**Effect of COVID-19 on Sexual and Reproductive Health of Pregnant Women in India: A Preliminary Study**

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**Abstract**

COVID-19 has proved to be a global emergency that has fractured the health care systems to an extent that its impact is too difficult be encompassed right now. India on 24th March 2020 declared a nation-wide lockdown to curtail the spread of corona virus. This unplanned and sudden lockdown has left pregnant women vulnerable to desensitized care. Ministry of Health and Family Welfare (MOHFW) issued several guidelines in context to the maternal services, yet administrative apathy is endangering the lives of pregnant women in India. This implies that COVID-19 is having a catastrophic secondary impact on the sexual and reproductive health of women. The paper foregrounds that as the health services were diverted to combat the virus, the reproductive health and rights of women leading to maternal and new born mortality were constantly compromised. The article also unveils that as the clinical impact of COVID-19 and the case of vertical transmission is still not known, the brunt of dehumanised care, obstetric violence, lack of PPE kits and delay in ambulance services are some of the secondary factors that proves that the collateral destruction caused by the pandemic is greater than the pandemic itself.

Keywords: COVID-19, vertical transmission, obstetric violence, Sexual and Reproductive Health.

*Pandemics are a magnifying glass that sheds light on social conditions, gender included.*

May-Britt Ohman Nielsen

**Introduction**

Coronavirus disease 2019 (COVID-19) has proven to be a global health crisis that first began in China but has gone on to affect billions of people globally. Scientists have established through their research that it happened because of an unprecedented coronavirus named ‘severe acute respiratory syndrome 2 (SARS-CoV-2)’ for which as of now there is no substantial treatment available. Governments and global organisations are primarily focussed on COVID-19[[1]](#footnote-1) crisis decision making. As a result of which it has been observed that there is an intense change in national health governance and the politically defined determinants of sexual and reproductive health and rights (SRHR). According to WHO (World Health Organization), “violence against women remains a major global public health and women’s health threat during emergencies”. The outbreak is a visible exhibition of the “lie of global health expertise”. (Dalglish, 2020) This has led to a sudden state of flux in the healthcare systems prompting many unanswered questions in people’s minds regarding the ramifications of COVID-19 on certain sections of people in society who are more vulnerable than others. Despite declaring COVID-19 a national disaster, the Indian Government has fallen short of providing necessary administrative strategies. India is nowhere close to achieving the WHO’s Sustainable Development Goal (SDG-3) that strives to ‘ensure healthy lives and promote wellbeing for all at all ages.’ (Rahman, 2020)

In February 2020, The United Nations Population Fund (UNFPA) Asia and Pacific Regional Office circulated its first guidelines and elucidated that SRH (Sexual and Reproductive Health) during a pandemic is a serious health crisis. (UNFPA, 2020) Pregnancy, being a crucial health condition is exemplified by specific and nonspecific changes in women’s body and the complications it might incur during gestation period is not a hidden fact for it has been validated numerous times by medical intervention. Therefore, in the pandemic affected world, a policy discourse on the effect of COVID-19 on pregnant women becomes an important discussion. The chance of pregnant women being affected with COVID-19 virus is debatable as the probability of vertical transmission[[2]](#footnote-2) is still unknown but various studies have established through their research that there is a higher possibility for certain obstetric convolution, for example, pre-term delivery and fetal mortality. (Rasmussen et al., 2020) The outbreak of Ebola in 2014-2016 in West Africa, SARS (Severe Acute Respiratory Syndrome) of 2002-03, MERS (Middle East Respiratory Syndrome) of 2012, and the Zika virus epidemic of Brazil in 2015-16, exposed that the threat to the lives of these pregnant women was not the virus but the shutting down of routine health assistance. For sexual and reproductive health (SRH) services, obstructions in information and delivery of services have caused serious problems for women’s health and well-being. As per studies, the unavailability and inaccessibility of contraceptive services during lockdown has approximately led to unattended contraceptive needs in 47 million women from under-developed and developing countries and almost 7 million unintended pregnancies. (Nanda et al., 2020) The repercussions of an unmet demand for contraceptives are proving to be catastrophic for women, causing high maternal mortality and risky abortions. (Lokot & Avakyan, 2020) The maternal health scenario in India is already in a state of flux. There are instances in which pregnant women have lost their lives when safe delivery, neonatal services became inaccessible due to the several outbreaks (Hussein, 2020) with no exception to the COVID-19 outbreak. WHO and Human Reproduction Programme (HRP) ‘have also highlighted SRH in its research roadmap for the COVID-19, as part of the overall WHO response to the outbreak.’ (Tang et al., 2020, pp.1-2)

