

COVID-19 Crisis and Women in Asia

Gender-based violence, sexual and reproductive health and care work

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Executive summary

As the COVID-19 pandemic continues to heighten pre-existing inequalities and vulnerabilities around the globe, understanding its multidimensional and gendered impacts is crucial for us to conceive of a way forward as a society. How the pandemic has been framed, ranging from a global health crisis to a war or battle situation, has, in turn, influenced the responses of both state and non-state actors. The pandemic does not exist in a vacuum — there are underlying social and gender norms, and power relations governing how it unfolds and how it is experienced. It is resulting in already marginalized and vulnerable parts of the population, such as women, being disproportionately impacted.

The challenge of uncovering the differential and gendered impacts of COVID-19 lies in the multi-layered, complex and diverse socioeconomic and cultural contexts in which women exist. We explore these contexts in this report using an intersectional lens that highlights that as multiple points of identities intersect, so do multiple points of unequal power relations and oppression. With a focus on India, Indonesia, Malaysia, the Philippines, Thailand and Vietnam, the report examines the impacts in three thematic areas characterizing women's experience of this pandemic: gender-based violence, sexual and reproductive health and rights and unpaid care and reproductive work.

To provide a snapshot of an evolving situation, we conducted a literature review of academic and general sources, including online news articles, policy reviews,

studies from research organizations, reports from intergovernmental organizations and press releases from local non-government organizations that were published from January 2020 to November 2020. We highlight the importance of upholding human rights in each thematic area in the responses of both state and non-state actors as duty bearers as well as in the struggles and agency of women as rights holders.

Across these six countries, the pandemic is playing out against a backdrop of ecological disasters, increasingly militarized and authoritarian environments and migrant and labour crises. Each of the three thematic areas is a unique landscape with specific challenges. What this report highlights is the following: the interlocking nature of these challenges and the urgent need for a holistic and inclusive gender-responsive approach based on a multi-sector analysis of the pandemic; the eradication of blanket solutions that do not recognize sector-specific needs, priorities and contexts and that view women as a homogeneous category; and the importance of women's leadership and participation as an avenue for empowerment that serves women's interests in all their diversity and not as a stopgap for state incompetence.

Along with its many disruptions, the COVID-19 pandemic has opened opportunities for reform. The way forward necessitates introspection and action at the structural, state, community and individual levels, recognizing that where power exists, transformative change can take place.

Introduction

In a world already riddled with structural inequality, the emergence and unfolding of the COVID-19 pandemic as a global crisis that has claimed several million lives (WHO, 2020c) has resulted in a cascade of social, economic and political consequences around the globe.

The effects of the COVID-19 pandemic in Asia and the Pacific, which vary across countries, are shaped by a combination of the socio-cultural, political and economic contexts and state responses. However, a consistent trend observed is the pandemic's differential impact on women, compounded by their intersecting identities (age, socioeconomic status, disability, sexuality, religion, indigeneity, geography, migration, refugee status and more). In times of crises like disease outbreaks, as shown by studies of Ebola, SARS and Zika outbreaks, power relations alter and heighten the inequalities that women experience (Dalaqua and others, 2019).

Clearly, pandemics are not gender neutral. Analysis of gender norms is important to uncover the gendered difference in patterns of exposure to the disease, access to health care and social services, shifts in traditional gender roles and stigmatization (Filipová, Dalaqua and Revill, 2020). Through our research, we want to highlight and elaborate how the COVID-19 pandemic affects the lives of women from six countries: India, Indonesia, Malaysia, the Philippines, Thailand and Vietnam. These countries were selected because of their distinct disparity in the number of COVID-19 cases and because of their crucial positions in global supply chains.

Eleven months into the pandemic, India, Indonesia and the Philippines were in the top-30 countries with the largest number of cases globally (WHO, 2020d). Transmission in these countries at that time was characterized by community transmission, as opposed to Thailand and Vietnam, which were registering fewer cluster cases. Although the World Health Organization (2020a; 2020b) reported Malaysia as having a robust universal health care system, it had entered a renewed lockdown as of January 2021, or Movement Control Order, due to a spike in COVID-19 cases that put its prided health care system under pressure (Walden, 2021).

The intended result of our paper is a nuanced surfacing of women's context-specific needs and issues brought about by the current crisis, responses by states and possible

recommendations to mitigate effects of the pandemic as well as to prepare for future humanitarian crises.

This paper explores trends on how women's lives have been affected to date by the COVID-19 global pandemic and government responses to the crisis in select countries. Specifically, it aims to:

1. Provide an intersectional analysis of the impact of COVID-19 on women's unpaid care work and their socioeconomic status as well as the consolidated responses made by women, including organized groups, to these challenges.
2. Identify significant changes in reported cases of gender-based violence and the contexts that surround it.
3. Assess the impact of the COVID-19 pandemic on women's access to sexual and reproductive health and rights services and on the intensification of their reproductive roles — in particular, the shifts and challenges in executing care work during a global pandemic.
4. Propose policy recommendations hinged on transformative changes for and by women that can be adopted by different countries.

In examining the impacts of the pandemic on women, focusing on gender is insufficient because such analysis could "reinforce the [gender] binary and competing understandings of disease burden by gender" (Ryan and El Ayadi, 2020). Drawing from Crenshaw (Carastathis, 2014), the study thus applies an intersectional approach that recognizes how multiple and co-existing identities and categories, like gender, age, sexuality, religion and ethnicity heavily affect the lived experiences of people. It asserts that the intersectionality of different identities results in varying degrees of discrimination, exploitation, marginalization, oppression and subordination.

Through a literature review that involved deductive searching of online news articles, policy reviews, studies from research organizations, reports from intergovernmental organizations and press releases from local non-government organizations published between January 2020 and November 2020, this work provides a snapshot of how the pandemic and responses

to it have thus far impacted women's lives in terms of gender-based violence, sexual and reproductive health and rights, and unpaid care and reproductive work.

This paper emphasizes that gender-based violence and the loss of agency in sexual and reproductive matters is a violation of human rights. To highlight this and the centrality of upholding human rights, especially in an unprecedented global crisis, the analysis and recommendations highlight the role of the state and non-state actors as duty bearers and how women and marginalized groups as rights bearers are empowered actors in their own development.

Gender-based violence

Gender-based violence includes acts of physical, sexual, mental or economic harm inflicted on persons on the basis of their perceived or actual gender identity. Such is its gravity and ubiquity that gender-based violence is considered a pandemic, with UN Women Executive Director Phumzile Mlambo-Ngcuka declaring it “a shadow pandemic” in an April 2020 statement. The United Nations High Commissioner for Refugees (2020) underscored that, aside from perpetuated acts, even “threats of violence, coercion and manipulation” similarly qualify as gender-based violence and that these transgressions manifest in private and public spheres. It happens in family settings, extends to the community and may even be perpetrated or condoned by governments (Kendall, 2020). Perpetuated by deeply entrenched systems of social, cultural and economic injustices, gender-based violence is documented in staggering numbers in situations of relative stability and in emergencies.

In a multiple-country study on male-perpetrated violence in Asia and the Pacific, an overwhelming proportion of rapists (72–97 per cent) did not receive legal sanctions (Fulu and others, 2013). A protracted history of impunity of perpetrators concealed the true extent of gender-based violence in Asia, with many countries having “no consistent definition, baseline data or systematic documentation of types of gender-based violence against women and girls” (The Asia Foundation, 2017). This phenomenon is captured by the paradox proposed by Davies and True (2015): The existence of gender norms that prohibit or constrain the reporting of gender-based violence is proof-positive of its pervasiveness. Moreover, the fear generated by impunity affects not just the victim-survivors, but also other women and girls who are at risk of being vicariously traumatized.

