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ACCESSING REPRODUCTIVE HEALTH CARE SERVICES FOR WOMEN DURING COVID-19 PANDEMIC: AN INTERSECTIONAL ANALYSIS FOR SOUTH EAST ASIA

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FEMINISTS
FOR A PEOPLE'S
VACCINE

CONTENTS

1. BACKGROUND

Southeast Asia (SEA) includes 11 countries[1] with a population by July 2024 of more than 695 million people, nearly 8.7% of the world population[2]. When the pandemic expanded to the region in 2020, most of the countries in the region responded effectively in its first wave with the closure of activities and borders, movement restriction and social distancing (Chu et al. 2022). However, when new variants of the virus came, with low resources for quick expansion of the vaccination program, the pandemic soared in many countries of the region. Infection cases and the death toll increased sharply. As of May 2023, Southeast Asian countries had reported nearly 36 million infected cases and nearly 366,000 deaths (WHO 2023).

Different measures were taken in response to the pandemic.. The responses shared a lot in common and followed WHO's guidelines (CSIS.2022). In general, the main measures included closing borders, closing schools, offices and public venues, movement restriction, social distancing with lockdown or curfew periods and vaccination. Non-COVID-19 health services were limited to only essential and emergency health services.

These measures had negative impacts on people's access to health care services. The closure of health services that were considered 'non-essential' such as immunizations, maternal care, and testing and treatment for chronic diseases like HIV and tuberculosis disproportionately affected vulnerable groups such as migrant workers, women, refugees, indigenous people. Those in rural or remote areas, faced additional barriers to accessing healthcare. The 2023 World Health Organization (WHO) report highlighted that delays in treatments for chronic illnesses had worsened health outcomes among these populations (WHO 2023). LGBTI people also faced increased discrimination when they lost their income, and had to be at home most of the time with limited access to health services tailored to their needs (Lee et al. 2024). In addition to challenges in accessing SRH services, reviews also reported increases in domestic violence and mental health issues (VanBenschoten et al. 2022; UNFPA 2020).

1- Bruney, Cambodia, Indonesia, Laos, Maalaysia, Myanmar, Philippines, Singapore, Thailand, Timor-Leste and Vietnam
2- South-Eastern Asia Population 2024 (worldpopulationreview.com)

Access to sexual and reproductive health (SRH) was limited during the pandemic and caused negative consequences. According to an estimation from UNFPA in 2021 in 115 low and middle-income countries, the pandemic disrupted contraceptive use for about 12 million women. This would lead to 1.4 million unintended pregnancies (UNFPA 2021). This review of UNFPA also showed that among the reviewed countries, 58% countries could maintain or even expand facility-based family planning services and 41% countries could not. A survey done by UNICEF 2020 with 84 countries found that family planning services dropped from 10% to as high as 75% in about 50% of the surveyed countries. A survey conducted by World Health Organization in 102 countries also reported disruption of family planning services from 'partial' to 'serious' in 59% of the surveyed countries (UNFPA 2021). With the increase of unwanted pregnancy, requests for safe abortion also increased (VanBenschoten 2022). However, access to abortion services was challenging especially for young people due to the classification of abortion as a 'non-essential' service, lack of transportation and financial capacity and legal restrictions (VanBenschoten 2022).

Closure of health facilities especially at the grassroots level or diverting services at these clinics to almost exclusively COVID-19 related services curtailed access of pregnant women and children to maternal and child health care. Difficulties in transportation, financial challenges and fear of infection contributed to the delay in seeking services. Thus, maternal and child mortality increased in low-income countries, particularly in rural regions where women already had limited access to prenatal services (Chmielewska et al. 2021; Osendarp et al. 2021).

Innovations such as telemedicine and mobile health services were implemented in different countries to continue providing essential care. However, these programs presented challenges of technology and skills so that marginalized women who were poor or lived in remote areas could not benefit (Tan et al. 2023).

This review looks at the impacts of COVID-19 on women's access to health services in Southeast Asian countries, especially reproductive health services and other needed services such as mental health and domestic violence prevention as these issues emerged during the pandemic.

2. RESEARCH QUESTION

This paper aims to understand the factors that influenced access of women to health care services in the SEA region during the COVID-19 pandemic. It focuses on women at the intersections of sexual orientation and gender identity, HIV status and sex work, as well as women at the intersection of disabilities, ethnicity, age and migration. The review was conducted in nine out of 11 countries in SEA: Cambodia, Indonesia, Laos, Malaysia, Philippines, Singapore, Thailand, Timor-Leste and Vietnam.

The paper answers the following questions:
- Which health care services were not available or not accessible for women during the pandemic?
- What were the factors that contributed to inaccessibility of women to health care services?
- Which strategies were taken to deal with these challenges in health care access, and by whom?
- What were the lesson learned?

3. RESEARCH METHODS

3.1. CONCEPTUAL FRAMEWORK:

The paper explores the complex interplay of gender, power, and social inequalities within healthcare systems, using two frameworks. It seeks to explore what equitable, inclusive, and rights-based healthcare for all individuals means in the pandemic context. Marginalised and vulnerable women groups were central to data collection and analysis. They included women among the economically disadvantaged and ethnic minorities, migrant workers, women with disabilities, women with HIV, sex workers, GBV survivors, transwomen and transmen, and women in same-sex relationships.