This paper aims to evaluate the impact of COVID-19 on pregnant women in India, within and beyond the intervention of government policies and schemes. With disparities in health care requirements and disrupted customary essential facilities, sexual and reproductive health of pregnant women has been hit hard as there is very limited or no access to isolation centres for women in labour or gestation[[3]](#footnote-3). For Indian women, to be pregnant in this time of pandemic can be a traumatic one. Their paranoia reaches its peak when they realize how their basic need to be in regular contact with maternity and clinical services expose them to higher risks. The article also tends to discuss the rights of Indian women in this context which constitutes an integral part of public health issues in need of urgent attention during the pandemic. The article has followed the content analysis methodology and resorts to netnographic and discourse analysis. COVID-19 being a recent phenomenon has significantly increased the responsibility of news media on influencing and promoting awareness about the pandemic as well as informing the people about various issues that have emerged due to the same. Due to the situation of being primarily homebound due to lockdown, the study was initiated with the design of netnographic research which is a naturalistic method that has strategically helped in analysing the news content. The article has developed on it addressing the sexual and reproductive health of pregnant women. Discourse analysis is another effective method that helps in giving voice to the voiceless, revealing the power structure that operates in society. Discourse analysis through various media reports has helped to locate the vulnerability index of these pregnant women vis-à-vis their human rights. It poignantly questions the punctured Health care system of India which has more or less failed to ensure the health and safety of pregnant women during COVID-19. The already weak health system has grown weaker due to the additional load of pandemic management. Though the preparedness to ensure containment of the pandemic related emergencies is dealt with promptness and care, the routine but essential healthcare is being neglected. (Vora et al, 2020)

**Effects of COVID-19 on Health Care Services and Workers**

Prime Minister Narendra Modi declared a complete lockdown of all activities in India from March 24, 2020, as a strategic move to curtail the spread of coronavirus. However, the lockdown was sudden and not planned well which led to unparalleled hardships for several vulnerable sections of the society, including pregnant women. For example, the lack of attentiveness from the State, indifference from the administration, pre-conceived discrimination and inequalities, the status of migrants, and the lack of PPE[[4]](#footnote-4) (Personal Protective Equipment) kits for the healthcare staff can be some of the major factors responsible for endangering the lives of pregnant ladies as well as their new unborn/new-born babies. For instance, since the COVID-19 pandemic the pregnant women in the villages are neither receiving food from healthcare workers nor any vaccination. COVID-19 has given a significant stress on health-care providers and systems in every country possible, destabilising their capability to ensure ‘responsive, respectful care and to support autonomous decision- making’. (Hall et al, 2020; Hussein, 2020) Thus, contradicting the *Pradhan Mantri Safal Matritva Abhiyan*[[5]](#footnote-5) which states that approximately 44000 women die every year because of pregnancy related issues whereas 6.6 lakh children lose their lives within 28 days of birth. In this context Sulakshana Nandi, national co-convener of *Jan Swasthya Abhiyan* (People Health Movement), Raipur, Chhattisgarh expressed in an interview with Gaon Connection, “it’s not surprising that maternal care in rural areas has been affected during the COVID-19 pandemic. Pregnant women are being discouraged from reaching hospitals during this time of the pandemic.” (Gupta, 2020)

