Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Editorial

Who safeguards pregnant women's autonomy during the COVID-19 pandemic?

A sequence of events quickly followed the detection of the novel beta coronavirus named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) [1]. The virus was first brought to the attention of the World Health Organization (WHO) on December 31, 2019 by officials from WHO's Country Office in the People's Republic of China. On March 11, 2020 the virus now termed coronavirus disease 2019 (COVID-19) was classified by WHO as a global pandemic with Europe as the epicenter [2]. Given the short time from detection until the global spread of SARS-CoV-2, health services such as antenatal care and maternity clinics implemented drastic changes in their services in order to secure a functioning organization. Due to the gravity of the situation, changes were necessary to ensure services and minimize the risks of virus transmission. However, one could wonder if the implemented changes benefit the health of pregnant women and their families?

Considering childbirth as a physical, social, cultural and emotional life event, it is of uttermost importance that the planned care takes all of these factors into consideration. The International Confederation of Midwives (ICM) states that a service-centered care rather than a woman-centered care risks contributing to an over-medicalization of pregnancy and childbirth [3]. Due to the urgency of the pandemic, decisions about changes of services had to be made quickly. But what was the focus in the planning, and who was involved in the decision-making? Ideally, women using the services should participate in all planning and designing of services; if this was not possible, who would safeguard the women's voices?

Pregnant women and women giving birth are in need of different levels of maternity care. For some women, highly specialized care during pregnancy and birth is needed. Admission to hospital of women with a low risk of complications during birth, may decrease their chances of a spontaneous vaginal birth without increasing the safety of their unborn child [4,5]. Furthermore, during a pandemic, the concept of community-centered care is required in well-developed healthcare systems and hospital care should be limited to those at high risk to decrease the risk of virus transmission and also to use hospital capacity wisely, and to protect patients and health care workers [6]. This lesson was also learned in 2003 during the Toronto SARS outbreak. Despite existing knowledge of the way to organize community-centered care during outbreaks, all homebirths were suspended in four of five Danish regions due to fear of spreading of SARS-CoV-2. Women are rightly questioning the foundation for making this decision. Why was it considered unsafe for a healthy pregnant woman with an uncomplicated pregnancy, and with no signs of infection, to give birth outside of a hospital even during the pandemic? The birthing woman is more likely to be infected in a hospital setting compared with her own home. The risk of infection should remain about the same and most likely lower for the attending midwife considering, more interactions with other healthcare professionals and patients in the hospital setting and that viruses may be transmitted in hospitals, even when preventive measures are taken [7]. Were women's rights to make a choice about the birth setting even considered when restrictions in maternal care were implemented? If not in the initial phase, then few months after? Do childbearing women have a voice now several months after WHO declared the spread of COVID-19 a pandemic; and if not, why not?

The implemented policies are not only affecting low risk pregnant women. Women in need of a higher level of maternity care are also highly affected by changes in services. In Sweden, partners are banned from attending all prenatal care visits including the fetal abnormality scan. This might appear logic, since the partner is not in focus in this prenatal appointment. However, the pregnant woman stands without social support if something abnormal is found. The same goes for parents who have previously experienced a pregnancy loss including stillbirth, where the pregnant woman now has to manage all appointments by herself without the support of her partner or a companion of choice. In most Swedish hospitals, the non-birthing parent is sent home after the child is born, leaving women who have just given birth, some by cesarean section, with their newborn(s), without social support. This combined with a shortage of staff in the maternity ward, may impose a trauma in the women, who may feel inadequate in caring for the newborn alone, while recovering after birth.

Moving forward, new steps are needed to ensure that pregnant women's autonomy in pregnancy and childbirth is respected. Thankfully, several research initiatives studying the effect of COVID-19 on parental experiences have been taken. Such research will provide important knowledge on the effects of implemented preventive measures regarding COVID-19 on the transition to parenthood. The COVID-19 pandemic is still ongoing and the lack of planning and involvement of women and those specialized in care for pregnant and birthing women have now become evident. Necessary measures must be taken to ensure that women's autonomy during pregnancy and childbirth is safeguarded at all times including during unforeseen events such as epidemics. To do so, several changes in the infrastructure of health services are needed. Women's voices need to be heard and accounted for in decision-making processes at all levels. Women must be involved in the design of antenatal and maternity care and a diversity of services suitable for different care levels that need to be implemented. In future plans for unforeseen events, the perspective needs to change from only securing the functionality of the organization to including a broader perspective of the health of pregnant women and their families in both short and long-term perspective.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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