The two frameworks are:

- The AAAQ standards for right-based health care services: with this framework, health care services should be Available (appropriate infrastructure/ distance/locational access), Affordable (‘economic’ access), Acceptable/appropriate (socio-cultural-political axes of access, including disability-friendly access), and meet Quality norms, and ethical standards

(FPV Campaign Concept Paper, 2024). In efforts to deal with the pandemic, health care systems of countries in the SEA region had to prioritise their limited resources to combat the virus, thus may have failed to make essential health care services available and adapt to the needs of certain populations such as marginalised and vulnerable groups.

- Vulnerabilities: this review employs the vulnerability framework of Tan et al (2023) which identifies five dimensions of vulnerability in the COVID-19 pandemic which affected people's access to health services. These dimensions include:

- Health vulnerability: Exhibit serious health conditions and lack access to health services; inadequate financial protection towards health. Chronically sick or disabled people, terminally ill or seriously ill subjects, indigenous people and migrant workers with poorer baseline health statuses, high risks of exposure to the virus, high risks of developing severe COVID-19 symptoms or COVID-19 complications, and lack of access to health services.

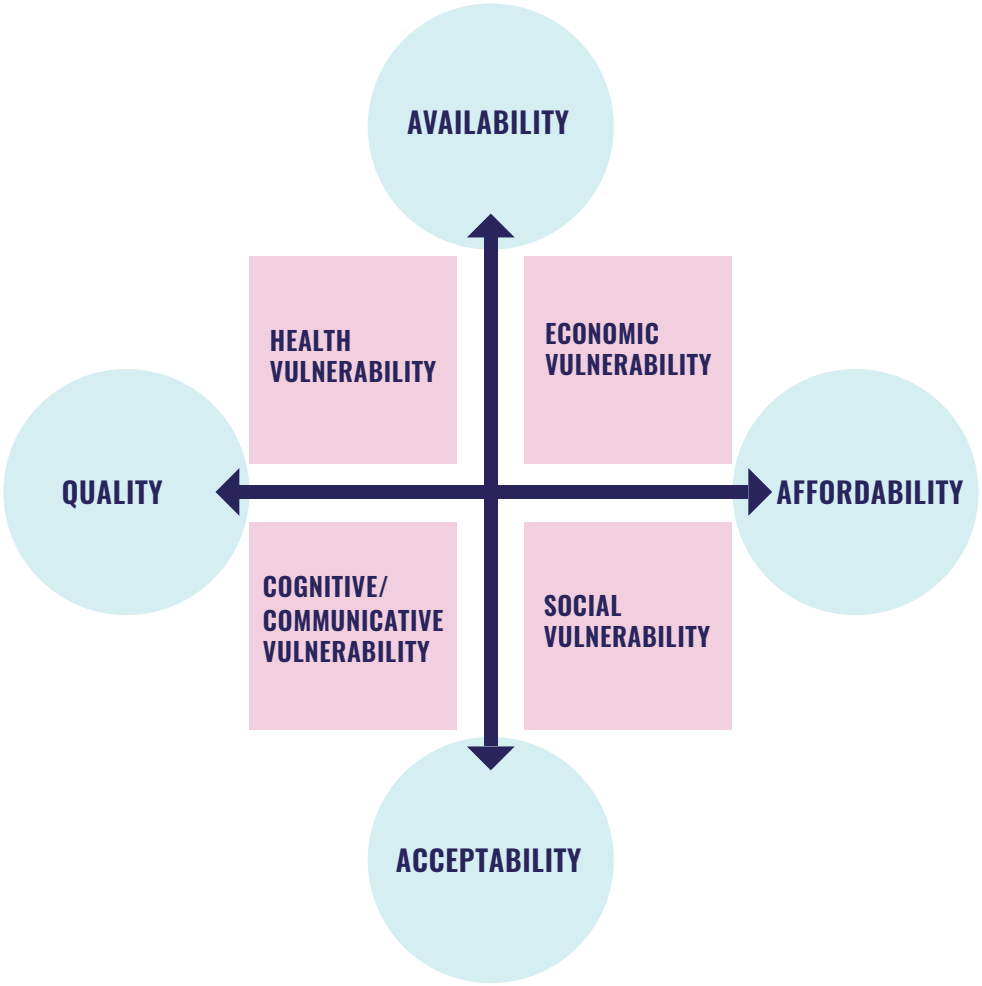
- **Economic vulnerability:** Epidemic-induced income shocks that could result in overnight and systemic poverty. Dependent persons, or impoverished people with adverse employment conditions (unemployment, working on temporary contract, part-time employment, self-employment, informal sector workers, or migrant workers); adverse financial conditions (having payment arrears, or low-income); digital and connectivity conditions (lack of internet access, or lack of access to computers or other digital devices).

- Social vulnerability: Disadvantaged in the distribution of social goods and services.

Populations living in poor quality housing (lack of access to necessities, e.g., water and sanitation) or in overcrowded housing; the socially isolated; populations vulnerable to violence (sex workers, domestic violence victims).

- Institutional or deferential vulnerability: Subject to formal authority of others or informal subordination to others. Prisoners, institutionalised older persons, physically and mentally challenged populations who are institutionalised, and school-going children.

