

Pregnant in a Pandemic: Health priority, responsibility, and gender in crisis

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Abstract: With nearly 5 lakh deaths, India ranks high on the list of nations that were ravaged by COVID-19. The pressures of the pandemic were felt more heavily by sub-populations that were already on the vulnerable ends of receiving public healthcare. One such group was that of pregnant and lactating women, who got access to vaccines much later than the general population. This delay was explained by the unavailability of data related to the administration of vaccines for pregnant women in India. This is unsettling only because the Euro-American vaccines (Pfizer, Moderna, etc.) had already been successfully delivered to more than a hundred thousand women, which means that official approvals of these vaccines were possible in India before they were eventually given the green signal. Israel, among other countries, made pregnant women a priority for the immunization programs, which resounds the recommendations made by India's National Technical Advisory Group on Immunization (NTAGI). This reaffirms the supremacy of the State in making the choice for its citizens in a free-market economy, which is rather desecrating because this is a matter of public health and the ramifications of non-availability, by experience, were lethal. A simultaneous shortcoming that aggravated the situation is from the demand side where the advocacy--for emphasizing the cruciality of vaccination for pregnant women, especially on account of their (and their fetus' or newborn's) comorbidities--was insubstantial and inappropriate. This paper, predicting the future of post-COVID health systems, analyzes the course India took with its policies on the issue, juxtaposes it with prominent case studies from around the world, and finally corroborates the implementation and perception of the policy's treatment on the ground with narratives of those who were violated and denied (public) care.

Keywords: Pregnant and lactating women, public health access, Immunisation, Bodily autonomy, COVID-19

COVID-19 AND ITS IMPACT ON WOMEN IN INDIA

The COVID-19 pandemic regulated, if not completely curtailed, access to public services leading to distress that was felt at both professional and personal levels. The situation was aggravated by the mental and economic stresses induced by the boundness to domestic spaces, especially for the vulnerable sub-populations. While there was no way out of homes for a significant period of the unrest, the vaccination drives hurried and created a sudden surge in the flocks of people standing in queues outside the vaccination centres and hospitals, owing to the information asymmetry of the vitality of these vaccines in the initial weeks after its introduction. This happened even when the vaccine was rolled out in age-determined batches. This was severely worsened by the panic created around the ineffectiveness of the CoWin app, which had long waiting times for booking slots and unsuccessful translations into getting vaccinated on the actual visits. While India was one the largest manufacturers of the vaccination, the socio-economic limitations forced many in the country to face hardships in trying to access the vaccine.

The CoWin app, launched in early 2021, started with registering and providing free vaccines to frontline workers, extending the same services later to the general population. The order of preference for this public service delivery was adjourned by the policymakers. Even in the absence of such a portal registration being mandated, the fact that women are restricted at home generally and require a greater effort to manoeuvre the public space was not taken into account. The pregnant women, as a sub-group, were faced with greater challenges, especially amidst the precarity that the pandemic was generally characterized by. Housewives, which compose the majority of pregnant and lactating women, bear the brunt of patriarchy. During the lockdown period, India recorded a 10-year high in reported cases of domestic violence. Despite the legal right, patriarchal socialisation forces women to accept life, even if filled with violence. This is reinforced by the National Family Health Survey (NFHS-4, 2015) data where one in three women reported experiencing physical, emotional, sexual, or spousal violence, and 77 percent do not report the matter to anyone. The stressors and the emerging one with COVID-19 at the time made it difficult for women, especially pregnant and lactating women, to access healthcare.

The second wave of the pandemic hit hard, exacting a heavy toll on the populations across various socio-economic backgrounds. India especially witnessed high rates of hospitalisation, with people finding it difficult to even find a hospital bed or medicine. It is during this difficult time, that the COVID-19 vaccines were introduced in a magnificent feat of global collaboration between various stakeholders. The Indian government did a praiseworthy job of ensuring that the vaccines are made available in cohorts to the populations and were speedily able to cover a wide percentage of people. However, prevalent socio-

cultural and economic difficulties made it difficult for a few vulnerable populations to access the much-needed care for prevention.

