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Research Article

Reproductive Rights, Women and Covid-19: Gaps and Challenges

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ABSTRACT

This paper explores the evolution of reproductive rights and health discourse, tracing its historical roots from early international conferences to its contemporary relevance amidst global challenges such as the COVID-19 pandemic. It critically examines the intersectionality of gender, development, and human rights within the framework established by the United Nations (UN) and other international bodies. The paper synthesises the discussions on reproductive rights and health, advocating for a rights-based approach that ensures equitable access to reproductive health services for all individuals. It underscores the ongoing challenges and the imperative of global cooperation to address these issues effectively in the post-pandemic era.

Keywords: Reproductive rights, Population growth, United Nations, COVID-19, Gender disparity, Social inequality, Alma Ata declaration, Human rights

INTRODUCTION

Reproductive health and rights have emerged as crucial components of global health and human rights agendas. This paper delves into the evolution of these concepts, beginning with seminal international conferences like the World Population Conference in 1954 and culminating in the International Conference on Population and Development (ICPD) in Cairo in 1994. These conferences marked pivotal shifts in addressing reproductive health within the broader contexts of development and human rights.

As evident from the Article 1 of the Charter of the United Nations sets the goal—'to achieve international cooperation … in promoting and encouraging respect for human

rights and for fundamental freedoms …' (CoUN, n.d.). As part of this overarching vision, National Human Rights Institutions (NHRIs) can hold governments accountable to their commitment to respect protect and fulfil reproductive rights. As defined in the International Conference on Population and Development (ICPD) Programme of Action (UNFPA, 1995) and further articulated in international human rights documents, national laws and other consensus documents.

Major deliberations which occurred in the last century have an important role in the genesis of the present concern for reproductive health. The First World Population Conference held way back in 1927 during 29 August-03 September in Geneva initiated it which was taken forward by the first population conference organised by the United Nations- World Population Conference during 31 August -10 September 1954 in Rome. It laid down the need to reflect upon how the continuous, consistently upward trends of the population growth in less developed countries, who have remained poor, needs to be addressed. Subsequently every ten-year World Population Conference was held. The next was in Belgrade during 30 August-10 September 1965 followed by the World Population Conference, Bucharest, 19-30 August 1974 (UN, n.d.). This conference is noted as a milestone for it strengthened the need to curb the growing population of the world, mostly contributed by the developing world. The discourse was geared towards the call given during the conference—'development is the best contraceptive'. It also paved the way for putting health at the core of the discourse on population. Subsequent global conversations in the form of these conferences recognise health as an important consideration for curbing the growing population. This is how in some ways, maternal and child health, gets embedded in the larger question of population growth. As a result, just about four years down the line, the Alma Ata Declaration happened putting the primary health care in a very relevant position to deal with population. Consequently, the Alma Ata Declaration—'Health for all' was the take away from the International Conference on Primary Health Care which was held during 6-12 September 1978 in the present day Almaty in Kazakhstan. It called upon the countries to put primary care into practice (WHO, 1978). However, the goal of 'Health for All' remained elusive.

The assessment of population during these conferences targeted reproductive women for curbing the population growth. Although infusing development was conceded as the only way, fertility reduction became the instrument to achieve it. The International Conference on Population held in Mexico City during 6-14 August in 1984 raised dissent as a reminder to the commitment for development (Bucharest) and health (Alma Ata). The less developed countries questioned how the Bucharest slogan 'Development is the best contraceptive' being materialised. In effect much of the 'development' support

for reproductive health care was supplied to them by the more developed countries in the form of contraceptives. This was questioned by the proponents of equitable distribution of resources, that it is the development per se which will actually help addressing the population issue and not the direct support for curtailing the population. This brought reproductive health in a big way in the core of the debate on population and health. Consequently, the conference was termed as 'International Conference on Population and Development' and was held in Cairo during 5-13 September 1994 (UNFPA, 1995). Thus, 'development' was consciously included in its nomenclature.