- Cognitive or communicative vulnerability: Diminished capacity to understand and communicate. Children, migrant populations, people with speech and/or hearing impairment, people struggling with communication due to low subjective well-being or poor mental health conditions.



3.2. DATA COLLECTION AND ANALYSIS

This paper was based on a literature review of online sources. Keywords related to sexual and reproductive health (SRH), accessibility, and health equity were used to search for relevant materials. Research papers, policies, technical guidelines, and media coverage from Southeast Asian countries were collected and thematically analyzed using the aforementioned conceptual frameworks.

Preliminary findings were shared with health equity experts from the countries reviewed. Follow-up interviews were conducted to gain their insights and gather additional information. The initial plan was to consult two experts from each country.

The nine countries included in the review were Cambodia, Indonesia, Laos, Malaysia, the Philippines, Singapore, Thailand, Timor-Leste, and Vietnam. Brunei and Myanmar were excluded due to the author's limited knowledge of these countries and the lack of strong networks with national experts there.

4. GENDER, HEALTH AND SEXUAL AND REPRODUCTIVE HEALTH LANDSCAPE IN SOUTHEAST ASIA

4.1. SOCIAL, CULTURAL, ECONOMIC, POLITICAL AND RELIGIOUS DIVERSITY

SouthEast Asia is among the most socially, culturally, economically, religiously and politically diverse regions in the world. It is home to over 650 million people, with diverse ethnicities, languages, and cultures. Indonesia recognizes over 1,300 ethnic groups, while Vietnam, Myanmar, and others host numerous ethnic minorities like the Hmong, Karen, and Khmer groups (World Bank, 2021). Multilingualism is widespread, with over 1,000 languages spoken in the region, fostering a rich cultural landscapes but also posing challenges for policy implementation and inclusivity (Ethnologue, 2022). In terms of economy, the region spans developing countries like Cambodia and Laos to advanced economies like Singapore, with disparities in wealth, infrastructure, and access to health and social services (ASEAN Secretariat, 2022).

These economic disparities often influence the accessibility of reproductive health services and the rights of marginalized groups. Governance systems range from democracies (Indonesia, the Philippines) to single-party states (Vietnam, Laos), constitutional monarchies (Thailand), and militarized regimes (Myanmar) (Human Rights Watch, 2022). This diversity impacts how sensitive issues are legislated and addressed. Religious plurality deeply influences societal norms and policy decisions. Islam, Buddhism, Christianity, Hinduism, and indigenous beliefs coexist,

often shaping attitudes toward contraception, abortion, LGBTQ+ rights, and sex work (Pew Research Center, 2021). Patriarchal norms prevail. Son preference is common in most of the countries in the region. Men are considered decision makers and women, house keepers. While Southeast Asian countries share overarching patriarchal tendencies, the manifestation of gender norms varies widely based on religion, economic development, urbanization, and cultural diversity.

4.2 INTERNAL AND CROSS-BORDER MIGRATION

Migration in general and cross-border migration in particular were among issues that countries in the region considered an important factor that influenced the spreading of the pandemic. Cross-border migration in Southeast Asia has been a significant socio-economic phenomenon, with millions of individuals moving across borders for employment and better opportunities. Before the pandemic, intra-ASEAN migration had increased from 1.5 million in 1990 to 7.1 million in 2020, indicating a significant rise in cross-border movements within the region (ASEAN Secretariat, 2022). Women constituted a substantial portion of migrant workers. In some labor-sending countries in Southeast Asia, women made up to 75% of newly deployed workers, highlighting their significant role in migration flows (IOM, 2021). Female migrants have predominantly worked in sectors such as domestic work, hospitality, and the sex industry, which are often informal and precarious, increasing their vulnerability to exploitation (Migration Data Portal, 2023). Female migration was more vulnerable to economic shocks than male migration, with gender norms around work leaving women more susceptible to economic losses and restricting re-entry into the labor force (Yale Economic Growth Center, 2024). The pandemic prompted a mass exodus of several million migrant workers from their host countries back to their countries of origin due to large-scale job loss, salary reductions, homelessness, and short-notice lockdowns (Migration Data Portal, 2021). Being afraid of infection, these workers were often kept in a camp for several weeks or months. Health care conditions in general and reproductive and sexual health in particular were often not provided here.

4.3. SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS RELATED POLICIES

Countries in the region maintain different policies regarding sexual and reproductive health such as contraception, abortion, same-sex marriage, transgenderism and sex work. These policies largely influenced the availability of these services during the pandemic and the accessibility of these groups to sexual

and reproductive health services. Most Southeast Asian countries provide subsidized contraceptives, but coverage is inconsistent. In Indonesia and the Philippines, religious opposition and stigma limit access. In contrast, Thailand and Vietnam offer comprehensive contraception under public health programs. Laws on other more sensitive sexual and reproductive health issues vary widely between countries in the region:

- Abortion: this is legalized in Vietnam, Cambodia and Thailand. In these countries, abortion service is very much available and provided on demand in early pregnancy until 22 weeks. Thailand allows pregnancy termination until 20 weeks. In Laos and the Philippines, abortion is criminalized.

- Same-Sex Relationships: Thailand is the first country to legalize same-sex marriage, from January 2025. It also leads the region in inclusive health policies, including access to reproductive health services for LGBTQ+ individuals. However, in more conservative countries like Malaysia and Brunei, same-sex relationships remain criminalized, severely limiting health access.