Beyond implications at the personal and community levels, ASEAN member states recognize that gender-based violence experienced by women and girls hinders social and human development (UN Women, 2018a). Eradicating violence against women and girls was a priority area of work in the ASEAN Committee on Women in its 2016–2020 Work Plan. The ASEAN Commission on the Promotion and Protection of the Rights of Women and Children shares this commitment, adding that effective response to violence rests on a

comprehensive understanding of its real extent and impact, which can only be facilitated by better data and evidence (ASEAN Secretariat, 2018). To build the capacity of member states to systematically collect and analyse violence against women and girls data, the ASEAN Violence Against Women and Girls Data Guidelines were developed and disseminated. While these are prescriptions based on best national and international practices, the adoption of the guidelines by member states has not been mandatory.

Where data collection systems are in place, there are marked variances. Women’s reported experience of violence perpetrated by an intimate partner ranges from 15 per cent in Bhutan, Japan, the Lao People’s Democratic Republic and the Philippines to 64 per cent in Fiji and the Solomon Islands (UNFPA, 2020f). In cases of sexual violence, the perpetrator is often not a stranger but a family member, friend or neighbour. In Vietnam, 68 per cent of survivors mentioned that they knew their attacker before the incident; in Thailand, this statistic was 91 per cent (UN Women and others, 2017).

Gender-based violence occurs mostly within kinship and community structures, making for a taxing pursuit of justice for victim-survivors. In 2016, UN Women reported how “cultures of reconciliation” are common in the region, in which victim-survivors are constrained and intimidated to avoid legal action. Criminal justice systems display disinterest, hostility and, at worst, even complicity, especially in crimes like trafficking. Gender-based violence then becomes “delegalized and privatized” when resolutions to these transgressions are imposed and affected by the social structures that enable the same.

Gender-based violence during emergency situations

Emergency situations, like the COVID-19 pandemic, disturb the “everyday normal”, creating “windows of opportunities” to transform prevailing social norms (Birkmann and others, 2010). Situations that completely incapacitate service systems can create a “blank slate” for “building back better” (Christoplos, 2006). Enarson (2006) explored how this context of rebuilding opens possibilities for women to “challenge prevailing gender

norms". For example, calamity cash assistance may embolden them to remove themselves from abusive relationships. Employment opportunities in fields crucial to recovery (such as construction) may motivate them to acquire new skills. Collective action may empower them to assume leadership functions to advance their welfare and that of others. However, NGO assessments suggest the contrary: In times of emergencies, traditional roles become increasingly pronounced (see for example, Briody and others, 2018).

Emergencies cause social displacement and economic disenfranchisement. Women can be removed from their communities and families and become dependent on others for survival. Following emergencies, essential survival structures such as police and health service become compromised due to exhaustion of staff and resources (Briody and others, 2018). Moreover, infrastructure is often severely damaged, leaving survivors with no recourse for support. Impromptu medical services delivered in non-clinical settings also risk denying women the requisite safety, privacy and dignity in health care. Large-scale loss of livelihood, assets and income limit even more the opportunities for women. These precarious conditions predispose women to more violence.

While a causal relationship has yet to be established between disasters and gender-based violence, the occurrence of the former correlates with increases in the latter. In a 2010 United Nations Population Fund (UNFPA)-commissioned survey by the Ministry of Social Welfare, Relief and Resettlement and Women's Protection Technical Working Group, during the post-Cyclone Nargis natural disaster in Myanmar, 31.4 per cent of survivors expressed fears of being raped. Eighteen months prior, only 1.4 per cent of the same respondents registered the same fear. In Nepal, after the 2015 earthquake, 245 children were rescued from human traffickers (UNICEF, 2015). A study by the International Federation of Red Cross and Red Crescent Societies on the aftermath of disasters in three countries — the Philippines (Typhoon Haiyan in 2013), Indonesia (Pidie Jaya earthquake and Bima floods in 2016) and the Lao PDR (Oudomxay floods in 2016) — highlighted how risks of sexual gender-based violence are exacerbated by disasters. In such situations, domestic violence and child marriage were found to be harmful incidents for women and girls (IFRC, 2018).

Analysis of public health emergencies from recent experience, including Ebola (UNDP, 2015) and Zika

(Oxfam International, 2017), suggest that gender-based violence "may shift in nature and scale" (Roesche and others, 2020). During the Ebola outbreak in West Africa, researchers observed "a silent epidemic of rape, sexual assault and violence against women and girls" (Yasmin, 2016). The prediction is so far consistent with the COVID-19 pandemic. In an April 2020 policy brief, UN Women released initial data that indicated surges in violence against women and girls were greater than 25 per cent where reporting systems were present.

Impact on the incidences of gender-based violence in Asia

It is important to clarify that gender-based violence, as a spectrum of transgressions experienced predominantly by women and girls, includes denial of crucial services, such as sexual and reproductive health services — which is a form of institutional violence (Montesanti and Thurston, 2015) as well as inequities in the domain of work. These are elaborated in the next sections. This section looks at violence experienced by women and girls in the context of the COVID-19 pandemic, compounded by their intersecting social identities and positions.

Mobility restrictions and domestic violence

Confinement and physical distancing intended to contain the pandemic left women with abusive partners or family members. Southeast Asia, similar to other regions, has witnessed a surge in domestic violence cases. The risk of acquiring the virus discourages victim-survivors from seeking hospital care. Shelters for women and children, whether managed by state and private entities, have limited admissions as a measure for preventing infections. In addition, women and girl survivors of violence have had limited access to financial support because funding has been diverted to pandemic responses (Lokot and Avakyan, 2020).

Two weeks after work-from-home arrangements were imposed in Indonesia, the volume of cases referred to the Indonesian Women's Association for Justice Legal Aid Institute increased threefold. Indonesia's National Commission for Violence Against Women detected similar levels of violence, with gender-based violence cases increasing by 12 per cent in the first few months of the pandemic. Sejiwa Psychiatric Health Services in Indonesia, an initiative of the Office of the Presidential Staff early in the pandemic (April 2020), received

upwards of 200 reports of domestic violence during 10–22 May.

In Malaysia, the lockdown compromised the ability of women in crisis to privately seek help. Karen Lai Yu Lee, the Programme Director of the Penang Woman's Centre for Change, reported being alarmed not just by the rising numbers of domestic violence cases but by the severity of what was reported (Jung, 2020).

Although support systems were put in place prior to the pandemic, the climate of fear at home keeps victim-survivors from seeking help in most cases. In New Delhi, India, the psychosocial programme at the International Foundation for Crime Prevention and Victim Care reported a drop in calls since the lockdown was imposed, from the usual 10–15 calls a week to only four. Jagori, one of the oldest NGOs managing a hotline for women experiencing domestic violence, observed a 50 per cent decrease in calls (The Hindu, 2020).

In Vietnam, the number of calls to the Women's Union hotline from women experiencing domestic violence during the period of social distancing restrictions rose by 50 per cent. The number of victim-survivors rescued or taken to the Women's Union Peace House increased by 80 per cent from the previous year.

To contain the spread of COVID-19, the Luzon Region of the Philippines went under community quarantine in the middle of March. As of June 2020, the Philippine National Police had recorded 2,183 cases of violence against women and 2,077 cases against children for that region (Gita-Carlos, 2020a).

Child, early and forced marriages

Declared by the Office of the United Nations High Commissioner for Human Rights as harmful human rights violations, child, early and forced marriages are part of community traditions in India, Indonesia, the Philippines and Vietnam. While these practices are declining due to campaigns to raise awareness of their harm, they have become a maladaptive response to economic pressures caused by the pandemic (Al Jazeera, 2020). Child, early or forced marriage gives girls' families financial relief in two ways: by acceptance of a dowry and by having one fewer family member to provide for. Shipra Jha, head of Asia Engagement at

the NGO Girls Not Brides, lamented how gains made over the past decade are now at risk of being eroded. Save the Children UK (2020) was concerned that up to 200,000 girls in South Asia would be forced into marriage in the first year of the pandemic. The Women and Child Development Department of the Government of Maharashtra, India reported a rise of 78.3 per cent in child marriage cases as of September 2020 (Relief Web International, 2020).

