

Effect of COVID-19 on maternal and neonatal services

Similar to the observations made by Ashish KC and colleagues¹ in Nepal, we previously reported an increase in stillbirths associated with the COVID-19 pandemic in the UK, from 2.38 per 1000 births (between Oct 1, 2019, and Jan 31, 2020) to 9.31 per 1000 births (between Feb 1 and June 14, 2020), but unrelated to clinical severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection.² This observation has been sustained, with the number of stillbirths remaining high in July, 2020 (14.2 per 1000 births). In media reports, this observation has been made in other UK hospitals. However, stillbirths are primarily antenatal in the UK. By including only women at 22 weeks' gestation or more and with confirmed fetal heart sounds, KC and colleagues extend our findings to less-resourced settings and show an increase in confirmed intrapartum stillbirths associated with a reduction in quality of care during the pandemic.

Because the reported increase in stillbirths might be an underestimate of the true indirect effect of the pandemic on perinatal survival, information is needed on the incidence of antenatal stillbirth in the study settings used by KC and colleagues. The increase in intrapartum stillbirths and reduction in intrapartum quality of care make unsurprising an increase in neonatal mortality, because some infants will die from neonatal sequelae of intrapartum insults that are resistant to basic neonatal care.

Moreover, KC and colleagues have documented an increase in preterm births during the pandemic, associated with lockdown and a reduction in care seeking for birth. Although an increase in preterm births has been observed in studies of pregnancies in women with COVID-19,³ this was primarily iatrogenic, making an increase related

solely to asymptomatic SARS-CoV-2 infection less likely. If the rate of ultrasonography-dated pregnancies changed during the pandemic, this could have contributed to estimates of lower gestational age at birth. To assess this, information is needed on any differences in antenatal screening during the pandemic and lockdown in particular, something that was preserved in 85% of sites in the UK.⁴

We agree that pandemic lockdowns have potentially harmful effects.⁵ The reductions in care seeking and their associations with adverse outcomes observed in Nepal and in the UK serve to emphasise the need for balanced public health messaging.

We declare no competing interests.

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