While reproductive health was a concern for a long time, the Cairo conference connected it with population and development taking into account the consumption imbalance between the less developed and the developed countries. It was very importantly noted that *health* is a necessity which cannot be understood without rights. Since population growth has been a long-standing concern, the thrust remained on the maternal and child health despite the intersection embraced by the ICPD. The obsession with growth of population has been connected with the processes of development and therefore the realms of health, especially of women. The recognition of gender disparity led to the International Conference on Gender and Development in 1995 held in Beijing. It became evident that the discourse on population, development and health requires cognisance of not only gender disparities but also social inequalities. This also connects with the larger global conversation on racism. Thus, in 2001 at Durban the International Conference on Social Development was held. It located that reproductive rights and choices of women differ based on social inequalities. In 2015, sustainable development goals (SDGs) took the Millennium Development Goals further and addressed reproductive health in two goals which engaged with gender (SDG5) and health (SDG 3) (UN, 2015).

Reproductive health is important and needs to be understood through choices and rights in the context of gender and social disparities. Reproductive health makes it imperative to have the right to be able to decide the choices, and be informed about the reproductive health services which would be available for use. What are the nuances through which they could access the services, are they affordable, are they acceptable methods of contraceptives? Therefore, from the decision making (for family building), to conception, to child bearing and birthing, to post child delivery, nuances need to be embedded in the perspective of choice and rights.

The interaction between care provisioning and care use- those who provide care for reproductive health and those who require reproductive health become very important. However, the societal structures are patriarchal. The reproductive choices are dependent on the power relations between men and women. In the dyad of co-habiting couple,

location of power determines whether the couple or the individual has the right to decide about the family building process. But we all know that it is not so much the couple who takes the decision. It is the larger familial setups, larger community setup in which the couple or the individuals would be located, become important in enabling the decision to be made.

DEFINING REPRODUCTIVE HEALTH

According to the WHO, sexual and reproductive health involves five key components, namely:

1. Ensuring contraceptive choice and safety and infertility services;
2. Improving maternal and new born health;
3. Reducing sexually transmitted infections, including HIV, and other reproductive morbidities;
4. Eliminating unsafe abortion and providing post-abortion care; and
5. Promoting healthy sexuality, including adolescent health

In an attempt to understand reproductive health, it is often stated as satisfying and safe conjugal life; capacity to reproduce and the freedom to decide if, when and how often to do so. It also therefore, preconditions to be informed, have access to safe, effective, affordable and acceptable methods of family planning including methods for regulation of fertility, which are not against the law. The right to access appropriate health care services, to enable women to have a safe pregnancy and childbirth, and to provide couples with the best chance of having a healthy infant, thus become the core of reproductive health.

In addition, reproductive health care includes care for sexual health. Its purpose is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases. It is seen as basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. The Paragraph 7.3 of the ICPD Programme of Action for ensuring reproductive rights establishes three main elements-right to decide freely and responsibly the number, spacing the information and means to do so; equal access to contraception and to the necessary information on reproductive health issues; and right not to be married before reaching adulthood and the right not to be forced to marry.

HISTORICAL EVOLUTION AND CONTEMPORARY CHALLENGES

The paper reviews the progression of international discourse on reproductive health, emphasising key milestones such as the Alma Ata Declaration in 1978, which underscored the importance of primary health care, and subsequent conferences that integrated health and population dynamics. It discusses how these conferences laid the groundwork for recognising reproductive rights as fundamental human rights, elucidating the connection between health, development, and gender equality.

Focusing on recent developments, particularly in light of the COVID-19 pandemic, the paper analyses the impact on women's reproductive health and rights. It examines issues of access to reproductive health services, contraceptive choices, and the exacerbation of existing inequalities. The pandemic has highlighted systemic disparities and underscored the need for resilient health systems that prioritise reproductive health as integral to public health agendas.

Intersectionality and Rights-Based Approaches

Drawing from existing insights, the paper explores the intersectionality of reproductive health with gender, social inequalities, and human rights frameworks. It examines how international bodies like the UN and WHO define reproductive health, emphasising components such as contraceptive choice, maternal health, and the right to access safe reproductive health care.

It may also be noted that information disseminated is very often minimal regarding the decision-making processes. There are evidences that the pandemic distorted this decision-making process. There were evidences of discrimination on the axis of age, gender, sexism, caste, class, religion. There are ample examples of coercion and violence during the pandemic. However much we might want to say that conjugal rights are enshrined in the marital relationship, but right dispensation of conjugal rights very often become the male partner's prerogatives. In such a backdrop, it is paradoxical that ICPD tells us very categorically the elements which are embedded within reproductive rights include the right to decide freely and responsibly, the number of children couple may be interested in, spacing of the child births, and family building process.