In Vietnam, the practice of *hai pu* (bride kidnapping) is widespread, especially among Hmong communities (Girls Not Brides, 2020b). Because there are no official documents for child marriages, the government response is limited (Cousins, 2020). In Indonesia, there are measures¹ to regulate the practice, but it rose during the first year of the pandemic. Laras Susanti, a researcher at the Center for Law, Gender and Society at Gadjah Mada University, wrote that by June 2020, around 24,000 applications for a license to marry minors had been submitted to Indonesian district and religious courts (Nortajuddin, 2020a). Indonesia's Ministry of Women Empowerment and Child Protection confirmed that Islamic authorities granted permits to more than 33,000 child marriages between January and June 2020, compared with 22,000 for 2019.

Trafficking and online sexual abuse and exploitation of children

Online sexual abuse and exploitation of children has long been pervasive in Asia, enabled by widespread poverty and ineffectual laws, and is now worsening as restrictions on mobility drive sexual offenders to online spaces. Cambodia, Lao PDR, the Philippines, Thailand and Vietnam are considered targets by foreign and local paedophiles preying on minors for sex (ECPAT International, 2016).

The Thailand Internet Crimes Against Children task force rescued more than 100 children from April to June 2020; in addition, a police task force obtained more than 150,000 files of child sexual abuse material and lodged 53 cases since mid-April to June (Nortajuddin, 2020b). The Philippines, cited in a 2016 UNICEF study as "the epicentre of the live-stream sex abuse trade", saw a spike in exploitation, with many children abused at home by a relative, who can earn up to \$100 per broadcast (Wongsamut and Blomberg,

¹ Indonesia's Marriage Law was amended in 2019 to raise the minimum age for marriage with parental consent for both sexes to 19 years.

2020). The Philippine Department of Justice was alerted to 418,000 cyber tips of online sharing and trading of images and videos of child sexual abuse in 2018. As of April 2020, there was a 260 per cent increase in cyber tips (SaferKidsPH, 2020). Duty-bearers attributed this to children increasing their time online as learning shifted to digital modes, on top of the worsening economic insecurity.

Militarized pandemic response

In Southeast Asia, states with a history of autocratic rule mobilized their armed elements to make up for inaction during the earlier phases of the pandemic. The governments of Indonesia and the Philippines, in particular, responded to the COVID-19 pandemic not as a public health emergency but as a security threat. In Manila and Jakarta, retired or senior army officers were placed at the helm of each government's COVID-19 task force instead of public health experts (Chandran, 2020). Maritime Affairs and Investment Minister Luhut Pandjaitan, one of the officials tasked by Indonesian President Widodo to reduce infections in the country's worst-affected localities, said the military and the National Police were joining forces to "get people to wear masks and maintain their distance" (Syakriah, 2020). This militarized approach stands in stark contrast to those of Singapore and Vietnam, where health experts were delegated the pandemic-response leadership roles.

The United Nations High Commissioner for Human Rights Michelle Bachelet expressed alarm over the Philippines' highly militarized pandemic response (UN News, 2020). Militarized crisis response is indeed concerning because higher rates of violence against women are found in militarized contexts. The increased presence of military and police armed personnel, Sharoni argued (2016), "paradoxically [heightened] the sense of insecurity of both women and minority groups".

In the Philippines, this is not a baseless fear. The women's organization Gabriela cited reports of police officers and quarantine enforcers abusing vulnerable women before they were allowed to pass checkpoints (Chiu, 2020). Then-Philippine Police Chief General Archie Gamboa responded by urging victims of the alleged "sex-for-pass" modus operandi in quarantine checkpoints to come

forward. Such is the alarm generated by these accounts that presidential spokesperson Harry Roque re-echoed the call, assuring appropriate action should survivors pursue proper legal channels (Gita-Carlos, 2020b).

Responses

Acknowledging the threat of psychological pressure, as evidenced by the large number of reported complaints of domestic violence, the Indonesian government launched a mental health service called Sejiwa (UNFPA, 2020e). Callers are connected to volunteer psychologists from the Indonesian Psychology Association, also known as Himpunan Psikologi Indonesia, or Himpsi (Mock, 2020).

In the Philippines, the Lunas² Collective, a volunteer-run online gender-based violence support group, partnered with the United States Agency for International Development to launch FamiLigtas,³ a campaign to raise awareness on gender-based violence and its many forms (*Manila Times*, 2020). Recognizing the risk of online sexual abuse and exploitation of children, an SMS campaign was initiated jointly by Save the Children Philippines, government ICT agencies and telecommunications companies (Relief Web International, 2020). The Philippine Commission on Human Rights developed e-Report sa Gender Ombud (Report It to the Gender Ombudsman), a website that aids in tracking and responding to gender-based violence cases during community quarantines. Violations monitored by this platform have included denial of services, violence against women human rights defenders, violence relating to the implementation of quarantine rules and violence against LGBTQIA+ individuals (Beltran, 2020).

Social media is a potent vehicle for advocacy campaigns, including movements to eliminate gender-based violence. But even in supposedly progressive spaces, backward patriarchal attitudes still manifest. In Malaysia, the Women's Affairs Ministry provided advice on how to avoid domestic conflicts during the lockdown through a series of online posters with the hashtag #WanitaCegahCOVID19 (#WomenPreventCOVID19). Some of the campaign's prescriptions for women included dressing up and wearing make-up while working from home. The

² Tagalog for "cure" or "solution".

³ Tagalog for "safe family".

campaign also suggested that women speak with an infantile tone, citing as a model the popular Japanese cartoon character Doraemon, a move that drew criticism from women's rights advocates (Yi, 2020).

Analysis

The experience of the six countries in dealing with gender-based violence in the context of the COVID-19 pandemic (as of November 2020) highlights the changing landscape of such violence — a landscape that brings both new challenges and new possible remedies.

As in all venues where women demand the fulfilment of their rights, there will always be pushback from repressive actors. Women are discredited and, worse, have more violence inflicted against them. While online communities have become vital resources, online spaces are also fertile ground for the perpetuation of violence against women and even the rise of new forms of violence. This violence is often enabled by the online anonymity of perpetrators who also have access to tools for evading accountability, such as layers of encryption and the use of virtual private networks.

At the same time, online spaces have been crucial in providing support and resources for survivors, especially when mobility is restricted due to varying degrees of lockdown. Moving forward, support for survivors will likely continue shifting more and more to digital modes. Technology is also a promising tool for solving long-standing problems in gathering data on abuses, particularly through e-reporting and tracking systems. Critical concerns include ensuring that protective measures are in place and that reporting mechanisms will not violate the basic right to privacy and data integrity.

It is also interesting to see how the militarized responses to the pandemic — often in countries with authoritarian-populist leadership — tie in with gender-based violence. Such responses are continuous with violence in personal spaces; after all, at the crux of gender-based violence is the removal of agency in personal and community settings. And this same spirit of seizure of freedoms ultimately extends to public life. Thus, the unfolding of gender-based violence during the pandemic and the unnecessarily militarized responses to the potential spread of the coronavirus have only

highlighted how misogyny and authoritarianism are intimately intertwined.

Emergencies, as noted, often come with concurrent spikes in gender-based violence. This pandemic, for the most part, has shown the same trend. But with much of the public's focus trained on preventing the spread of the virus, it is important to ensure that the critical issue of gender-based violence is not left behind. Current circumstances present a unique opportunity to convey the scale of the problem at hand and work towards addressing it. Porta (2014) qualified pandemics as "an epidemic occurring over a very wide area, crossing international boundaries and usually affecting a large number of people", a description that is equally applicable to gender-based violence as a phenomenon. Peterman and others (2020) noted that much attention (and action) is directed to pandemics caused by emerging diseases, while there is yet to be adequate recognition of gender-based violence as a global pandemic.