- Sex work is criminalized in most Southeast Asian countries, limiting access to reproductive and sexual health services. Programs led by NGOs have helped improve access to HIV prevention and treatment, but broader reproductive care remains challenging.

4.4. UNIVERSAL HEALTH COVERAGE (UHC) AND SOCIAL PROTECTION IN SOUTHEAST ASIA

Most Southeast Asian countries have made progress toward UHC, aiming to provide equitable access to health care, including reproductive health services. However, the extent of coverage and accessibility varies significantly. Thailand has been one of the region's leaders in UHC since 2002 through the Universal Coverage Scheme (UCS). Reproductive health services, including prenatal care, contraceptive services, and delivery, are fully covered. However, access challenges remain for undocumented migrants and ethnic minority groups. In Vietnam, health insurance covers some reproductive health services, including antenatal care and contraceptives, but coverage can be incomplete, particularly for women in remote, mountainous regions. Ethnic minority women often face cultural and language barriers in accessing care (McKinn et al. 2019). The Jaminan Kesehatan Nasional (JKN) program in Indonesia includes reproductive health services, but gaps in coverage persist,

particularly for contraceptives and abortion care, which is highly restricted except in specific medical cases. In the Philippines, the Universal Health Care Act of 2019 expanded coverage, including access to contraceptives and maternal care, but high levels of stigma around reproductive health care services continue to affect utilization, especially among young women and marginalized groups.

Access to reproductive health care for women with disabilities remains limited in most Southeast Asian countries due to physical, communication, and attitudinal barriers. A 2020 UNFPA report highlighted that facilities in many countries, including Cambodia and Laos, lack accommodations like wheelchair access or sign language interpretation. Women from ethnic minorities in countries like Vietnam, Myanmar, and Laos face significant barriers, including limited healthcare infrastructure, language differences, and cultural stigma.

A study in Vietnam found that ethnic minority women are less likely to receive antenatal care due to geographic isolation and cost barriers (World Bank, 2020). Migrants and refugees in countries like Thailand and Malaysia often lack health insurance and rely on NGOs for reproductive health services. Refugee women in Malaysia face heightened barriers, as the government excludes them from public healthcare systems. Access to contraception for adolescents remains limited due to legal, cultural, and parental consent barriers. The Philippines has the highest teenage pregnancy rate in the region, exacerbated by inconsistent implementation of reproductive health laws. Many marginalized and vulnerable groups were not covered by social protection:

- Migrant Workers: Malaysia initiated temporary health programs for migrants, though fear of arrest limited participation. In Thailand, migrant workers received some benefits under UHC, but undocumented individuals faced barriers.
- Women in the Informal Sector: In Vietnam, cash transfers prioritized informal workers, but many women were excluded due to the lack of formal registration.
- Transgender Individuals: these communities received little to no direct support. They depended on support from NGOs or their own communities.
- Elderly Women: Social pension schemes in Thailand and Vietnam helped elderly women, although benefits were minimal compared to living costs. As a country in which the majority of people are farmers, many elderly people, especially elderly women in Vietnam, were not in a pension scheme.
- Women with Disabilities: Most countries lacked targeted support for women with

disabilities during the pandemic. In Cambodia, some NGOs provided relief packages, but government programs often overlooked their needs.

4.5. CAPACITIES IN COPING WITH PANDEMICS BEFORE COVID-19 IN SOUTHEAST ASIA

Southeast Asia had faced several major pandemics and infectious disease outbreaks before COVID-19, including SARS (2003), H5N1 avian influenza (2004–2007), and H1N1 swine flu (2009). The region's responses highlight varying levels of preparedness, infrastructure, and lessons learned. Early lockdown, surveillance system, early vaccination distribution and quarantine were the success strategies used by countries in the region. Although Vietnam has limited resources, its proactive approaches, community engagement and strong government control contributed to effective responses during SARS and H5N1 (WHO, 2007). Among the countries in the region, Singapore and Thailand are among countries with advanced preparedness for epidemics (MOH Singapore, 2015; UNDP, 2016). Vietnam and Malaysia are classified as having moderate preparedness (MoH Malaysia, 2010) while Myanmar, Cambodia and Laos are seen as more vulnerable to epidemics because of limited healthcare infrastructure and funding, cross-border movement and weaker surveillance systems (ADB, 2008).

5. ACCESS TO HEALTH SERVICES

5.1. MATERNAL AND CHILDCARE SERVICES

Reduction of maternal and childcare services was reported in all countries. Research also recorded an increase in stillbirths, maternal mortality, ruptured ectopic pregnancies, and maternal depression (Chmielewska et al. 2021). The main reasons were the closure of services, mobility restriction and concerns about getting COVID-19. Lack of comprehensive guidelines for maternal and childcare services in the context of the pandemic was also among the reasons (Ekawati et al. 2023).

In Malaysia, records after the first wave of the pandemic showed a monthly reduction of 19.23% in child health attendance, 10.12% in women's health, 9.10% in antenatal care and 6.5% in contraception (Mohd Ujang et al. 2023). Coverage of antenatal care services was maintained during the pandemic but postnatal care was reduced (Mohd Ujang et al. 2023). Access to immunisations for children and breastfeeding support services were also reduced (Mohd Ujang et al. 2023).

