Editorial

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Women and children first: the need for ringfencing during the COVID-19 pandemic

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Hospitals all over the world are overwhelmed by admissions for coronavirus patients. Elective, nonessential procedures and surgeries are being cancelled to free up hospital resources for patients sickened by coronavirus disease 2019 (COVID-19). In-vitro fertilization and other reproductive medicine interventions have stopped. Nurses, doctors, and other personnel are strained to their limits. Obstetric services and labor and delivery units have been affected as space and personnel are being commandeered for non-obstetric patients. Physicians, nurses, and other personnel usually assigned to obstetric services are assigned to other clinical services in the hospital to supplement overwhelmed personnel. This adds to the strain pregnant women and their families already have to endure.

We are still at the beginning of finding solutions, but for now, recommendations in the US and in Germany for COVID-19-positive pregnant women correspond to the recommended approach and treatment of non-pregnant COVID-19 patients: physical distancing, isolation, no accompaniment by unnecessary people. Medical treatment should also comply with the recognized treatment guidelines of non-pregnant patients.

Under the growing strain and stress of the coronavirus pandemic, it is not difficult to lose sight of the essentials. Women still become pregnant, they are still pregnant, they still go into labor, need to be taken care of in labor, and they are still having babies, some of whom will require resuscitation and rapid access to neonatal critical care. We should not lose sight of an essential that secures the future of families and society: putting women and children first.

This essential means that only those changes that are well supported in deliberative (evidence-based, rigorous, transparent, and accountable) clinical judgment should be made in response to the coronavirus pandemic. Organizational leaders should be clear about the clinical concept of "elective" and the organizational application of this concept, to prevent making disruptive changes that could unjustifiably make women and children second, or even last. "Elective" means that a form of clinical management is time-sensitive, in that it can be postponed as long as there is no short-term or long-term increased risk of disability, serious morbidity, and mortality. For example, hysterectomy for asymptomatic, benign myomas would be elective. While pregnancy is a condition and not a disease, pregnancy is never elective, by its very nature. Justified prohibition of elective surgical procedures during the COVID-19 pandemic does not apply to scheduled obstetric surgical procedures that are well supported in deliberative clinical judgment, such as cesarean delivery.

Recently, several New York City hospitals had instituted a ban on support persons in response to the coronavirus epidemic, resulting in an outcry from expectant parents, doulas, and midwives, and a petition that has received more than 600,000 signatures. The ban was contrary to recommendations made by both national and internal professional organizations and the World Health Organization (WHO) which encourage that pregnant women are accompanied by a support person, who poses no threat to laboring women and babies, other patients, or health care professionals, when accepted standards of infection control are followed. This ban was quickly rescinded by the New York Department of Health with an executive order and the Secretary to the Governor said: "Women will not be forced to be alone when they

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are giving birth" [1]. In Germany, there is a wide range of hospital recommendations, from not allowing a support person to allowing only one.

Pregnant women have been told for the longest time that regular prenatal visits, tests, and examinations are necessary to ensure a healthy pregnancy. Now, changes have been proposed due to the COVID-19 pandemic that recommend reduced prenatal visits and tests including reduced ultrasounds.

Some US midwives are suggesting that in spite of documented dangers of homebirths [2], pregnant women should consider a homebirth to protect themselves from becoming infected with COVID-19 in hospitals. No professional organization supports that recommendation [3–7], and British midwives now strongly urge women the exact opposite and to deliver in the hospital where requisite resources are present and where delivery is considered safer.

There is and there will always be an ongoing need for hospital-based maternity services. Delivering a baby is not an elective procedure. All deliveries have an inherent risk of complications. Women need the care and support of professionals and properly resourced hospital-based maternity services.

In England, a large percentage of maternity units have been closed, and homebirths have been stopped or restricted [8]. One way to achieve this goal in this crisis is to implement the proposal of the Royal College of Midwives (RCM) that maternity services be "ringfenced" during this crisis to ensure women and babies continue to receive safe care without compromise [8]. The term "ringfencing" has its origins in the ringfences that are built to keep farm animals in and predators out. In finances, a ringfence is a virtual barrier that segregates a portion of an individual's or company's financial assets from the rest. Human and material maternity resources should be ringfenced from redeployment that impairs the capacity of labor and delivery units to ensure that women and their newborns continue to receive the safest possible care.

The International Academy of Perinatal Medicine has added its voice to these advocacy efforts, with its "New York Declaration" on "Woman and Children First", which was presented at the United Nations on July 7, 2008 [9, 10]. The declaration defined sources of bias against the just allocation of health care resources for women and children in the low-income countries. The lack of prioritization for health care for women and children is not confined to these countries. This can also be a problem in the US and other high-income countries.

The essential of putting women and children first during the coronavirus (and next) pandemic requires that hospitals sustain access by pregnant women and newborns to timely, effective, and safe prenatal and in-hospital care for the non-elective condition of pregnancy. Reasonable and prudent ringfencing should be used to protect human and other resources required to meet this goal. To the extent consistent with meeting the clinical needs of all patients, maternity services should be ringfenced from the crisis atmosphere that, understandably, has emerged in hospitals as they respond to the extraordinary clinical, psychological, social, familial, and personal challenges by the COVID-19 pandemic. Putting women and children first in this crisis will ensure that we do not lose sight of the fact that pregnant women and their newborns represent our future. Hospital-based ringfenced labor and delivery and neonatal services are a safeguard to ensure a safe future for all of us.

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