Perhaps experience with the COVID-19 pandemic amplifying vulnerabilities can be a potent launching point for awareness-raising on gender-based violence as a pandemic. Raising critical awareness on pandemics as social phenomena will hopefully draw out a sense of urgency among duty-bearers for enhanced and better-coordinated responses to the pandemic of gender-based violence.

Sexual reproductive health and rights

Sexuality is a delicate and controversial subject because it is both a private and political matter. It relates to intimacy, pleasure and bodily autonomy as well as sexual norms and stigma. States have traditionally regulated sexuality and reproduction through laws (Lewis, 2004). Sexuality and reproduction are inherent components of (local) cultures. Religion has a regulating power in the delineation and implementation of social norms and values governing sexuality (Cense, Neef and Visscher, 2018). But cultures are not static, and constantly are changing. Thus, the social meanings related to sexuality are changing too.

Bodily integrity and women's and girls' autonomy in decision-making in all aspects of their own bodies as well as full access to appropriate sexual and reproductive health information and services are bedrocks of gender equality (Zaman, 2017). The importance of sexual and reproductive health and rights is highlighted in the Programme of Action of the 1994 International Conference on Population and Development, the 1995 Beijing Platform for Action, the Millennium Development Goals and now the Sustainable Development Goals. However, religious, racial and cultural ideologies try to exert control over women's sexuality and reproductive choices. Religion has always regulated women's access to and enjoyment of rights. While it is true that many of the world's religions claim to support gender equality, in practice, religion and religious interpretations are often used as tools to deny human rights, especially sexual and reproductive health and rights (Zaman, 2017). Asia and the Pacific are experiencing a sharp rise in conservatism and religious extremism with harmful ideologies that discriminate against and violate the rights of women and girls in particular (UNFPA, 2017).

Many countries in Asia — despite inconsistencies in implementation — have exhibited strong leadership in advancing the goals of the International Conference on Population and Development, and there has been progress in promoting many components of sexual and reproductive health and rights and the full realization of these rights (UNFPA, 2017). But the pandemic has rolled back many of these achievements. Countries, from low to high income, that implemented a lockdown because of the COVID-19 outbreaks deliberated on what counted as "essential services," and those deliberations about what counted as essential sexual and reproductive

health services revealed entrenched political and ideological tensions about sex, reproduction and sexualities (Schaaf and others, 2020). Unsurprisingly, countries that consider sexual and reproductive health and rights as non-essential have made it more difficult for their health system to fulfil such rights, and this will affect the uptake of services in communities because they no longer have formal justification to claim the services provided through these rights.

Impact on sexual and reproductive health and rights in Asia

Disease outbreaks similar to COVID-19 affect women and men differently. In many ways, epidemics aggravate existing inequalities for women and girls and other marginalized groups (UNFPA, 2020d). The shift in resources towards addressing the public health emergency can cause disruptions in essential health services for women and girls, such as sexual and reproductive health services (de Paz and others, 2020). Lack of critical resources, such as sexual and reproductive health services, means increased rates in both teenage pregnancy and maternal mortality.

Studies show that the lockdown measures to contain the COVID-19 outbreaks have resulted in significant disruptions in essential services and supplies (see for example, Nanda, Tandon and Khanna, 2020). Regarding sexual and reproductive health services, delays and stoppage in information and service delivery are estimated to have had a grave impact on women's health and well-being (Nanda and others, 2020), although men's health has also been affected.

A Guttmacher study (Riley and others, 2020) outlined the potential effects of the pandemic on people's sexual and reproductive health and rights: These are a shortage of medication (contraceptives, antiretroviral drugs for HIV, antibiotics to treat sexually transmitted infections); a shortage of clinicians who can provide sexual and reproductive health services because they are diverted to cases related to the pandemic; and the diversion of financial resources for sexual and reproductive health programmes to COVID-19 responses. Riley and others (2020) estimated that the potential annual impacts of a 10 per cent proportional decline in the use of sexual and reproductive health care services resulting from COVID-

19-related disruptions in 132 low-and middle-income countries is alarming, particularly for the well-being of women and girls. A 10 per cent decline in the use of short- and long-acting reversible contraceptives would result in more than 48 million additional women with an unmet need for modern contraceptives and potentially 15 million additional unintended pregnancies; a 10 per cent decline in service coverage of essential pregnancy-related care would result in more than 1.7 million additional women experiencing major obstetric complications without care and potentially 28,000 additional maternal deaths. And a 10 per cent decline in service coverage of essential newborn care would result in 168,000 additional newborn deaths.

Adolescents' sexual and reproductive health information and services

The data in the Philippines demonstrate the challenges of accessing sexual and reproductive health services by vulnerable groups (such as youth and LGBTQIA+ communities) and individuals during the lockdown periods, especially in Samar Province and the Bangsamoro Autonomous Region in Muslim Mindanao (Oxfam, 2020). In Malaysia, an 18-year-old girl in Penang tossed her baby out of her apartment window in July 2020. She was not the first; a baby-dumping phenomenon has been a constant issue in Malaysia for the past decade. But it is just a symptom of a larger problem: Many women and young girls face unwanted pregnancies due to limited access to relevant information and services and lack of societal empathy needed to support their sexual and reproductive health choices. In Vietnam, Linh Hoang, a 23-year-old Vietnamese student who co-founded a sex education start-up called WeGrow Edu, explained how young people in Vietnam are left without information and support as their sex lives evolve (*Tuoi Tre News*, 2021). She believes that many young people who lack sex education at home or in school rely on abortion as a form of birth control. This situation has been exacerbated by the COVID-19 pandemic.

Reproductive health and contraceptive services

The six countries in this study experienced disrupted routines and uptake of essential procedures. In the Philippines, the Likhaan Center for Women's Health, an NGO that provides health care to women in marginalized communities, reported that sexual and reproductive

health services had become extremely hard to access during the pandemic. The Philippine Commission on Population and Development revealed that one in three women (about 600,000) will not be able to acquire the family supplies they need; the Commission estimated 214,000 babies from unplanned pregnancies will be born next year (Crisostomo, 2020). In Uttar Pradesh, India's most populous state, an estimated 5.8 million couples were not able to access contraceptives between March and September 2020, resulting in 421,601 unintended pregnancies, 120,580 live births, 256,338 abortions and 309 maternal deaths (Nanda and others, 2020). Another study in India found that 35 per cent of respondents reported a need for contraceptive advice, service or products. But 31 per cent of women who were seeking such services were unable to leave home due to fear of COVID-19 infection, and 30 per cent of them reported that the wait time for an appointment was one to two weeks (MSI, 2020).

Access to abortion

Several NGOs have reported that the pandemic has negatively impacted the uptake of abortion services. The Ipas Development Foundation India did a study on the short-term impact of COVID-19 on access to abortion services and found that 47 per cent, or about 1.85 million abortions, were compromised due to the increased burden on the health care system. MSI (2020) supported this finding in its report: The perceived availability of abortion services from a clinic decreased from 61 per cent to 44 per cent; and 13 per cent of the respondents in India reported a need for abortion services during the pandemic, with almost a third of them reporting that the clinic in their area was closed.

Prenatal and postnatal care

Pregnant women reportedly have experienced delays or were refused hospital care. In India, some of these cases were reportedly due to religious discrimination, transportation shortages and economic hardships. One woman in the village of Basta, Bihar state gave birth to a stillborn child; another report in June revealed that a pregnant woman died in an ambulance because no hospital would admit her and her child. In the Philippines, several pregnant women were also reportedly refused hospital care. In April 2020, Katherine Bulatao, a pregnant woman and resident of Caloocan City, died after reportedly was refused admission by

six hospitals; some hospitals couldn't accommodate her due to stringent containment measures placed on medical facilities; the staff at the other hospital asked the couple to pay a downpayment of P30,000.00 (approximately 600 USD) before Bulatao could be admitted (Valenzuela, 2020). In that same month, Mary Jane Alvide died while in labor after being reportedly turned down by four medical facilities; allegedly some of these facilities demanded advance payment before admitting patients (Luna, 2020).