But in order to connect these enshrined assumptions, the reality is reflected by the academically popular National Family Health Surveys (IIPS and ICF, 1995, 1999, 2007, 2017, 2021). The data, like most other sources, shows that literacy levels are fairly high for creating awareness giving us that enabling environment to be able to access

services, to be able to question, to be able to ask for what my right would be. If you look at the literacy levels of women, it has improved from about 55 to 68 and now to 73, in the last three NFHSs from 2005-06 to 2019-20. We still have about a quarter of women who are getting married below the age 18. And this is we are talking of a time just about two years ago, we also had women to the tune of about 7% who were either pregnant or have already had a child by the time they were in the age group 15to 19 years (IIPS and ICF, 2021). While it is laudable to note the reduction from 16 to about 7%, the fact that this is still happening, is what I would wish to draw your attention to. The question of reproductive choices and rights go for a toss. Similarly, while we do see very encouraging improvements in both infant and child mortality, we also see that access to any kind of contraception is still stacked at about 67% and therefore the prevalence of unmet need remains close to 10% and spacing between child birth is to the tune of 4%. To make a point over here is that despite this kind of a scenario where we are seeing an upward trend vis-à-vis women's literacy, child mortality, increase in marriage age, for instance, we still have just about 42% of women who have access to money, which may be helpful in enabling them to take any decision regarding their own health. While 75% of women are in a position to take a decision regarding their own health, meaning to say whether they would want to see a doctor or they would want stay back and take some home remedies. Yet, notably, only about a little over half of them (42%) have any access to money. So, it can be imagined what kind of decision making must be happening and who are the care providers where they could be going to. While it is important to recognise that the women are participating in decision-making, the access to resources to be able to execute that decision making, also becomes important and that is where perhaps access to money becomes extremely important to be able to do anything.

Reproductive Health and the Alternative Sexuality

The dispensation of health services system impact on the service educating about contraceptive methods, provisioning of contraceptives, counselling about choices and rights. Thus, not only the information, but the actual process of making choices and asserting rights are influenced by the social, cultural economic milieu and legal safeguards in which we are embedded. The very idea of early marriages, for example, breaches the basic right enshrined by the UN agencies and WHO. So, when we consider such international bodies and how we understand reproductive health, we need to connect these in the local systems and make efforts to ensure contraceptive choices as a well as safe infertility services, along with improving maternal and new-born health, reducing unsafe abortion, and mechanisms to promote healthy sexuality. This is also the context where we need to address alternative sexual choices. Most of

the time, in any such discourse we ignore the transgender populations. We talk about men and women per se in terms of reproductive health services and programmes. But the issues that have come up regarding the LGBTQI vis-à-vis access to vaccination services during COVID-19, we need to revisit much of this 'simplified' binary version of sexual and reproductive health. In case of the adolescents, with very little intra-family (and with adults) interaction, their reproductive health needs as transgender are of relevance.

Violence Against Women and COVID

This probably takes to the next level, wherein the vulnerability of such conditions of differential and restricted access bring an entirely different dimension of the right based realms of gender and women to engage with. More than 50% of women and about 42% of men feel that it is all right if the spousal violence happens in a domestic relationship (IIPS and ICF, 2017). This justification is attributed to the reasons as varied as going out without spousal permission, allegedly not caring for the house, arguing with the spouse, refusing compliance with conjugal rights, not cooking properly, spousal suspicion, disrespect for the in-laws. These are 'valid' reasons to get beaten up and to beat up because more women as compared to men, justify it. But the saving grace is that over time period from 2015-16 (NFHS 4) to 2019-20 (NFHS 5), we do see declining trends of physical violence during pregnancy. But let's remember that this is also the time when a lot of COVID induced restrictions were put. The last phase of the NFHS data collection actually happened, during the pandemic. In the backdrop of empirical evidence that we have, where do we position women to get a sense of what needs to be done for the reproductive rights and choices that makes the difference? The number of births at home has risen almost three folds during COVID. The ANC services were closed down and could not be accessed. Even when the services opened, transportation was not available. So, the whole social landscape within which lives were located- from economic outcomes to the intimate relationships, were badly affected. The pandemic completely changed child bearing preferences and contraceptive use. Access to any kind of health services was challenging. Telemedicine became an alternative. There was exposure to intimate partner violence or spousal violence, which the 'stay home' policy brought as a baggage, although it was largely to save the individuals from exposure to the virus. But this exposed women to a different kind of burden what gets recognised as the 'shadow pandemic'. The stay home policy paved way for the abusive partners to perpetrate violence as the women experiencing it could not move out of the house. They had to stay home with people with whom they were not safe, with whom they were not in a conducive relationship yet were expected to stay home with them.