Anganwadi workers[[6]](#footnote-6) and Sahiyas (ASHA)[[7]](#footnote-7) are having a completely different experience of the whole COVID-19 scenario. They have expressed their concern over not visiting the workplace as they are deprived of PPE kits and masks. On the contrary, post- lockdown the migrants were left with no mode to earn their livelihood and thus, returning to their native village was the only option, supposedly safe for survival, which consequently created a lot of pressure on the Anganwadi and ASHA workers as they were assigned to take these migrants to respective hospitals to undergo screening and identification, as a result of which home visits were almost impossible and thus, ANM[[8]](#footnote-8) (Auxiliary Nurse Midwives) were assigned to take care of pregnant women or anyone who requires treatment. SAMA: Resource Group of Women and health, 2020). This scenario further suggests how keeping track of pregnant ladies for their routine check-ups is being side lined, amidst the pandemic. Despite the ‘Ghar Pahuch Seva’ initiative by the government particularly in Chhattisgarh, it is becoming difficult for the Anganwadi workers to visit door-to-door due to large population. Health care workers are scared to take any stand as even they haven’t received masks and sanitizers. According, to the First National survey on the Impact of COVID-19 in Rural India, 42% of the Indian women couldn’t undergo pre-natal check-ups, vaccination during the lockdown. Thich proves that the union ministry of health’s orders related to mandatory prenatal check-ups and vaccination of pregnant ladies in the community health centres were ignored. (Gupta, 2020) Ramiya who works under ASHA healthcare has expressed very blatantly in the conversation with the journalist over the phone “forget about government ambulances, because of the lockdown, it is difficult to get private vehicles for pregnant women or any other important work”. (SAMA: Resource Group of Women and health, 2020)According to the guidelines of *Pradhan Mantri Surakshit Matritva* *Abhiyan*, firstly, there must be at least one pre-natal check-up happening every month, secondly every gynaecologist should help a woman with one OPD which must happen on the 9th of every month. (Gupta, 2020) The pandemic has stimulated many alterations in the health ecology in all the countries, such as the balance in providing the SRH delivery in both public and private sector, which results in differences in cost of SRH facilities and care as government funds have been reduced due to COVID-19 budget crisis, variations in supplying products based on priorities and a greater shift and reliability towards online forums and tele medicine.

The prevalent cases demonstrate that the mere presence of guidelines stating that pregnant women must be provided essential services in no way ensures that they will be able to access it. (Sahu et al., 2020) Specific health arrangement in the absence of getting the mandatory status of ‘essential services’ through the RCH (Reproductive and Child Health) programs for the holistic employment of maternal health during the coronavirus pandemic has made the situation worse and unaccountable. Public health agencies have showcased a paradoxical picture between their job to assist the authorities in mitigating the pandemic and in dealing promptly with the requirement of its huge population. The disparity between the privileged and the underprivileged in accessing quality healthcare poses a serious threat to the entire country’s containment of transmittable viruses. (Narain, 2016) Therefore, the State and Central government needs to step in and regulate the cost and the treatment, to monitor the private hospitals so that they enable non-COVID ambulances and generate helpline numbers to safeguard the condition of these women. Rekha Sharma, the chairperson of the National Commission for Women (NCW) wrote to the Union Health Minister Harsh Vardhan on the excruciating pain of pregnant ladies and the purported refusal of ambulances to them during these times of crisis. In the letter, she also claimed that the non-availability of resources, inadequate services including ambulances and the constant denial of hospitals for taking admissions of pregnant women has led to postponing their delivery, resulting in death in some cases. The commission did agree that it’s a matter of ‘great concern’ for them and all possible measures will be taken so that there is no lapse on the part of medical authorities in these grave situations. (Press Trust of India, 2020)

**COVID-19 and the Lesser-Known Facts**

COVID-19 being a recent phenomenon has very limited scientific data to analyse its brunt on sexual and reproductive health. The risk of vertical transmission either during pregnancy or breastfeeding is one of the many clinical questions that need further introspection. However, it seems reasonable to assume that if the mother is COVID-19 positive, the new born could possibly be infected, be it in utero or prenatally, which will require the baby to be placed in an isolation ward to avoid any further exposure. (Rasmussen et al., 2020) WHO had also organised a joint mission constituting of 25 national and international experts. They travelled to the affected regions of China and investigated 147 pregnant women of which 64 were confirmed cases, 82 were suspected and 1 woman was asymptomatic. 8% of the women had critical diseases and 1% became severe. The investigation made the WHO conclude that pregnant women were not at a higher risk of getting infected. However, they failed to consider the cases of vertical transmission or neo natal[[9]](#footnote-9) aftermaths and also about Intra uterine transmission, which can be one of the most complicated effects of contagious diseases like COVID-19 during pregnancy that needs to be studied. (Schwartz, 2020) There are other pertinent questions as well, for instance, whether SARS-CoV-2 in any way leads to critical illness and death for pregnant and postpartum[[10]](#footnote-10) women which have clearly been experienced in other outbreaks. Secondly, could COVID affect pregnancy at different stages which may lead to complicated reproductive outcomes for future pregnancies as well? Thirdly, the presence and tenacity of the virus in bodily fluids including amniotic fluid or breastmilk is still unreciprocated which emphasizes that the risk of sexual transmission from the mother to the baby is still suspected and a matter of concern. (Tang et al., 2020)