Sector-specific needs and issues

The gendered impact of COVID-19 is clear, especially for women and girls. Women and girls living in intersecting vulnerabilities, particularly those in contexts with fragile economic and health systems, are more exposed to vulnerabilities and face increased barriers in accessing sexual and reproductive health services.

The Thai Women Human Rights Defenders, an NGO working on the rights of people living with disability, reported that their members, who are more vulnerable and exposed to health risks than other people, face increased barriers in accessing health services, including sexual and reproductive health services (Protection International, 2020). In India, women living with disabilities are unable to access valuable information related to the coronavirus and sexual and reproductive health products. Hygiene products have been difficult to obtain during this time, according to one account, because it is men who usually leave the house and "women are shy to ask them to get sanitary pads" (CRR, 2020). When lockdown began in India, many migrant workers were left without food, shelter and employment. Almost half of those workers were women, which means considerable health risks for those who were pregnant. The situation is more dire in rural areas because local health workers cannot reach rural women due to the lockdown and social distancing measures.

In the Mekong region, which includes Thailand and Vietnam, UNICEF, UN Women and CARE International (Nguyen and others, 2020) found in a joint study in September 2020 that access to health and sexual and reproductive health services was being impacted by fear, particularly among ethnic minorities and undocumented pregnant migrant workers.

The pandemic has affected supply chain management and procurement in many countries. This impedes not

only the supply chains of contraceptive commodities and supplies, menstrual health and hygiene items and medicines but also the supply of drugs used for medical abortions and antiretroviral drugs (Moran and van Tujil, 2020). In general, people living with HIV or AIDS are at higher risk of catching respiratory diseases, infections and related complications. The disruptions in the supply chain of medicines significantly affect this population because they may lead to shortages in medical supplies. In the Philippines, a TLF Share study found that Filipinos living with HIV were exposed to further risks because of the coronavirus pandemic; mobility challenges in accessing health care and treatment for HIV were also observed due to the imposed lockdowns in several regions of the country; and women living with HIV faced domestic or intimate partner violence during the lockdown (TLF Share, 2020).

Responses in six countries

The pandemic responses of countries at all income levels are rooted in the idiosyncrasies of domestic politics. Political elites play favourites by supporting their own patrons or constituents. There is also escalating hostility towards marginalized, racial and ethnic minorities who are more prone to be stigmatized as carriers of COVID-19 (Schaaf and others, 2020). Against this backdrop, many international and national organizations leaders have stepped up to assist vulnerable populations in accessing sexual and reproductive health information and services.

These are some responses to the COVID-19-related impacts on sexual and reproductive health and rights in the six countries selected for this study (APF, 2020; APTN, 2020; CRC, 2020; MSI, 2020; Nguyen and others, 2020; Oxfam, 2020; UNFPA, 2020c):

India

UNFPA visited 57 facilities to monitor the availability and quality of family planning services in Odisha and Rajasthan states. UNFPA then established 10 adolescent-friendly health clinics in Odisha.

The Centre for Enquiry into Health and Allied Themes, despite restrictions on movement and transportation shortages, has provided for women in need of abortion services.

Civil society organizations, including the Family Planning Association of India, have had a crucial influence on the government of India to include sexual and reproductive health in the list of essential services to ensure uninterrupted delivery of care services.

ARMMAN, a Mumbai-based NGO, launched a pan-India free virtual outpatient services system for pregnant women and children (Motihar, 2020).

The Family Planning Association of India, the Foundation for Reproductive Health Services India and other service-providing organizations have been offering family planning and safe abortion services during the pandemic (Motihar, 2020).

Indonesia

UNFPA established a content management platform for 26 digital sexuality education content producers. They have reached more than 60,000 female sex workers through online outreach and provided them with information on HIV prevention and treatment.

Della, a young trans woman activist living with HIV from South Sumatra, led other young transgender activists to protect their community. With the support of the Srikandi Sejati Foundation and the Asia Pacific Transgender Network, Della and fellow transgender activists distributed food and hygiene products and provided a cash allowance to enable members of the community living with HIV to go to HIV treatment hubs (Romero, 2020)

Girls Not Brides (2020a) released a compendium of resources for sexual and reproductive health and rights that may be useful to their member organizations as well as women and young girls at risk of child marriage.

Yayasan Siklus Indonesia, an NGO working on public health issues, is providing online and offline sexual and reproductive health consultations to young people through 46 health service providers.

Malaysia

UNFPA is providing sexual and reproductive health and rights outreach for low-income families to address their challenges in accessing services (due to movement restrictions in the country).

The Human Rights Commission of Malaysia (SUHAKAM) developed a policy brief on COVID-19 and women that highlights the issue of impeded access to sexual and reproductive health services in the country. The inputs and recommendations in the brief will be incorporated into SUHAKAM's COVID-19 temporary measures bill.

The Reproductive Rights Advocacy Alliance Malaysia (Persatuan Hak Kesihatan Wanita) published an editorial in *The Star* to urge the Ministry of Health to adopt four strategies to address the widespread baby dumping in the country due to unintended pregnancies as well as to protect the rights of girls and women: (i) provision of comprehensive sexuality education, (ii) provision of non-judgemental contraceptive services, (iii) de-stigmatization of abortions and provision of more opportunities for women and girls to continue their education and progress in their careers and (iv) provision of non-judgemental abortion services.

Staff with Persatuan Sahabat Wanita Selangor, a women's rights NGO, found an undocumented migrant worker who had given birth in her workers' quarters without medical assistance. The organization provided the mother with food to address her immediate needs and offered fully sponsored medical assistance in a hospital. The mother declined the latter out of fear of being arrested by law enforcement officials (ILO, 2020)

Philippines

As of October 31, 2020, UNFPA had reached 2,500 pregnant women with cash assistance in disaster, conflict and COVID-19-affected areas. It disbursed cash to 50 traditional birth attendants. UNFPA is also supporting a 24/7 safe pregnancy helpline for pregnant women having difficulty accessing birth facilities in southern Luzon.

The Philippine Commission on Population and Development set up helplines to assist those who have questions on family planning, sexuality, COVID-19 and gender-based violence.

The Commission on Human Rights called for the inclusion of hygiene and menstrual kits in government-provided relief goods.

In May, OXFAM's Sexual Health and Empowerment network, along with NGOs that work on sexual and reproductive health and rights, called for the continuous

and unhampered delivery of sexual and reproductive health services during the lockdown period.

Access to sexual and reproductive health services during the pandemic is extremely difficult. The Likhaan Center for Women's Health remains open to help women who may need timely and sensitive sexual and reproductive health procedures.

Thailand

The Ministry of Public Health, with the support of UNFPA, will implement a one-year project on safe delivery, targeting vulnerable populations in areas with high maternal vulnerabilities.

During the lockdown, the Planned Parenthood Association of Thailand negotiated with local authorities to obtain approval for cross-border movement for accessing sexual and reproductive health services.

The Asia Pacific Transgender Network, an NGO based in Thailand that champions the health, legal and social rights of transgender people, collated resources (including sexual and reproductive health information) for transgender and gender-diverse communities. The organization also called on the government to protect LGBTQIA+ youth who are forced to stay at home during lockdown restrictions, especially from the latter's parents and legal guardians who are not supportive of their sexual orientation, gender identity and expression.

Youth LEAD, an NGO in Thailand, curated a series of feature stories about how trans youth have responded to the needs of their community amid the pandemic. The young activists shared their stories of struggles (from accessing sexual and reproductive health services, antiretroviral drugs and other medical assistance) and of how they have responded and helped other members of the community — sharing rooms and distributing relief packages and antiretroviral drugs (UNAIDS-AP, 2020)

Vietnam

UNFPA developed a mobile application for piloting telehealth interventions for the provision of sexual and reproductive health and family planning services. The application aims to reach ethnic minorities and migrant workers.