The other dimension which is important in the concern for reproductive choice and

rights is the realm of social inequalities. The access to resources varies due to social inequalities. Therefore, the burden of ensuring reproductive choices and rights too differs across social groups. But we do not really have any data to talk about other than the crowd source data or the micro studies that have been conducted. For instance, In the USA, COVID related mortality has been higher among the people of colour (Gawthrop, 2023), who are also vulnerable on other indicators. In India, we really have no idea what has happened to the groups who are socially marginalised and remotely located geographically and social, both in rural and urban spaces. There is no data breakup in terms of gender, age or social identities. Some state agencies managed to put some of these identifiers like gender together. There are more women lost their jobs as compared to men because of the vulnerabilities in which women seem to be located. Most women who were working in low paid jobs, were unable to return to their jobs. Such unforeseen economic instability is likely to have affected their reproductive choice and rights. The large increase in overall unemployment has meant that many people have lost their work-related health insurance, resulting in reduced access to health care.

Many of the anecdotal reports, blogs and press media accounts, informing about COVID suggest that it has impacted the sexual and reproductive health adversely. To quote from one of the studies by Population Council which very categorically highlights that because of the COVID the face-to-face interactions with the grass root level workers was almost nil and therefore a lot of services which could be provided by way of verbal communication by the ASHAs and ANMs among the women in the local setups, the services could be provided due to the absence of face-to-face interactions. The restrictions because of social distancing created barriers in access to RH services. Consequently, unsafe abortions were inevitable as no formal services were available. So, in-person provisioning of services declined something to the tune of 10% globally (Motihar, 2021; Bankar and Gosh, 2022). The crowd sourced and micro level studies too suggest that because of COVID reproductive choices and reproductive services have been severely affected.

There were also similar reflections that we see in India through one of the micro level studies which was done in about 208 migrants who got stranded. Women among them reported about their problems of disruption in ANC services, poor menstrual hygiene due to lack of washrooms and water (Acharya, 2022). COVID-19 pandemic has reshaped the social landscape, including people's intimate lives, and economic realities of people's lives. The impact of the pandemic on women's sexual and reproductive health (SRH) and reproductive autonomy is tremendous. It is visible on their childbearing preference, contraceptive use, access to contraception and other SRH

services. Telemedicine for contraceptive care; and exposure to intimate partner violence (IPV) during the pandemic has been evident. The nearly universal imposition of stay-at-home requirements begun in mid-March 2020, and the widespread uptake of social distancing have led to growing economic and social insecurity. Anecdotal reports and press accounts have described the impact of the pandemic on women's sexual and reproductive health (SRH) and well- being. Social distancing and the disruption caused by the pandemic have created physical and economic barriers to contraception and other SRH services.

The COVID-19 pandemic has exposed the vulnerability of SRH care provision globally. Face-to- face provider-user interactions crumbled due to overwhelmed healthcare systems, increased work burden for front-line workers, community concerns for viral exposure, increased fear of visiting health facilities, and needs for social distancing and travel restrictions. The pandemic has exacerbated the barriers to access reproductive health services, led to suspension of clinical services and disruption of supply chain (Ramarao *et al.,* 2020). During the pandemic, women's access to contraception and other SRH services—as well as their ability to pay for these services—has been constrained. Access to in- person health care has been severely limited, and people may have avoided seeking out available services because of fears that they or a family member would be exposed to COVID-19 as a result. With 10% decrease in use of reversible contraceptives, an additional 48 million women at risk of pregnancy will have unmet need for contraceptives and over 15 million will experience an unintended pregnancy (Ramarao, 2020).