Clinical knowledge being very imprecise puts the pregnant women in a more vulnerable state and renders effective management protocol essential. On the other hand, countries -be it- developed or under-developed, that have implemented lockdown and quarantine measures have exempted SRH from “essential services”. Contemplation as to what may be considered as “essential services” expose and prolong the ever persisting political and ideological clefts about sexuality, reproduction and sex. When SRHR (Sexual and Reproductive health and rights) is considered non-essential it automatically liberates the health system from fulfilling these rights, and thus the community’s justification for claiming these rights weaken. For instance, some developed states like United States have regarded abortion as illegal, and the various US agencies have requested WHO to stop addressing SRHR as essential. (Nichols, 2020; Glenza, 2020)

**The Unequal Effects on Class Hierarchy**

In order to understand the difficulties faced by pregnant women from different backgrounds, it becomes essential to acknowledge the struggles of pregnant women contextualized in the milieu of pre-existing socio-structural inequalities. Women from the privileged class were reported to be suffering from anxiety due to the cancellation of appointments of weekly check-up and delay in life-saving procedure. However, the telemedicine services have come to their rescue for instance, the availability of doctor online and issuing vehicle pass has eased their situation to some extent. (Kim & Zuckerman, 2019) It is quite contextual to note that the telemedicine is a resource of the privileged with phone and internet facility and such resources do not percolate below, where more than 22% of Indians live below the poverty line. (Sharma, 2019) Integrated Child Development Services (ICDS) of India happens to be the world’s largest programme for early childhood care and development. It constitutes of six services: ‘supplementary nutrition, preschool non-formal education, nutrition, health education, immunisation, health check-up and referral services which is carried out by 1.36 million functional Anganwadi centres situated in various parts of the country. (as of June 2018). Pregnant women are also a part of it as beneficiaries and are provided with required nutrients and protein supplements. However, the pandemic has affected these services during lockdown as the Anganwadi centres were shut down from mid-March. Approximately 34% of such households claimed that they haven’t received the additional grains whereas 11% wasn’t sure. (Gupta, 2020) Pregnant women are suffering in terms of medical services also, as most of the ambulances being diverted to issues related to COVID-19, women found it extremely difficult to access maternal health facilities due to a lack of transportation services. Furthermore, lack of clean water, scarcity of essential supplies for safe delivery, poor road conditions and very few emergency transportations, results in delayed transfer to hospitals during obstetrical emergencies. (Thorne et al., 2020) The main challenge they face is during the first and third trimester when they are required to visit the OPD section to undergo diagnostic treatment which includes tests and scans every week to be informed about any abnormalities regarding bleeding, chances of abortion, or miscarriages. (Diniz & Andrezzo, 2017) This further suggests that negative repercussions in maternal and neonatal mortality are certainly inevitable because of this pandemic.

**Ground Report**

The study attempts to take up a qualitative analysis of a few cases which reflect a more nuanced and pitiable condition of pregnant women from economically weaker sections of Indian society. In Delhi, a 28-year-old woman had to give birth in the vehicle allotted for emergency response on her way to the Safdarjung Hospital. Two other cases were also reported from Hyderabad and Moga (Punjab) where the situation was even more critical as they had no mode of transportation whatsoever, and thus their husbands had to take their wives on two-wheelers. The women in Moga reached the public hospital which was shut down, she then turned to a private hospital for help but they denied admission. As a result, both women ended up delivering on the roadside. (Bisht et al., 2020) A similar incident was recorded in UP, of Meethi and her husband who were having a tough time in surviving the pandemic. Due to the lockdown, Meethi’s husband was left with no job, income, and food resources. Meethi though pregnant was deprived of all basic amenities and resources for safe delivery. Then again, the public hospital being shut down left them with very little option as to how and where she will deliver her baby. (SAMA: Resource Group for Women and Health) During a conversation with one of the health workers, another migrant woman has described her experience; she expressed how the nation-wide sudden lockdown created panic among people and specially on those working on wages were severely hit. The factory owner asked all the workers to leave without paying them their wages. Lack of money gave them no choice but to leave and due to no alternative available they decided to walk along the railway tracks with their two-year-old child in their arms. Despite being in the seventh month of her pregnancy, she walked 1000 km on foot to reach her native place to cope up with the agony of COVID-19 and the lockdown. (News 18, Uttar Pradesh, as cited in SAMA, April 2020)