UNFPA provided guidance on maternity and antenatal and elderly care to the Ministry of Health and to the Ministry of Labour, Invalids and Social Affairs. The organization also delivered critical supplies for pregnant women and women who have given birth.

The sex education start-up called WeGrow Edu, co-founded by four university students, sent gift boxes (filled with sanitary pads, pregnancy tests, condoms, and guides on how to use them) to students staying at home during the pandemic.

Bayer Vietnam collaborated with the General Office for Population and Family Planning to conduct a seminar on the causes of unintended pregnancy and the benefits of contraception.

The iSee organization, a local Vietnamese NGO, provided relief and hygiene products to members of the transgender community.

Analysis

While the pandemic has disrupted the fulfillment of sexual and reproductive health and rights across the countries in the study - limiting access to information and services for adolescents, routine reproductive health services and contraceptive services, abortion services and prenatal and postnatal care, among others. However, such disruptions are only symptomatic of the much-deeper problems in place before the pandemic.

Foremost of such problems is how social structures mediate access to and uptake of sexual and reproductive health and rights services. While individuals retain agency, it is shaped by the dynamics between the cultural discourses on sexuality imposed by such structures as the state, churches, mass media and families. For instance, COVID-19 has exacerbated difficulties in adolescent access to sexual and reproductive health information services — something that was stigmatized even before the pandemic, with many young people around the world lacking the legitimacy or ability to openly seek services. This has led to a large gap in metadata on adolescent sexual and reproductive health needs and has made it even more difficult to establish global estimates on adolescent sexual and reproductive health outcomes. With adolescent sexual and reproductive health services excluded from “essential” health services during the

pandemic, the gaps in this already-unreported need have only widened further.

Patriarchal values and attitudes — like social norms and negative views of family planning and comprehensive sexuality education — have impeded access to sexual and reproductive health services. Interrupted access to such services, especially during a pandemic, triggers heightened anxieties and negatively impacts the mental health of women, especially pregnant women and young mothers. Impeded access to relevant information and services, coupled with a lack of societal empathy in support of individuals' sexual and reproductive health choices, has disastrous impacts, as we have seen in the case of widespread baby dumping in Malaysia.

These structures and the values and attitudes they impose have also forced NGOs and women leaders to take up the slack, especially in delivering services and information to vulnerable populations. There has been an outpouring of organized responses to sexual and reproductive health and rights challenges during the pandemic, and this is largely because states have traditionally placed various legal obstacles to regulate sexuality and reproduction, particularly of women and young girls. Despite various international human rights instruments highlighting the importance of sexual and reproductive health and rights, many countries — including the six countries in this study — still debate the significance of these basic human rights.

Two critical points emerged in the examination of responses across the six countries. First is that one-size-fits-all responses do not adequately address the increased barriers to accessing sexual and reproductive health services, particularly for vulnerable populations with intersectional identities. Second is the importance of accountability, given the primary role of the state as duty bearer in reducing disaster risks and given the simple fact that initiatives led by a government have the potential to be more sustainable and impactful. Those who are entrusted with the responsibility for handling various aspects of governance should be held accountable for what they are expected to do to ensure a significant reduction in disaster risks.

Reproductive work

Even before the COVID-19 pandemic upended the world, the bulk of unpaid household chores and care work was already consigned to the women's sphere by virtue of the gender and sexual division of labour. Women are expected to perform social reproductive work, including childcare and the heavy load of household management, ensuring that all aspects of the household run well. On the other hand, men see themselves in charge of the economic and productive sphere and are thus exempt from participating in the domestic sphere. This gender and sexual division of labour applies to the countries featured in this work (Ketunuti and Chittangwong, 2020).

A pre-pandemic 24-hour time-use survey of men and women in these countries affirmed that even for employed men and women, it is still the women who perform the lion's share of domestic work (OECD, 2018). Hochschild and Machung (2012) called this the "second shift" of women — the domestic chores still expected of them after arriving home from work. Statistics also show that the low global female labour force participation rate is influenced by the gender stereotype that it is normal, and even highly encouraged in some cultures, for women to stay home and perform household chores and care work.

The undervalued and unpaid care work done by women must be highlighted as an important aspect of the economy because it is this unrecognized labour that reproduces the productive sphere (Fraser, 2016). It is the taken-for-granted work of women that puts food on the table, washes the clothes and cleans and organizes the home of the workers in the economic sphere, not to mention the emotional and mental work that managing the household entails. Thus, when the COVID-19 pandemic emerged, the burden of performing the bulk of domestic work significantly increased for women because it is during a global health crisis that care becomes an important foundation of society.

Impact on reproductive work in Asia

The COVID-19 pandemic has resulted in significant changes in both the economic and domestic spheres for women. The imposition of mobility restrictions, closure of schools and child-care services and the shift to a work-from-home set-up for non-essential workers

has resulted in a majority of household members being confined within their home — the social reproductive sphere and the productive sphere collapsing into one.

In India, where both joint or extended and nuclear families exist, women's experiences during the imposed lockdown varied. With more household members to share the domestic work in joint families, it was expected that women in these households would fare much better than in nuclear families when it comes to the amount of unpaid domestic work that they do. A study conducted by Deshpande (2020) looked into the amount of unpaid care work done by women in both types of family structures during the COVID-19 pandemic. What she found is that even though women in extended families would have more capacity to distribute domestic work, they still registered a significant increase in the amount of their unpaid work during the imposed lockdown, albeit lower than those registered by women from nuclear families.

In the Philippines, the closure of schools that shifted the teaching mode to distance learning meant that parents, mostly mothers, took on the role of educating their children (Magsambol, 2020). This brought with it emotional and financial burdens, especially to poor families in which there are parents who did not go beyond a primary or secondary level of education. These families cannot afford to hire a home-based tutor to take on the additional load, which was initially absorbed by government schools and other private educational institutions.

In Vietnam, the economic participation of women has decreased, resulting in their time stretched in the performance of household work and care responsibilities (Hill, Baird and Seetahul, 2020). Ironically, it might be difficult for Vietnamese women to bargain when it comes to this role because the level of participation in household decision-making is often determined by economic contribution to the household (Giang and Huong, 2020). Additionally, Vietnamese society considers serving husbands as a "luxury" for women (McLaren and others, 2020).

According to Mukundan (2020), women in Malaysia found themselves, more than ever, immersed in doing responsibilities at home that will affect their emotional and mental health in the long run. This is also attributed

to the fact that formal care work in Malaysia remains limited. The option to outsource formal care work is also affected by the risk of COVID-19 transmission because care work involves extensive physical contact.

Married women in Thailand are said to be primarily in charge of decision-making at the household level (Nguyen and others, 2020), but this does not always translate to empowerment for Thai women because it mostly zeroes in on matters relating to household management, which is a considerable dimension of unpaid and unacknowledged domestic work. In general, if women's autonomy to participate in decision-making is only limited to household management, it negatively impacts their agency to decide on other matters affecting their well-being.

Even before the pandemic, a study in Cambodia revealed that women spend 11 times more hours doing unpaid care work than their male counterparts (Mercado, Naciri and Mishra, 2020). When mobility restrictions were imposed in the country to avoid the spread of the coronavirus, families opted to live in the countryside, with men in search of income-generating activities and women in charge of domestic work (von der Dellen, 2020). This exacerbated the already-stretched time spent by women in taking care of the family.

These snippets of the unrecognized and undervalued domestic and care work done by women are not specific and unique to each country. They show that women in these countries experience this increased burden in varying degrees. But what is unique in the additional burden of being assigned to do care and reproductive work under a global health care crisis is the greater pressure on the part of women to ensure that every member of the household is healthy.