Fertility Preferences

Individual fertility preferences are shaped in part by the broader socioeconomic context. Pandemic-related worries about finances and job stability, as well as general unease about the future, may be shifting how women feel about having children. More than 40% of women reported that because of the COVID-19 pandemic, they changed their plans about when to have children or how many children to have. Changes in fertility preferences were more common among women without any children (45%) than among those with children (38%) in the USA (Lindberg *et al.*, 2020). In India 36% changed fertility plan as evident from a micro study on migrants (Acharya, 2022). As regards the family building process at global level, one in three women reported that because of the pandemic, they had to delay or cancel visiting a health care provider for SRH care facility, or had trouble getting their contraceptives. The corresponding figures for India was more than half the women (56%) seeking ANC had to postpone

the visit or got no care. Globally, lower-income women (37%) were more likely than higher-income women (32%) to report this change. In India the share was 62% and 21%, respectively (Acharya, 2022). In contrast, 17% of women wanted to have a child sooner or wanted to have more children because of the coronavirus pandemic. Globally, more than one-third women (34%) wanted to get pregnant later or wanted fewer children because of the pandemic. The figures for women in India was 21% (Lindberg, 2020; Ramarao *et al.*, 2020; Acharya, 2022).

Nationwide Lockdown

In India, during the nationwide lockdown, there has been an increase in cases of sexual violence, which the UN calls a 'shadow pandemic'. India is unable to ensure family planning with 30 million women wanting contraception or abortion and this could skyrocket due to the crisis. About 70% of health and social workers are women, operating in infection prone zones, but their protection is not prioritised (WHO, 2019). Confinement of women to households during lockdown has made them more susceptible to sexual violence. Women have to face challenges such as overloaded hospitals, travel bans, lockdowns and border closures, which makes access to services difficult. An increased financial hardship during the pandemic has further marginalised women where they do not have means to access the health services. United Nations Sexual and Reproductive Health Agencyhas warned that the pandemic has 'severely disrupted access to life-saving sexual and reproductive health services' (UNFPA, 2022).

Right to Health

Indian Ministry of Health and Family Welfare categorically stated that pregnant women must be provided with all essential maternal health services. Uttar Pradesh, Bihar and Kerala halted programmes like vaccinations, door to door services and even prenatal check-ups for women. Healthcare workers and assistant nurse midwives engaged in reproductive healthcare department were directed looking after COVID-19 infected persons. It is estimated that there were at least 1,400 to 2,000 maternal deaths due to the lockdown because of poor access to family planning and healthcare services. This has hampered antenatal care, intrapartum, immunisation, safety in abortion services, etc. (Ganguly *et al.*, 2020). More than 70% of private hospitals were closed till they engaged in vaccination services. Due to such exacerbating circumstances, it is estimated that 25.6 million couples would not be able to access contraception and abortion services. This violates a woman's right to *meaningful choice* over her reproductive organs.

Legal Safeguard towards Reproductive Rights

There is legal safeguard for women's right to survive pregnancy and childbirth as well as the right to guaranteed access to reproductive health services. The obligations of the state have been well described under Article 12 of the Committee on the Elimination of Discrimination against Women (CEDAW) (UN Women, 2016). It recognises availability of health care services, goods and facilities without discrimination. It should be largely accessible physically and economically, and be of good quality. The CEDAW has been severely undermined as healthcare facilities are not available due to the reluctance of state authorities. Disruptions in pharmaceutical supply chains have impacted the availability of contraceptive methods and medical abortion drugs. This makes services inaccessible and women are forced to take drugs without supervision or seek help from people who lack training. Nonetheless, states have withdrawn their assistance by not stirring up any provisions for reproductive services, as well as moving reproductive healthcare workers to COVID-19 relief.