Rajani, a community-level health worker dealing with issues on women's health and rights exposed the harsh realities of migrant women through the conversation she had with a pregnant woman from Ranchi, she shared this information with a newspaper over the phone. She described how she came to know about a pregnant woman in a village which was 12 kms away from the block headquarter. Even after all the inconvenience and struggles that the pregnant lady faced along with her family, they couldn’t save the baby. The lady supposedly complained about labour pains early in the morning yet due to lack of commute her family couldn’t arrange any vehicle on time to reach the Referral Hospital and by the time she arrived she was heavily bleeding. She was then referred to Sadar Hospital of Ranchi and the doctors felt she was in high risk and thus she must be treated in Rajendra Institute of Medical Science (RIMS) hospital. She then had to travel in that critical state, however, this entire constant back and forth led to a lot of blood loss and she lost her baby. Rajani expressing her views on this entire episode raised a very pertinent question – “Now who will take responsibility for this (loss of a child)?” (SAMA- Resource group of Women and Health, 2020)

Such incidents signify how the prevailing vulnerabilities increase the miseries of the marginalized women when additional constraints are imposed without any prior planning and information from the State authorities. Maternal health care is specifically essential concerning women’s health issues thus, the inclusion of antenatal[[11]](#footnote-11) (ANC) and postnatal care (PNC) and the delivery, easy accessibility to contraceptives, abortion, and facilities for those who are facing domestic or any kind of violence, etc. should be made compulsory.

**Obstetric Violence[[12]](#footnote-12) and Women’s Right to Sexual and Reproductive Health**

Health equity is a concept constructed on the ethical impulse of distributive justness, highlighting the fundamental principles of human rights. To ensure health equity in a diverse population, every individual and group should be treated differently, prioritizing those sections that are more vulnerable and requires more attention in treatment or any other health facilities. (Diniz et al., 2012) The concept of inequity is generally misinterpreted as health disparities, but ironically inequity proves to be the result of unjust health disparities. Equity denotes that every individual should be granted equal opportunity to access full health services according to their potential and that no one should be deprived of this opportunity. Thereby one should also understand that the needs vary from individual to individual, from time to time, and from region to region. Thus, the focus of equity in terms of health in no way means eliminating health disparities but to reduce or omit such differences in factors that can be prevented and are unjust. Pan American Health Organization states that ‘Gender Equity’ in health implies eliminating unnecessary and unjust disparities in health services and survival strategies, unbiased distribution and accessibility towards resources in all aspects: technological, human and financial, according to individual needs. It should be kept in mind that people contribute according to their economic capability towards health finances and not their need for services and thus responsibilities should be entrusted upon equally and men and women should be rewarded for their contribution to health production with respect to their placing value on non-remunerated health services also. (Diniz et al., 2012)

Two factors form the base of unjust and preventable treatment; firstly, the differences in the contributing power of social elements (external elements that affect one’s health), and secondly, the difference in opportunity to access several health facilities due to lack of information and understanding. The understanding and knowledge of COVID-19 and its effect on pertinent issues like sexual proximity, pregnancy and breastfeeding is still vague and evolving. Issues like these persist in day-to-day life, thus having misinformation about these may affect the health of the new born as well as the mother which emphasises on how important it is to disseminate correct information. Although, WHO has tried to clarify on topics related to pregnancy, childbirth and breast feeding yet the information hasn’t reached out to the community. According to WHO, the delivery of pregnant women with COVID-19 symptoms can be done through normal vaginal delivery and it should be practiced in all active cases whereas, Caesarean section (CS) should be conducted only in cases that requires it. (Sahoo et al., 2020)