In the Philippines, antenatal care, breastfeeding services and complementary feeding messages and advice were disrupted during the community lockdown (Angeles-Agdeppa, Goyena, Maniego 2022) . Newborn screening coverage reduced from 91.6% to 80% (Padilla & Manalo 2023). Almost half of the people who took part in the research reported deferrals of visits mainly due to lockdown restrictions, transportation problems, and financial issues (De Guzman, Banal-Silao 2022).

In Thailand, a slight decrease in breastfeeding was reported during the COVID-19 lockdown. (Piankusol et al. 2021). About one third of postpartum women received postnatal care (Aye et al. 2022). Access to postpartum services for women among the socially deprived groups such as employees in the informal sector (i.e. market vendors, agriculture, massage therapists, domestic workers), caregivers residing in conflict-affected areas and rural communities, migrants, and minor ethnic groups were most affected by the pandemic. Among people who lost manufacturing jobs during COVID-19 pandemic in Thailand, 91% are women. Women also accounted for 58% of the overall jobs lost (Khatiwada, Hilal 2022). In addition to reduction in income during the COVID-19 pandemic, women working in informal sector jobs also had limited access to social security schemes and stimulus packages by the government (Ketunuti and Chittangwong 2020). Nearly 45% of the new mothers reported feeling a high extent to some extent of worry. Additionally, the lockdown had several economic consequences which were significantly associated with negative maternal mental health (Sirikul et al. 2021).

Indonesia experienced a similar trend of reduction in maternal and child care (Helmyati et al. 2022). The national expert in Indonesia emphasized in the follow-up interview that this reduction may last beyond the pandemic especially ante-natal care check-ups. According to her, post COVID-19 monitoring in Indonesia showed that the immunization of children had already returned to normal levels but ante-natal care remained lower than before the pandemic.

In Timor-Leste, maternal care services were improved (Kleine-Bingham et al. 2023). This could be due to Timor Leste being designated as an ‘emergency setting’ internationally which equipped it for rapid scaling up of any new intervention due to the infrastructure. For example PCR testing was scaled up rapidly and there was an early application of border controls to delay the onset of community transmission in Timor Leste. Further, the pilot telehealth clinics indicated that capacity-building for telemedicine could be rapidly implemented (Paratz et al. 2022).

In Vietnam, closing non-COVID 19 services at commune and district health centers during the pandemic caused difficulties for pregnant women to access and use maternal health services. Pregnant women had to go to a private hospital for check-up and delivery (CCIHP 2022). These challenges were worse for more vulnerable women such as ethnic minority women and migrant workers who were far away from the health facilities at district or provincial level and lost their income due to the pandemic.

To help pregnant women access health care services, different innovations were used. For example, in the Philippines, door-to-door antenatal care and family planning provision were implemented (Marzouk et al. 2023). In Thailand, telemedicine helped improve postpartum contact and contraceptive utilization (Sothornwit et al 2023). In Vietnam, the Ministry of Health developed a mobile app to ensure the continuation of maternal and child care services at grassroots level (CCIHP 2021). The digital and online initiatives helped women access maternal and child care services, although not everyone could access them. Poor women who could not afford a smart phone and women who had difficulties in communication such as illiterate women, women with disabilities may have had challenges in using telehealth services.

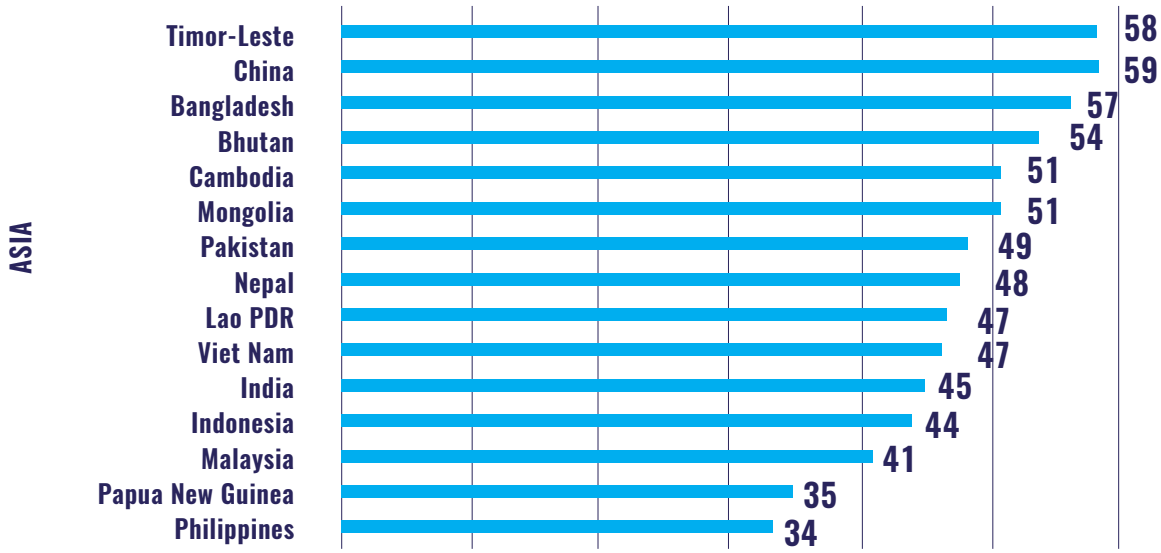
In addition to initiatives implemented by the government, responses in health care during the pandemic also showed the important role of civil society. For example, in Vietnam, medical doctors actively provided maternal and child health care consultations through their individual or group facebook pages from the early time of the pandemic. Later, recognizing the effectiveness of this method, many public health facilities from commune to center level established their facebook groups and officially interacted with community people to provide services through this channel.