Part of this are the additional layers of work, at least in the early days of the lockdowns — sanitizing all the goods purchased from the market, constantly cleaning and disinfecting the house, enhancing the family members' immune system by purchasing medicines and constantly reminding them to drink vitamins and sanitize themselves (Chauhan, 2020). All of these were safety and precautionary measures communicated to the public by both health care workers and government officials. Yet, when these conversations reached the level of the household, it was rarely acknowledged that the burden of safeguarding the health of the family members largely fell on the women.

Sector-specific needs and issues

The level of the increased burden of reproductive work is varied for women across different sectors and socioeconomic backgrounds. Women's multiple and intersecting socioeconomic status and identities contribute to the increase or decrease of their burden in doing unpaid social reproductive work. Thus, the sector-specific needs of women must be assessed to provide appropriate interventions.

For instance, access to social services and other economic opportunities is limited and sporadic in the far-flung rural areas of the countries in the study. When the pandemic containment responses led to closure of micro, small and medium-sized enterprises and mobility restrictions, there was a surge in urban-to-rural migration because of the low cost of living in the countryside. Women in rural areas suddenly found themselves living with family members who used to work or study in urban areas. This meant more individuals to feed and take care of. For some rural women, this might also entail stretched hours fetching water from the well and other sources and collecting fuelwood (Tankha, 2020).

During the COVID-19 pandemic, individuals at the lower end of the economic strata, particularly single parents and families, experienced "the heaviest levels of unpaid care and domestic work" (Bolis and others, 2020). In general, this can be attributed to longer hours of cooking preparation and more clothes to wash, not to mention the struggle for families without a stable source of clean and potable water. Additionally for families living in extreme poverty, there has been the added layer of finding alternative ways of income generation.

Employed married women who are in a work-from-home set-up find themselves torn between attending to their regular work functions and meeting the care needs of their family members. Although recent studies found that men were participating in reproductive work during the COVID-19 pandemic, the amount of unpaid care work that they engaged in was not significant enough to alleviate the heavier load for women (Chauhan, 2020; Hill, Baird and Seetahul, 2020; Ngyuen and others, 2020). In the long run, this might result in lower female labour force participation, or when married women search for employment, they might prefer "less secure, but more flexible work" (Mukundan, 2020).

The majority of both formal and informal care work is highly dominated by women (Durgova, 2020), compounded by the community work that also largely falls on them. This becomes more problematic for women who are front-line workers but also assume the domestic work and care roles inside the household. In the case of a health crisis, household care needs likely get compromised. On a more societal level, Fraser (2017) called this the crisis of care, wherein the care and reproductive roles needed to prepare the workers in the formal economy becomes depleted because the ones assuming these roles, mostly women, also find themselves working full hours.

Responses

The nature of reproductive work and care roles remain largely invisible and undervalued. Consequently, this work is excluded in national accounting systems that policymakers draw their evidence from (Chauhan, 2020). Community-based women's organizations are pushing back to create solidarity among themselves to alleviate the burden of doing unpaid care work.

A group of organized women by the Self-Employed Women's Association in India found a way to offload the unpaid care work of informal workers. They cook food and distribute meals to such families, helping not only the informal workers but also generating income for themselves through the community work (Muralidhara and Chettri, 2020).

In the Philippines early in the pandemic, various groups from the private sector and civil society organized relief operations to pool personal protective equipment and disinfecting and sanitizing products for front-line workers (Rappler, 2020). This may have benefited some female front-line workers from the formal care economy, but it did not necessarily translate to a trickle-down effect at the household level.

The effective containment measures imposed by the governments of Vietnam and Thailand facilitated the early opening of schools (Asian Society, 2020). Face-to-face classes were allowed, provided that all health protocols were observed. This unburdened women of the teaching load that was inevitably passed on to them during the school closures.

At the household level, women and girls are also attempting to negotiate in distributing the unpaid care

roles and domestic work to other family members. With husbands forced to stay in the house, they are witnessing the demanding work of doing household chores and care responsibility. There is a hope that this might result in a more equitable distribution of household labour in the long run.

In general, responses to address the unprecedented increase in the burden of unpaid care work done by women remain scattered and often insufficient. There is still a pressing need to analyse the multiple issues surrounding unpaid work and juxtapose it against a backdrop of an economy fuelled by unrecognized care work.

Analysis

Care has been defined as the "individual and common ability to provide political, social, material and emotional conditions that allow the vast majority of people and living creatures on this planet to thrive — along with the planet itself" (Luciana, 2020). In this definition, the interdependencies inherent in care are apparent whether at the household level or between households and the state. Understanding these interdependencies is crucial to recognize and redistribute unpaid care work and to advance a society built on universal care. It is equally important to view this in the context of neoliberal ideology that positions care as the innate work of women that, in turn, has led to the exploitation of care providers who are mostly women, the devaluation of care work and the "invisibilization" of care work in macroeconomic, labour and social policies of the state.

In the context of the COVID-19 pandemic, the nature of care and reproductive work, which requires close and sustained physical contact, has added a layer of risk to the organized responses at the community and state levels. Combined with the collapse of the perceived divisions between the productive and reproductive spheres at the household level, it has compounded the burdens faced by women and has further steeped them in time poverty, all of which are detrimental to women's economic participation and empowerment. The prevailing gendered division of labour and socialized gender expectations for women in terms of overseeing the domestic sphere greatly affects their agency in negotiating and redistributing care work to other members of the family. Even though there were reports of men's increased domestic work participation

during the imposed lockdown, it did not translate to a noteworthy decrease in women's share of the work.

While all this reveals an aspect of the pandemic's gendered impacts, it is also a consequence of a system that for too long has pushed aside community care and social welfare in favour of individualized notions of self-care and self-improvement. To eradicate blind spots and move towards developing care-centred and gender-responsive state policies, national accounting systems must measure the value of unpaid care and reproductive work. A deeper structural shift entails an examination of the systems that govern and define care and reproductive work and a move towards viewing care as a broader social capacity and activity that both shapes and is shaped by social and power relations.

Conclusion and Policy Recommendations

From this assessment of the impact of COVID-19 on women and the corresponding responses of governments and civil society in India, Indonesia, Malaysia, the Philippines, Thailand and Vietnam, several common threads of experience emerged.

First is the interlocking nature of concerns under the thematic areas of gender-based violence, sexual and reproductive health and rights, and reproductive and unpaid work. Many aspects of these concerns have knock-on effects on each other — apparent, for instance, in how responding to gender-based violence requires sexual and reproductive health services or how unpaid work leads to economic disenfranchisement that makes women more vulnerable to violence or limits their access to critical sexual and reproductive health services.

The same is true for nearly all issues under the sexual and reproductive health and rights umbrella and indeed for most women's issues. Given this, a gender-responsive approach to the pandemic must employ a holistic approach — one that considers health and economics but also takes into account factors that may not be easily apparent. This goes beyond simply extending aid to women or providing them hygiene kits. What it calls for is an approach that is based on holistic analysis and a nuanced understanding of the needs of specific sectors.

Second is the necessity to veer away from one-size-fits-all responses. What is apparent from the experience of all six countries is the importance of an intersectional lens. Across all three thematic areas, clear differences were found in the impact of the pandemic in various sectors, which have different needs, resources and contexts. Failing to adequately address these could have disastrous consequences not just for the sector in question but for the general population. For instance, the lack of access to information on the coronavirus among women living with disabilities in India (CRR, 2020) could affect that population group along with the rest of the country. After all, information is a critical tool in slowing the spread of the virus, and given the nature of COVID-19, the rest of the country remains at risk as long as one sector is vulnerable.