This whole idea of developed vs. developing countries, despite the fact that we spend less than 2% of the GDP on health which needs to be increased. In comparison to some other countries including the USA which has the capitalist system, 11%"12% of the GDP goes into health (PGPF, 2023). Despite that, one in three women delayed or did not want to visit any health care facility because of the fear of catching the infection. The corresponding scenario in India suggested that more than half the women did not and could not do that for similar reasons. The point is that while we do not have a system which needed to be in place, a lot of discussions in academia and in the policy making regimes have suggested that there is a need to increase the budgetary allocation for health care and this is perhaps the time which tells us very importantly that 1.17% of the GDP for health is absolutely not enough. The Union Budget in last two three years has been contemplating increase to about 2.5%"3% of the GDP. Perhaps given the scenario of the pandemic, even this may not be adequate. We could not ensure the family planning services to roughly three million women. They remain in need of any kind of contraception and abortion support. This certainly has sky rocketed during the pandemic. About 70% of health and social workers who are women at the grassroots have continued doing their jobs, often without any protection. Even now little or no information is available. So, the point therefore, is that we need to understand the reproductive health- care services and choices, and bring on board the role of state over and above what perhaps becomes relevant as individual, couple, family and community.

The larger global discourse on reproductive choices and rights as per the ICPD vis-a-vis WHO, our own Ministry of Health and Family Welfare assures that pregnant women

must be provided with all essential services. But provisioning of the services was halted as a larger frame of adherence to lockdown became relevant in terms of availability of transportation, care provider, or care taker within the household for instance. This hindered the mobility of women who needed to go out for care. So all of this perhaps becomes very relevant in taking cognisance of how could the state address the needs of the health services, in this realm of public private partnership. About 70% of the services in the private hospitals shut down due inadequate manpower or staying away (safe) from the infection, safeguarding the personnel, etc. (Mohanty, 2020). This is a bit of a paradox when we are trying to take cognisance of a situation created by the pandemic. A doctor in the government district hospital had been serving through the COVID period including the second wave, was found dead by suicide after killing all his family members which included his doctor wife, son and a daughter. A note running into three pages and had reference to the third wave and reflected the dismay—'I have seen enough during COVID and I cannot face the omicron any more' (The Tribune, 2021). This shows how stressed the doctor could have been to take such a step. The care providers- at all levels of work hierarchy were experiencing stress and anxiety. Those taking decisions, executing; working at the lowest level- the sanitation workers, particularly in the hospice, were all reeling under tremendous pressure of illness and death. The sanitation workers, especially women, were in the direct contact with the infected persons, their body fluids, bedpans, beddings, etc.

The Article 12 of CEDAW provides for women to have fair opportunity to be able to access their sources. What could be happening to women who are vulnerable on the basis of their social identity, on the basis of being differently- abled, or on the basis of tribal identity is a matter of concern? Drawing from the NHFS data, it is appalling to note that if all these services and choices that we have been talking about are supposed to be for everybody, each one of us are expected to be able to access them equally, the data speaks differently. Ideally, the state is responsible to ensure fundamental rights and aspire towards the directive principles enshrined by the Constitution. Prevailing inequalities, however, lead to differential access to these services. A stark evident is provided by the NFHS-5 in the gap between the life span of women. Those from Dalit communities, live about three and a half years less than women who are from privileged caste groups. The average age at death for Dalit women is 66.31 years as compared to the privileged caste women who live up to 70 years on an average. So, with this kind of disparity already existing it is not very shocking to note that nearly twice as many children among the SC as compared to the privileged caste die before celebrating the first birthday. The infant mortality rate among the SC 40.7 per 1000 live births is almost double of 28 per 1000 live births among the 'Others' or the privileged castes. The child mortality rate or death of the children before age 05 years

is nearly ten time more among the Dalits (48.9) as compared to the 'Others' (4.6). Severely underweight children among the Dalits are about 11.5% as compared to 8.8% among the privileged castes.

Nearly a quarter of SC women report distance as a problem to access healthcare as compared to about 18% of the Others. There are micro level studies which do tell us that when we are looking at the access geographically most vulnerable communities are located in the outskirts so there's a possibility of the distance becoming one of the important factors why access to services cannot happen among the Dalits. Similarly, there are a couple of micro studies in the western parts of the country including her own. It has come out very clearly that when an underprivileged user of a health care service approaches the health care provider, the time spent in the interaction is lesser than the time spent with somebody who is from a privileged community. It is important to reiterate the constitutional rights in the light of K. Puttaswamy vs Union of India case judgment. The Puttaswamy judgment specifically recognised the constitutional right of women to make reproductive choices, as a part of personal liberty under Article 21 of the Indian Constitution (Justice K S Puttaswamy v Union of India 2012a: para 72, 2012b: para 46, 2012c: para 38).