An Interview with a national expert from Singapore also showed that measures taken by the government could not reach the most vulnerable groups, especially groups that were considered taboo, illegal or undocumented. However, there were many initiatives from civil society organizations and groups that were implemented to respond to the specific needs of these groups.

5.2. CONTRACEPTION

Peoples' access to contraceptive methods, especially in poor and developing countries during quarantine periods, reduced across the region (Yazdkhasti 2020). This increased unwanted pregnancies. Thus, contraceptive methods were recommended to be added to the essential 'family goods basket' and provided for free (Yazdkhasti 2020). However, these practices were not recorded in countries in the region. In Vietnam, for example, contraceptive methods were not listed in the list of 'essential goods' which were allowed to be transported during lock-down or social distancing time (Vietnam Ministry of Industrial and Trade, 2021). It was not provided in the 'essential package' for individuals and families during lockdown and social distancing.

The main reasons for reduction of contraceptive utilization were fear of infection, disruption of services due to closure or lockdown and travel restrictions, and lack of staff due to the staff/ facilities diverted to COVID-19 (Hardee et al. 2024). The below table showed the contraception security score (highest score: 100).



There is not much data on access to contraceptive methods among marginalized and vulnerable groups. However, the closure of health facilities and limited opening times of pharmacies during the pandemic could prevent people especially those who were living in remote and mountainous areas from accessing contraceptive methods when they were needed. When family planning services fall under 'non-essential' services, contraceptive methods are not among the 'essential goods', and not easily accessible.. In 2021, trucks that carried sanitary pads and diapers were stopped from circulation on the streets in Ho Chi Minh City (Vietnam) because sanitary pads and diapers were not in the list of essential goods (Duc Minh 2021). In Laos, special camps were established to receive Laos workers who returned from Thailand to prevent the transmission of the virus from these workers to the community. However, SRH services such as family planning and maternal and child health care services were not included at these camps. Later, telehealth services were developed to respond to people's needs (Sayarath and Lorkuangming 2021).

5.3. ABORTION

Poor access to contraceptive methods increased unwanted pregnancies, thus the need for abortion seemed higher during the pandemic. In Malaysia, requests for safe abortion increased by 48% in 2020 compared with 2019 (Van Ooijen et al. 2022). In Laos, unwanted pregnancy among young girls increased during the pandemic because children had more time at home but did not have access to sexuality education and contraception (VanBenschoten 2022). Mitigation measures prevented young people from accessing safe abortion services especially in the countries that restricted or banned abortion such as in Laos and in the Philippines. Limited access to safe abortion may have resulted in unsafe abortion. However, data on unsafe abortion in the region during the pandemic is limited. In Vietnam, the records of an online counseling programme for young people revealed that the programme received increased requests for abortion from young people overseas such as Indonesia, Malaysia, the Philippines and even Russia (CCIHP 2021).

5.4. HIV PREVENTION AND TREATMENT

Access to HIV prevention and treatment was reduced during the pandemic. COVID-19 emergency responses took precedence, leading to movement restrictions and shutdowns. Issues like diversion of healthcare resources away from HIV care to the COVID-19 response led to reallocation of providers and hospital space resulting in serious setbacks to HIV-related policy implementation (VanBenschoten 2022).

However, adaptations in the time of the pandemic also presented opportunities for innovative care delivery. For example the expansion of HIV differentiated service delivery interventions. The health authorities allowed longer gaps between visits and larger-volume prescription refills to delay returns to healthcare facilities or using post services to deliver the medicine (Ahmad, Fuller, Sohn 2024). These measures were requested by people living with HIV/AIDS (PLWHA) and activists to enable access to service as well as to save time and reduce travel expenses to service-delivery points. In Malaysia, about 60% of PLWH expressed concerns about accessing anti-retroviral treatment (ART) during the pandemic (Hung et al 2022). However, research also recorded significant organizational, programmatic, and treatment protocol changes to reduce patient flow and concentration, including less in-person visits, increased telemedicine and telecommunication with patients and clients (Vicknasingam et al 2021).

In the Philippines, 37% PLWH experienced reduced visits to the hospital/clinic; HIV testing was decreased by 65%, with 4 in 10 PLWHA reporting decreased HIV-related testing frequency. Additionally, 82.7% of PLWH reported concerns about access to ART during the pandemic (Hung et al. 2022). The rates of HIV testing, antiretroviral therapy coverage, and HIV treatment initiation decreased, reflected in the reduced number of new HIV infections in the Philippines between 2019 and 2020. The number of pregnant women with HIV during this same period increased (Alibudbud 2021). HIV centers for testing and ART remained open during the pandemic in the Philippines.