In 2018, WHO recommended on intrapartum care[[13]](#footnote-13) for an encouraging childbirth experience and raised “the concept of experience of care as a critical aspect of ensuring high-quality labour and childbirth care and improved woman-centred outcomes, and not just complementary to provision of routine clinical practices.” Amidst the pandemic the efficiency of many hospitals which had otherwise improved their services in terms of maternal care, and childbirth rights have now deteriorated which led to complications due to longer stay in hospital, ‘renal failure, sepsis and disseminated intravascular coagulopathy[[14]](#footnote-14)’ which poses a threat to the lives of pregnant women. The necessity for mechanical ventilation and mortality rate among them is higher compared to the non-pregnant women. (Zarchi et al., 2020) There are also rampant debates on how some restrictions and intrusions being applied in childbirth due to the pandemic are not necessary, they have no scientific base and are disrespecting human dignity and in no way aims at limiting the spread of virus. These constitute obstetric violence, incorporating unnecessary involvements done without any medical proofs (for instance, caesarean and instrumental delivery). New Indian Express reported that after the survey of the Health Management Information System, under the Ministry of Health and Family Welfare, it is observed that there is a 43% drop in institutional deliveries since March 2020. This is a matter of great concern for the reproductive health of women as it incurs questions on safe delivery. Economic, Social and Cultural rights committee on April 2020 recommended that the states should lift “all value-added tax” and also subsidize the cost of hygiene products during the outbreak ensuring its widespread accessibility. Another persistent issue is the immediate separation and isolation of the new born from their mother which prevents breastfeeding incurring problems for the baby to adapt to the social changes for instance it has been observed that the isolation of the new born disrupts and harms the immunity and physiology of the baby which interferes in the process of maternal milk being given to baby and thus the child is devoid of breastfeeding benefits and not just that even in terms of external factors keeping the baby and mother separately will create extra burden on health system. (Sadler, et.al, 2020)

The quarantine measures and lockdown results in a lot of serious issues for pregnant women because any possibility of abnormalities to the mother or the baby is being diagnosed late which risks the life of the baby and the mother, and it may sometimes prove fatal. This is particularly affecting those women who are from lower socio-economic backgrounds, whose access to contraception and health services are very limited, and thus, they are suffering the most with the highest natal mortality rate. (Thorne et al. 2020) Renu Singh who is associated with ASHA sangini expressed, “as of now, pregnant women are being asked to come for check-ups only in the ninth month [most women deliver in the ninth month], and not to come during the fourth and seventh months. But if the check-up is performed only in the last month and if they were at risk, how would doctors treat them?” Public hospitals are either shut down or full of COVID patients which forces them to visit private hospitals that are beyond their reach in terms of expenses. So here comes the most pertinent question about the right of women from these backgrounds, is the non-availability of hospitals their fault? How would they get access to opportunities and health care services which are their fundamental rights? WHO published guidelines for COVID-19’s clinical management on March 13, 2020 to recognise the dangers and insecurities and clearly mentioned that all the pregnant women, even the ones confirmed or suspected COVID-19 infection (considering the sincerity of maternal condition) should have easy approach towards women-centred, respectful, skilled care. The mode of delivery should be individual based and caesarean section should be done only if it is medically subscribed. After birth women should be able to establish skin to skin contact, sharing the room with the new born and breast feeding should be mandatory even if they or their baby have been suspected or confirmed of being COVID-19 positive. Despite clear recommendations from WHO rights of women and new born are being breached. Protocols that should be followed only in the case of women whose condition is severe are being imposed on any other women who are being admitted to hospital. Even the UN Population Fund’s (UNFPA) director, Dr. Natalia Kanem presaged that the emergence of coronavirus pandemic has ‘severely disrupted’ the right to use sexual and reproductive health (SRH) and gender-based violence (GBV) services ‘at a time when women and girls need these the most.’ (UNFPA, 2020)

A case from Madhya Pradesh reported by a local newspaper depicts the denial of accessibility to a pregnant woman by a government hospital in Indore, where the doctor denied checking the patient and being present anyway near her due to fear of getting affected and thus, prescribed medicines without a check-up. The woman was then taken to the private hospital which charged twenty-five thousand rupees even though it was difficult to arrange the money in such a short span the husband somehow managed it, yet when he returned, they were referred to the government hospital. This irrelevant back and forth resulted in the delay of treatment which further resulted in the woman’s death. (Shrivastava & Sivakami, 2020) This is classified as another type of ‘obstetric violence’, catalogued as ‘health system condition and constraints’. Similar cases were also reported from rural areas, where it seemed that women were facing severe problems in accessing government-run maternal hospitals. In another case from Telangana’s Gadwal district, the husband blamed the hospital and authorities as they delayed the treatment as a result, his wife passed away along with her baby in the hospital, as she was denied treatment in four hospitals. (Bisht et al., 2020)