The national guidelines for pregnant women (ICMR, 2020) infected by COVID-19 identify them as a vulnerable group, accounting for the fact that pregnancy alters the immune system and the group (CDCP, 2021) is likelier to get infected with a moderate to severe disease, and require intensive care than their non-pregnant counterparts. The odds of pregnant women diagnosed with COVID-19 (WHO, 2021) virus being admitted to the intensive care unit were determined to be 62 percent higher, and the odds of needing invasive ventilation were 88 percent higher. Pregnant women (NLH, 2022) with symptomatic COVID-19 infection, when compared to non-pregnant women with COVID-19, are 3 times more likely to be admitted to an intensive care unit, 2.9 times more likely to require invasive ventilation, 2.4 times more likely to require extracorporeal membrane oxygenation, and 1.7 times more likely to die.

The impact also led to instances of pre-term delivery (considered to be three times higher than during COVID-19 times) and hypertensive disorders which act as a cause for concern for the woman and healthcare providers. This not only puts expectant mothers at risk but also their babies, facing medical complications in the womb itself. COVID-19 restricts air supply within the body, making access to oxygenated blood and a healthy placenta, difficult for the baby. Data from WHO (WHO, 2021) also showcased that the transmission of the virus from the womb or during childbirth, while rare, was possible. The case fatality rate (CFR) among pregnant women (ICMR, 2021) and postpartum women was 5.7% during the second wave, which was significantly higher compared to the scenario encountered in the first wave with a CFR of 0.7%.

The risk categorization makes vaccination a prioritization for the defined group. The risks to pregnant women and their foetuses have continued, with a high rate of maternal mortality, stillbirth, and premature birth. Real-time scientific evidence, or lack thereof, along with reports of rare risks of blood clots, and thrombosis from the vaccines was considered the reason for state actors to allow vaccination for pregnant women. This lack of access to life-saving medication created a precarious situation where in-person consultations were critical given that certain health challenges like preeclampsia might be missed over teleconsultation but had to find a way to protect themselves from COVID that was air-borne. Reports of women not getting admitted to any hospital despite their pregnancy if they were COVID-positive, and while some with economic capital were able to afford private help, the rest found it difficult to find to navigate optimum care.

A report (UNICEF, 2021) suggested that disruptions of essential health services across South Asia due to COVID-19 may have contributed to 11,000 more maternal deaths in 2020 than the 57,000 maternal deaths recorded in 2019. These disruptions especially caused major tremors in India, where 80 percent of the

South Asian population resides. The exact toll of the pandemic in terms of death rates and consequential impact might never be calculated, anecdotal evidence across media platforms highlights the gravity of the picture for populations left behind.

The guidelines by the Ministry of Health and Family Welfare in India advised against vaccination for pregnant, lactating, and breastfeeding mothers and recommend individual practitioners follow maternal care as a priority. The denial of the constitutional right enshrined under Article 14 and Article 21 of the Indian constitution and de-prioritization of the sub-population without scientific evidence thus highlights the supremacy of the State in determining the decisions for its citizens. It was stated that evidence was required before allowing the cohort to receive the vaccination, as concerns for the child's health became paramount, discounting the lives of the pregnant women. However, women at various stages of their pregnancy are excluded from clinical trials for 'safety' reasons. Inevitably, this leads to a lack of data regarding the determination of the efficacy of the vaccine, thus leaving pregnant women out of the vaccination efforts.

Scientific evidence and global experiences highlighted the need for vaccinations and their safety. Across the globe, countries such as Australia, Canada, Israel, Singapore, the United Kingdom, and the United States led by example by vaccinating pregnant populations and witnessed positive experiences. Israel reported high hospitalization rates among pregnant women who had tested positive for COVID-19 and even developed complications due to it with their pregnancies. The Israeli government was among the first to vaccinate their pregnant and lactating populations with the Pfizer-BioNTech Vaccine.

Post corroboration of real-time data that pointed to the inaccuracy of any suggestions related to vaccination putting pregnant women at risk, other countries followed Israel in vaccinating their women. Britain had earlier restricted vaccination access to pregnant women and lactating mothers citing exclusion from human trials as their reason. However, this was short-lived and soon Britain started administering the Moderna and Pfizer-BioNTech vaccines to pregnant and lactating populations in their country.