However, the ban on use of public transportation disproportionately affected socioeconomically deprived communities, prevented individuals from accessing testing hubs and PLWH from attending follow-up visits. (Tactacan-Abrenica et al 2022). Courier services to deliver ART were expanded nationwide. Online consultations were used for case management. Research in the Philippines showed that participants who were diagnosed with HIV during the pandemic increased their risk on the vulnerability scale due to mental and financial stress of losing jobs and incurring additional expenses for ART as well as challenges in managing their HIV status (Pantelic et al. 2024). In 2022, an increase of 50% in new HIV infections among children (due to sex-trafficking) was noted; the rate among children under 15 years was 21%. The country's growing HIV epidemic (Alibudbud 2023) was made worse due to stigma, and limited sexual health services.

In Thailand, participants reported optimal ART adherence as a consequence of local HIV service delivery responses, convenient ART refills and online support interventions (Nitpolpraseret et al. 2022). COVID-19 had also disrupted testing and treatment for sexually transmitted infections and HIV services for sex workers (Janyam et al. 2020). Community-based organisations provided immediate and various critical public health responses to support the sex worker population, such as delivering free ART and COVID-19 test kits to them, as their needs and predicaments were largely hidden, even before the pandemic (Cromarty 2021). Among transgender people, barriers to adherence of PrEP (Pre-Exposure Prophylaxis) included side-effects, inconvenient access to health services (especially during COVID-19 lockdowns), forgetfulness resulting from busy schedules and low self-perceived HIV risk (Janamnuaysook et al. 2024). The telemedicine service became more popular among transgender people during the COVID-19 pandemic and was not related to a higher risk of being HIV-positive. It proved to be an effective alternative channel to access HIV testing (Homkham et al. 2023).

Individuals from key populations (KPs) (WHO 2022) in Singapore (55.6%) were affected by the pandemic in terms of reduced hospital/clinic visitation frequency, and decrease in HIV testing. Singapore was most affected (88.9%). Reduced consumption or complete stop of PrEP/PEP was reported in more KPs in Singapore. One-third of KPs studied in Singapore utilised telehealth services to refill PrEP medications remotely (Hung et al. 2022). Sex workers had experienced an increase in food insecurity (57.3%), housing insecurity (32.8%), and sexual compromise (8.2%), as well as a decrease in access to medical services (16.4%) (Tan et al 2021).

In Vietnam, research showed that MSM and transgender people had difficulty in accessing HIV testing services and HIV prevention materials such as condoms and lubricants. Social distancing made outreach activities which were delivered by community-based groups impossible. Interruption of supply of testing and prevention materials in addition to loss of income by transwomen resulted in them turning to sex work for cash/food or shelter exchange with increased risks of STIs/HIV and violence, including sexual violence(Giang et al. 2021). Research also showed that community-based groups were proactive in finding ways to support each other through the crisis. The bigger groups with more resources would share their resources including food and HIV prevention supplies to smaller groups (Giang et al. 2021).

5.5. GENDER-BASED VIOLENCE

SEA is a region where gender inequity norms prevail. Increased work and care-burdens on women, increased tensions from financial stress and pandemic with lockdowns became a deadly cocktail increasing violence against women and forced sex (O'Hara and Tan 2022). The increase of gender-based violence during the COVID-19 pandemic was recorded worldwide, not in SEA alone. In Singapore, being non-heterosexual, having more children in the household and being young were predictors of intimate partner violence (IPV). Sex workers experienced greater economic hardship during the pandemic as a result of a reduction in the demand for sex workers. This phenomenon has also caused the out-migration of sex workers and a shift of sex work towards online spaces (Li, Taeihagh, Tan 2023).

In Vietnam, helplines and shelters that supported women who experienced violence recorded a significant increase in distress calls. In one panel discussion on GBV during COVID-19, counsellors shared sobering stories of victims of domestic violence and the extent and nature of challenges they faced. A support center counsellor shared that one of her clients wished the COVID-19 virus infected her, so that she could take refuge in a quarantine camp to be away from her husband – the perpetrator[3]. Support services for women who suffered domestic violence were also limited during the pandemic. Another counsellor reported that restrictions of lockdown meant challenges in taking a victim of extreme violence to the shelter[4]. Children were transferred to online study without sufficient education on prevention of online bullying and harassment (VanBenschoten 2022). In addition, support services for this form of violence were often not available in countries in the region.

5.6. MENTAL HEALTH CARE

Mental health problems increased during the pandemic and people from vulnerable and marginalized groups were at higher risk of anxiety and depression. In Malaysia, young people and women from low-income households reported greater severity in symptoms of depression, anxiety, and stress than those from high-income households during the lockdown (Wong et al 2023). About 88% of women

3- Author: Personal note in the panel discussion on Impact of COVID-19 pandemic on GBV in Vietnam (2020).
4- Author: Personal note in the panel discussion on Impact of COVID-19 pandemic on GBV in Vietnam (2020).

respondents in a 2020 study reported a higher level of COVID-19 pregnancy-related anxiety. Younger and first-time mothers were more likely to be anxious (Kalok et al. 2022). In Thailand, the COVID-19 pandemic produced high levels of anxiety and concerns about additional stigma among MSM living with HIV. Participants reported optimal ART adherence as a consequence of local HIV service delivery responses, convenient ART refills and online support interventions (Nitpolprasert et al. 2022).