Health policy and programmes of India have acknowledged this kind of unjust treatment and violence against women and thus, have come up with guidelines to combat and improve this sort of unprofessional behaviour. Healthcare services like ‘Laqshya’ and ‘Suman’ are working towards providing equal accessibility to all pregnant women. Even the Ministry of Health and Family Welfare[[15]](#footnote-15) has incorporated maternal and child health within the realm of essential services. (Shrivastava & Sivakami) Particularly ‘ensuring safe institutional delivery’ should be dealt with as the right of every woman. SRH and rights are a vital public health concern during Pandemics, and it should be dealt with utmost importance. As this pandemic still exists it becomes significant for the scientific society to generate solid clinical, epidemiological, and psycho-social behavioural links between COVID-19 and SRH rights, outcomes. (Tang et al., 2020) Perhaps, timely intervention through epidemiological research and scrutiny of the vulnerable section of people to access the immediate effects on their SRH is the need of the hour. Most importantly there is a need of solidifying operational plans and actions to ensure the protection of SRH rights during the pandemic. This requires the involvement of not only medical practitioners but also government authorities and the ones involved in policy making to work in co-ordination and regain the trust of the people.

**Dealing with Pregnancy in Containment Zones**

Ministry of Health and Family Welfare has defined containment zones where COVID-19 cases exist. Red zones specifically, mean those areas where the highest numbers of COVID cases have been recorded. Such areas and roads are completed isolated and barricaded to curb any chances of the spread of the virus. In those areas, women are facing additional problems in accessing medical care. A recent case came from the Muthialpet containment zone which is situated in Tamil Nadu- Puducherry border, a woman was going through labour, when her father could not find any mode of transportation. However, he finally found an auto-rickshaw owner who agreed to offer his vehicle; luckily the policeman who went along with the father in his desperate search drove the auto-rickshaw. But not all women get such helpful hands. For instance, another case was reported from Ranchi, where a Muslim couple was not allowed to leave the containment zone and was denied medical pass. As a result, the lady somehow managed to deliver the baby at home with some assistance from neighbours. Regrettably, due to lack of medical care and attention, the new born passed away. (Bisht, 2020) A migrant worker just 25-year-old from the border district of Kasaragod, Kerala, had to give birth in the ambulance on her way to the nearest hospital in Mangalore. They had to go through a lot of transportation obstacles as they were blocked from Karnataka by government officials because of a nationwide lockdown. (Bisht et al. 2020) Indian Council of Medical Research (ICMR), on April 21 laid down guidelines which were addressed to all the pregnant women from containment zones.

Despite these guidelines and official government advisory related to COVID, the ground reality is shoddy. Lack of conveyance to health facilities which was already the priority concern for women in rural areas has been exasperated due to lockdown. Availability of medical pass is rare and in case of privilege class women, they are left with no other option than to resort to home delivery. And if they somehow reach the hospital lack of human resources puts them at a higher risk of maternal mortality which is a concern for all the public health services. Therefore, it’s time to realize that the vulnerable period of pregnancy requires the same urgency and treatment as the novel corona virus outbreak.

**Conclusion**

Looking back, we find childcare dangerous practices without any proper treatment and evidence based has been carried out since ages. COVID-19 scenario lays forth the vulnerability of the rights of these groups due to mal-treatment and how it has increased during these times of crisis. Rather than providing effective treatment as a response to the outbreak, these detrimental practices violate women’s rights and exposes structural gender difference and discrimination. The present scenario suggests very convincingly how normal it is on the part of health system to ignore and invade on the rights of pregnant women and their new born babies. As the world is addressing the global pandemic, one should ensure that the women and the girls aren't left unattended. Regular access to medical facilities in context to safe delivery, contraceptives and abortion services must be ensured. There should be a direct mode of communication from the government authorities to reach out to those in need because the struggle is real. Sexual and reproductive health must be included in essential services and appropriate information regarding the guidelines should be disseminated to vulnerable women. One must not forget that even before the outbreak of coronavirus women were already marginalized, thereby any effort to curb the spread of COVID-19 cannot side-line sexual and reproductive health issues which will remain to exist even after the pandemic gets over. Pandemics such as COVID-19, has forced the health system to rethink on restructuring and reorganising delivery of services. Besides focussing on the Pandemic, the authorities should also ensure to maintain the faith of the people in the health system by continuing to render accessibility to health systems in order to avoid excessive morbidity and mortality arising from other health conditions. (Vora et al, 2020) Together, these actions would begin to ensure that pregnant women are prioritised and accounted for not just now, but during all future public health responses.

