, and optimal use of telemedicine services might be useful for reducing stillbirths and neonatal mortality.

I declare no competing interests.

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