6. DISCUSSION

While data is not available for all countries included in this review, existing data confirms that pregnant women, women facing social and economic disadvantages, young women, sex workers, women living with HIV, migrant women and transgender women in the region were particularly vulnerable to these challenges. The common challenges were closure of services, transportation disruptions, financial hardships, reduced medical supplies and human resources. For abortion, legal restrictions created more barriers for women especially young women to access safe abortion care. Economic vulnerability due to the pandemic also hindered people from accessing quality services (VanBenschoten et al. 2022). Stigma and discrimination toward PLWH, LGBTQI+ and sex work contributed to increased risk of HIV transmission and violence among these groups.

The COVID-19 pandemic placed significant strain on UHC and social protection systems in Southeast Asia, highlighting systemic gaps and exacerbating inequities, particularly for marginalized groups such as poor, migrant women, transgender individuals, elderly women, and women with disabilities. Many Southeast Asian countries implemented or expanded social protection measures during the pandemic but informal workers, including sex workers and migrant women, were often excluded.

The findings also underscore that some issues had more prolonged impacts than others due to the intersectionality of vulnerabilities. For example, while child immunization services could be quickly restored after the pandemic, the absence of services like antenatal care, safe sex practices, safe abortion, intimate partner violence, cyberbullying, sexual violence, and mental health challenges may take longer to address due to the persistence of gender inequity norms and stigma related to HIV and LGBTQI communities. Additionally, the lack of monitoring for non-communicable diseases (NCDs) during COVID-19 could lead to further sexual and

reproductive health complications that will require attention in the post-pandemic period.

As the literature shows, many of the AAAQ standards for right-based SRH care services were not met during the pandemic. Closure of SRH services made these services unavailable, or not available at locations that people could access.

Pregnant women and their children had to travel long distances and that became a deterrant – not just for additional transport and protection costs during a period when incomes in households reduced, but also because of fear of being infected. This was a common reason reported by women for not seeking ante-natal or post-partum checkups or family planning services during the pandemic. Women from marginalized and vulnerable groups such as transwomen, migrant workers and sex workers were most affected by income loss. Governments in the SEA region provided COVID-19 treatment for free. But SRH and other health services fell outside of this ambit. This made SRH services both unavailable and unaffordable for women, especially women from marginalized and vulnerable groups.

The review also highlighted that while economic factors are important, availability and affordability of SRH services are not only dependent on the level of development of the country in question. It also relies on the government's capacity to maintain SRH services during the pandemic and address the intersectionality of health inequities in their response plans. For instance, despite being the most developed country in the region, key populations (KPs) in Singapore experienced significant barriers in accessing STIs/HIV prevention and treatment services compared to other countries. Meanwhile, Timor-Leste achieved better maternal care utilization during the pandemic, demonstrating that economic development is not the sole determinant of SRH outcomes, and that prior robust infrastructure and services in emergency settings made a difference.

The review further emphasized the importance of a multi-stakeholder approach in responding to the COVID-19 pandemic. In countries where the private sector plays a key role in healthcare provision, such as Malaysia and Singapore, governments should offer support to private healthcare providers so they can share the burden of SRH service delivery during public health crises.

While online platforms can be valuable resources for increasing access to

information and services, women from the most marginalized and vulnerable groups may face significant barriers in using these platforms. These barriers include challenges related to technology (lack of smartphones), infrastructure (limited internet availability), and skills (difficulty navigating online information safely). The review also highlighted that the challenges faced in SRH during COVID-19 created opportunities to improve SRH services by shifting toward a more person-centered approach. For example, providing larger quantities of medication to reduce the frequency of health center visits for ART, or offering the option of receiving medication by mail, which was not feasible before the pandemic, became common practices during the crisis and could be continued in the future. Additionally, civil society organizations (CSOs) demonstrated their capacity to respond quickly to the specific needs of vulnerable and marginalized groups, showcasing their value during the pandemic.

The review also revealed a significant gap in data on marginalized and vulnerable women. Many studies were based on small-sample scoping studies, and while some reanalyzed national data, key information on groups such as women with disabilities, women living with HIV, sex workers, and informal female migrants were either very limited or unavailable.

7. RECOMMENDATIONS

Sexual and reproductive health (SRH) is a vital aspect of everyone's life. However, cisgender and non-cisgender women, particularly those from marginalized and vulnerable groups, were disproportionately affected during the pandemic. SRH services must remain robust during the pandemic and should be made inclusive for both cis-gender and non-cis-gender women.

An intersectional approach is essential in pandemic response strategies to address the overlapping five dimensions of vulnerabilities (health, social, economic, institutional, and communication vulnerabilities) that affect different populations. The involvement of representatives from these vulnerable communities in the planning, implementing and monitoring of pandemic responses is crucial to ensure their needs are properly addressed.

A multi-sectoral approach, and the participation of civil society, is necessary to ensure the continuity of SRH services and to reach the most vulnerable and "hidden" groups.

The capacity to respond to gender-based violence and mental health challenges during the pandemic must also be strengthened. This includes developing protocols for supporting survivors of gender-based violence and addressing mental health issues both during and after outbreaks. These protocols should be tailored to meet the specific needs of various vulnerable groups.

Governments must commit to collecting and making available both quantitative and qualitative data on SRH issues affecting marginalized and vulnerable groups, disaggregated by gender. Only with comprehensive data, can effective and efficient plans be developed to respond to the pandemic and mitigate its impact.

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