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1. 1. COVID-19- Corona Virus comprises of a large family of viruses which is highly infectious and can be easily transmitted from one person to another. The outbreak of Novel corona virus was first noticed in a seafood market in Wuhan city of China. The causative agent for COVID-19 has been officially named as SARS-COV-2. [↑](#footnote-ref-1)
2. 2. Vertical Transmission- It involves the passing of a disease-causing agent (pathogen) from mother to the baby either pre/post or during birth. This transmission generally occurs across the placenta, through the breast feeding or due to direct contact after birth. [↑](#footnote-ref-2)
3. 3. Gestation- The word ‘Gestation’ comes from the Latin word ‘gestare’ which signifies to bear or to carry. For humans, gestation period is generally for 9 months as it involves the development of foetus from the time of conception to actual birth. [↑](#footnote-ref-3)
4. 4. PPE Kits - Personal Protective Equipment kits are designed to safeguard the health of an individual by minimising the exposure to the virus and thus preventing its transmission. The kit includes, face shield, helmets, face masks and gloves. [↑](#footnote-ref-4)
5. 5. Pradhan Mantri Safal Matritva Abhiyan was introduced by the Prime Minister of India on 31st July, 2016 and was promoted by the Ministry of Health and Family Welfare (MoHFW), Government of India. The Program claims to provide a minimum package of antenatal care services to women specifically in their 2nd/3rd trimesters of pregnancy. It also aims to provide quality antenatal care at no price usually on the 9th of every month during their pregnancy. [↑](#footnote-ref-5)
6. 6. Anganwadi worker is the most important functionary of the Integrated Child Development Services (ICDS) scheme in India. She is a community based front line worker of this program and plays a crucial role in promoting child growth and development. She is also an agent of social change, mobilizing community support for better care of young children. [↑](#footnote-ref-6)
7. 7. Sahiya or Accredited Social Health Activists (ASHA) workers are nominated by Village Health Committee. They largely support door to door delivery of health care services in India. [↑](#footnote-ref-7)
8. 8. Auxiliary nurse midwife (ANM), involves village-level female health worker from India who acts as a mediator between the community and the health services. They form the base in the health organisation pyramid and ensure safe and effective treatment to the village communities. [↑](#footnote-ref-8)
9. 9. Neonatal mortality- Is generally the first 28 days of life and is the most crucial time for a child’s survival. The new born babies face the highest risk of dying in their first month. Mortality during neo-natal phase is significant in indicating both maternal and new born health and care. [↑](#footnote-ref-9)
10. 10. Post-partum or postnatal period occurs just after childbirth. It is commonly referred to the first six weeks post childbirth. According to WHO postnatal period is the most neglected yet the most crucial phase in the lives of mothers and new born babies. [↑](#footnote-ref-10)
11. 11. Antenatal care (ANC) - Antenatal care also known as prenatal care is basically a preventive healthcare. It involves medical check-ups to avoid any abnormality during pregnancy and prevents potential health problems. [↑](#footnote-ref-11)
12. 12. Obstetric violence involves violation of women’s rights in terms of reproductive autonomy. It usually occurs in both public and private medical practices at the time of pregnancy, childbirth and post-partum period. [↑](#footnote-ref-12)
13. 13.Intrapartum care: The World Health Organization (WHO) recommends on Intrapartum care for a positive childbirth experience ensuring good quality and effective care regardless of the infrastructural lapse or level of health care. [↑](#footnote-ref-13)
14. 14. Disseminated intravascular coagulation (DIC) - Is the clotting of blood throughout the body which subsequently blocks the small blood vessels. Symptoms generally involves chest pain and shortness of breath. Clotting leads to bleeding resulting to complications during pregnancy. [↑](#footnote-ref-14)
15. 15. Ministry of Health and Family welfare is an Indian ministry, holding a cabinet rank and is charged with the health policy in India. It is accountable for all the programs relating to the family planning. [↑](#footnote-ref-15)