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COVID-19 and maternal and perinatal outcomes

Authors' reply

We thank all correspondents for their interest in our report.[1] A common point is the need for better quality studies in this area, which we wholeheartedly echo. Quality and consistency in reporting, particularly of key outcomes such as maternal death, stillbirth, and preterm birth, are essential if we are to tackle these scourges of maternity care.

As always, systematic reviews are restricted to covering what has been published. Susannah Leisher and the International Stillbirth Alliance call for the inclusion of a relevant preprint paper. We recognised that the COVID-19 literature is a rapidly evolving field with high rates of preprint publication. In consultation with editors and reviewers, however, we agreed to exclude such papers to avoid the pseudo-inflation of the sample size and undermine confidence in the findings of the analysis, but acknowledge that this exclusion might have a greater effect on data from LMICs, which are recognised to be less likely to secure publication.

We agree with Clara Calvert and colleagues, and did highlight in our Article, that the finding of an increase in maternal mortality relied on just two data sources, only one of which presented national-level data. The finding is consistent with another report from India not included in the quantitative analysis,[2] and with national-level evidence from Kenya reported in a preprint publication.[3] But we agree that this early identification of increased maternal mortality cannot necessarily be extrapolated throughout the global population and that further investigation is required.

We share Lizbeth Ochoa and colleagues' confidence in the finding that preterm birth seems to have decreased, in high-income countries at least, during the COVID-19 pandemic. We support their call for further robust investigations using population-level data of a high quality and considering stillbirth and preterm birth together. They suggest that we should have included another study in the quantitative synthesis.[4] However, we were unable to include this otherwise excellent study because the report included four different time frames around three different implementation dates without extractable raw data.

We read with interest Zeus Aranda and colleagues' experiences in delivering maternity care at their Partners in Health project sites and congratulate them on their successes. Key lessons include the importance of responses to local need based on acceptable and available models of care and resources, highlighted in their community health worker programmes in Lesotho, Malawi, and Mexico. The response to the COVID-19 pandemic has driven an explosion in remote access to health care, community reporting, and the use of technology in a diverse range of settings. We should use this opportunity to improve the coverage of pregnancy and neonatal surveillance data.

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1 Chmielewska B, Barratt I, Townsend R, et al. Effects of the COVID-19 pandemic on maternal and perinatal outcomes: a systematic review and meta-analysis. *Lancet Glob Health* 2021; **9:** e759–72.

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3 Shikuku D, Nyaoke I, Gichuru S, et al. Early indirect impact of COVID-19 pandemic on utilization and outcomes of reproductive, maternal, newborn, child and adolescent health services in Kenya. *medRxiv* 2020; published online Sept 9. https://doi.org/10.1101/2020.09.09.20191247 (preprint).

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