In spite of these international regimes, the fact that these constitutional and legal safeguards for various population groups have failed to address the gaps as desirable. Therefore, Dr B R Ambedkar, a thinker par excellence which India has produced and many of us recognise him as the messiah of the downtrodden. Given his vast knowledge and pragmatic understanding of the Indian society and its embedded inequalities, it is important to think of him beyond being just a messiah. He is one of the foremost statesmen who embarked upon the concerns for women's health. Way back in 1930s in the Bombay Legislative Council discussion on 10 November 1938 (GoM ED, 1989), disability of the parents was acknowledged as the prime reason for impacting on children physically, mentally and financially. He was one of the forerunners who saw the reproductive rights of women as important for their development. He proposed limiting the number of births for the health of the women and the children instead of the conventional stand which was for controlling the population. He also saw this as a measure to prevent maternal and infant deaths and reduce morbidity among them. In this vein, he favoured termination of pregnancy to prevent unwanted births.

Therefore, recognising the relevance of women's health in development, attention may be drawn towards Ambedkar's efforts in taking note of status of the mica mines and workers engaged therein. These observations became the foundation of the Labor

Welfare Fund Bill. Mica Mines Labour Welfare Fund Bill was used as an opportunity to study the socio-economic status of workers in the mines. It was his efforts which got the maternity benefits to working women in 1942; Maternity Benefits to women Mine workers was extended and working underground was prohibited for women. Decades later, as a signatory to The Alma Ata Declaration, in 1978, India professed the same and aspired to achieve it too.

CONCLUSION

It can be emphasised that while Dr Ambedkar brought the notion of justice, equality, liberty and fraternity to sensitise all people especially the downtrodden in the contemporary India, his concern for women and their health is also evident right from the Mahad Satyagrah also called Chavdar Tank Movement led by B. R. Ambedkar on 20 March 1927 (Ambedkar Today, 2019) when he mobilised the people to reach out for what was their right to life- the clean drinking water from a public tank which was not accessible to those who were labelled as 'Untouchables'. His concern for the vulnerable and the marginalised; and for the health is an obvious culmination of connecting the two for an enquiry.

There are international for a deliberating and guiding the trajectory of reproductive health, state as an agency with directives, community and the familial systems within which women are embedded. Therefore, it is important to locate proactive realms of promoting reproductive rights within the health care systems. It needs to be emphasised that whatever mode, whatever service, we might be using, the inclusive measures for development become important particularly in the times of pandemic. The care providers, job providers or the industrial setup providing certain services need to incorporate women's right—from the general health to menstrual hygiene to sexual and reproductive health services. The intersections between these coordinates become very important if one wants to make sure of the choices that can be made for the reproductive health both of men and women, and not to forget the issue of infertility. Different agencies- government, quasi-government, non-government and private-participation from all will enable overcoming the challenge in addressing reproductive health as committed in various international platforms.

The evolution of reproductive rights and health from early international conferences to contemporary challenges highlights the ongoing struggle for equitable access to health services. These insights underscore the importance of a rights-based approach that considers the intersectionality of gender and social disparities. Achieving universal reproductive health requires sustained efforts and global cooperation, particularly in the aftermath of the COVID-19 pandemic.

RECOMMENDATIONS

- Proactively promote rights of women through online education, social media, etc. Electronic medical consultation, home visits by midwives, psycho-social support, and ample screening should be facilitated in India in the times of health emergencies.
- Monitor medical supply chains and have sufficient stock to avoid shortages. Mandate states to provide reproductive services. Ensure adequate supply of essential products such as sanitary napkins, contraceptives, family planning kits and other hygiene products.
- During the pandemic, victims of sexual violence were locked up at home with their abuser. This calls for strategic plans which ensure swift redressals for the grievances suffered. Facilities such as counselling, shelter homes, temporary employment, etc. should be provided. The helplines which would not collapse due to surge need to be put in place. The governments in Canada, US and Spain have appropriated funds and provided accommodation to women during COVID-19. Similar steps need to be considered for women during health emergencies in India too.
- In the long run, it is essential that the government creates a dynamic and uniform platform for receiving and redressing the sexual and reproductive grievance of women. Along with this the platform, feedback and accountability mechanisms need to be established to ensure effective functioning.

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