Despite this, India did not follow suit until June 2021. While the same vaccines were available in India, the Government stood its ground and prevented pregnant and lactating populations from getting vaccinated. Not only does this show poor judgment structurally but also the reinforcement of a categorical exclusion of women from healthcare decision-making. For pregnant women, live attenuated vaccines are contraindicated, meaning they might cause harm to the mother and foetus. (FOGSI, 2021). None of the COVID vaccines available in the market globally are live attenuated, other vaccines which may have some theoretical considerations regarding transmission are the viral vector vaccines. Research

shows that infants born to mothers who receive two doses of an mRNA COVID-19 vaccine — such as the Pfizer-BioNTech or Moderna COVID-19 vaccine — might have a lower risk of hospitalization due to COVID-19 infection in their first six months of life. mRNA COVID-19 vaccines cannot cause any genetic alterations or changes within the DNA. Viral vector vaccines such as the Janssen/Johnson & Johnson COVID-19 vaccine have been given to pregnant women in each trimester of pregnancy in clinical trials. No harmful effects were found. The Federation Of Obstetric and Gynaecological Society of India (FOGSI) stated this as their argument for including pregnant and lactating women within the ambit of COVID vaccinations, there was no reason for them to be left behind. It was also observed that the advantages of vaccines outweigh the risks that there might be any exposure to the foetus to the number of vaccinations. The side effects of Covid-19 vaccines do not differ from any other vaccines and act as additional immunization for children. When pregnant women are vaccinated their children might be immunized before delivery, increasing chances of survival and cutting down the risk of COVID-19 infection. The antibodies may protect the baby for six months or more after birth. This is a critical period of development for the baby and increased immunization during the period boosts the chances of survival greatly. In addition, the study showed that the mother's antibodies make their way into her breastmilk, likely protecting infants from COVID-19 for at least a few days after they consume the milk.

Moving forward, it is essential that healthcare structures and systems work alongside scientific evidence and protect the most vulnerable populations. Pregnant and lactating women are among the most vulnerable population and usually are not attended to till the end in times of crisis, as evidenced by COVID-19.

While prioritizing women, it is also important to look at vulnerability through an intersectional lens. Factors such as caste, class, and sexuality are often disregarded while mapping health provisions. This must be integrated within the ambit of data collection itself. Access to healthcare provisions is even more of a challenge within communities that face social exclusion such as Dalit women, transgender individuals, and individuals from backward populations.

Gender and age-disaggregated data and information must be available for policymakers to assess the situation and develop appropriate, evidence-based responses. Such data must be collected and analysed, ideally covering several years to track changes and take corrective action. Building public awareness and expertise among both medical professionals and intersectional experts through information campaigns and training of frontline workers is also important.

Caste as an additional social factor makes it necessary to look at data through various lenses. The imbalance between the social, economic, and political capital limits access to healthcare for those at the lowest rungs of society. This is particularly true for Dalit women who face both gender and caste-based

discrimination, disrupting access and stifling their voices. Hence, their voices must be brought to the forefront, and conversations of systemic change must include these.

In a world trying to recuperate and rebuild itself post-pandemic, it becomes pertinent to create more robust public structures, particularly in the health sphere. Caregiving must be revisited to be made more inclusive to ensure preparedness. The state must look at building robust health systems that are prepared to bounce back from emergencies like COVID-19. This means spending more time and resources on detecting possible disease outbreaks, continued vaccine development, and strategies to deploy them effectively keeping in mind different socio-economic strata.

Multisectoral and stakeholder engagement is essential to ensure that different perspectives are considered and responsibility is shared. This not only ensures accountable systems are in place but also well-managed supply chains and distribution systems. It becomes clear that essential goods and medical equipment such as oxygen-related equipment, blood banks, and hospital beds must be arranged for in anticipation of massive caseloads as witnessed in the second wave of the pandemic. Along with these, a strong judicial system that works proactively to protect the interests of citizens must be in place. Current bodies must be strengthened and regulatory bodies must be set up to support them. Unless these regulatory bodies work in tandem with the legal structures, lapses are unaccounted for and lives are lost.

The coming together of multiple stakeholders is imperative to ensure the healthcare system is strengthened and women are not left behind in emergency situations like the COVID-19 pandemic.

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