Using an intersectional lens also means analysing and understanding other factors that contribute to the

situation of women and other marginalized sectors during a pandemic, especially those factors that may not be easily apparent. The different intersections of overlapping identities, as mentioned earlier, lead to varying degrees of discrimination, exploitation, marginalization, oppression and subordination. Here, an analogue could also be made to the overlapping crises faced especially by marginalized sectors. During the pandemic, many of the six countries also experienced multiple and often overlapping challenges, such as the monsoons and flash floods in India; the super typhoon in the Philippines; and pro-democracy protests in Thailand. The concurrence of crises and intersection of identities could pose a problem because some sectors may have more urgent needs that also vary and evolve. Resources to respond to emerging problems may already be limited by the existing ones. A gender-responsive and intersectional approach looks at the situation beyond the pandemic and takes into consideration the entire constellation of external factors and other crises that may seem unrelated but in fact mediate the impact of COVID-19.

While the direction in response should be intersectional — meaning towards sector-specific analysis and response, its breadth should be universal — meaning information, resources and services should be available to all. In the countries in this study, there were multiple barriers to access, such as lack of resources, migration status, age, disability, education and steep direct and indirect costs, even before the pandemic. Restrictions on mobility brought by the pandemic made it even more difficult to seek help and access services. One of the notable solutions in the responses canvassed through this study, particularly in the areas of sexual and reproductive health services and gender-based violence, was the shift to online services and telemedicine. This shift made it easier for victim-survivors to report cases, ask for information and seek help. It should be emphasized that access to the internet remains inequitable — something that might easily be overlooked. And as UNICEF (2020) noted, social media and access to high-speed internet reduce the impact of isolation in industries like mining and agriculture, but they also bring new sets of risks related to gender-based violence (Nguyen and others, 2020).

Third is how policies and their implementation before the COVID-19 outbreak determined the impact and responses across the three thematic areas in all

countries. For the most part, the pandemic has only been an aggravating factor — as is seen with adolescent access to sexual and reproductive health information and services, which has been further restricted by COVID-19. Similar to Jayaraj’s earlier diagnosis regarding baby dumping in Malaysia (Rawther and Jayaraj, 2020), the impact of COVID-19 and corresponding responses — or lack thereof — across the thematic areas are only symptomatic of longer-term and more entrenched problems thriving before the pandemic.

On a deeper level, these responses are also determined by the political landscape, as Schaaf and others (2020) observed, as well as broader social and cultural contexts. As mentioned earlier, countries that view sexual and reproductive health and rights as non-essential likely make it more difficult for the health system to uphold these rights. Public perception and attitudes towards sexual and reproductive health and rights affect provision and access; here, agency and choices are shaped by social institutions — like churches, mass media and families — and their respective discourses on sex, reproduction and sexuality. Many of these were in place before the pandemic, but they introduced new dimensions to the pandemic’s impact and shaped corresponding responses across countries. Existing social norms and attitudes on gender roles and the division of labour, including the structure of the family, in which women are responsible for reproductive and care work, greatly affected the distribution of reproductive work, with women again bearing the bulk at a time when the reproductive and productive spheres had collapsed into one.

The same is evident in the impact on and responses to gender-based violence and violence against women and girls. For instance, domestic violence is seen as a private concern, and norms might prohibit or constrain reporting it. It is important to take into consideration such underlying norms and attitudes embedded in the broader social and cultural contexts, especially because traditional roles become more pronounced in times of crises (Le Masson and others, 2016). Combined with what policies are in place and how they are implemented, the gender roles and social norms in play could serve as a preliminary predictor of the impact of COVID-19 on women and the effectiveness of the response.

Fourth is how the pandemic has highlighted the importance of women’s leadership and participation. Women-led civil society and women’s rights organizations have an important role in delivering

services, disseminating information and in advocacy (Ngyuen and others, 2020). This was apparent in the responses surveyed by this study, including such initiatives as the Mumbai-based ARMMAN’s free virtual outpatient services system for pregnant women and children across India (Motihar, 2020); the Likhaan Center’s continued provision of sexual and reproductive health services in the Philippines; the Asia Pacific Transgender Network’s collation and distribution of critical resources for transgender and gender-diverse communities in Thailand; the Yayasan Siklus Indonesia’s provision of online and offline sexual and reproductive health consultations to young people; the advocacy work of the Reproductive Rights Advocacy Alliance Malaysia (Persatuan Hak Kesihatan Wanita) to address widespread baby dumping due to unintended pregnancies; or the local NGO iSee’s distribution of relief and hygiene products to members of the transgender community in Vietnam, to name a few.

While these efforts are laudable, it is important to emphasize the role and responsibility of the state, especially because it is a duty bearer and because initiatives will likely be more impactful and sustainable if led by the government. As women- and community-led organizations continue plugging gaps, women must contend yet again with added burdens and more unpaid work, which were found to have already increased because of the pandemic. Many organizations are mobilizing not just because it is their advocacy but out of necessity — because the issues they work on have life-or-death importance, especially in the context of a pandemic.

Finally, the experiences of the countries included in this study indicate the importance of a rights-based approach to the pandemic. Such an approach is all-encompassing, leaving no one behind — regardless of race, gender, class or ethnicity. Emphasis is given to the protection and fulfilment of rights, such as the right to live free from violence; the right to work; the right to an adequate standard of living; the right to social security; and sexual and reproductive rights. As Kenis (2020) noted, the pandemic is an opportunity to rethink and reshape social norms and structures towards more equal, inclusive and sustainable societies. And in this regard, the experience of India, Indonesia, Malaysia, the Philippines, Thailand and Vietnam indicate the path forward: to use a holistic approach that aims for universal access while remaining attuned and responding to intersectional realities; that understands the interconnected aspects of a crisis while keeping

sight of the broader political, social and cultural contexts in which it occurs; and that recognizes the important role of women-led civil society and women's rights organizations in responding to crises while continuing to seek action and accountability from duty bearers who are primarily responsible for doing so.

This is a difficult balancing act. It is even more difficult for countries accustomed otherwise to start trying now in the context of COVID-19. The pandemic has brought us unprecedented disruption and upheaval. But as this study underscores, the total breakdown of service systems could create a blank slate for building back better. Today, the same opportunity is present to build new, better, genuinely rights-based regimes around the world. We live in a time unlike any before — but that may be exactly the impetus we need. In so many ways, there is no time like the present.

Recommendations

The recommendations outlined in this section are anchored on the intersectional analysis of the thematic areas of gender-based violence, sexual and reproductive health and rights, and reproductive and unpaid work that exhibit how different systems of oppression and power are linked. These intersections can take place at different levels — individual, household, community, national and structural.

At the structural level, it is evident across all thematic areas that neoliberal ideologies are a driver in how

attitudes, behaviours, perceptions and responses of both state and non-state actors to the pandemic are shaped. At the state level, how the COVID-19 pandemic is framed as a “health crisis” or “public health emergency” or even as a “battle” in public political discourse impacts policy development and responses along with societal perceptions and cooperation with the state-imposed measures. The discourse on COVID-19 as a (i) crisis or emergency and (ii) health crisis poses a twofold risk: first, a notion that there is a normal state to which society will revert to, failing to realize that the pandemic and its impacts and dimensions are a product or consequence of social, political and economic structures and decisions. Second, by qualifying the pandemic as a health crisis, its other aspects and impacts may be obscured, leading to a limited solution whereby health takes precedence instead of a coordinated approach that includes environmental, political, social and economic dimensions to advance a paradigm shift (Revet, 2020).

At the community level, organizing and consciousness-raising through virtual or socially distanced means to question prevailing gender norms and dominant beliefs, such as the gendered division of labour at the household level, traditional care roles and the manifestations of gender-based violence and to progress the right to self-determination in one's reproductive life, will be necessary in forming an enabling environment for achieving social justice. Consciousness-raising at the individual level is empowering, and even in restrictive conditions, there is power in knowing one's rights to services.

Unimpeded access to sexual and reproductive health services and victim-survivor assistance

Classify sexual and reproductive health services as essential.	The disruption of sexual and reproductive services and supply chain for contraceptives, HIV and abortion medication deprives women and persons of diverse sexual orientation, gender identity and expression and sex characteristics, especially those in disadvantaged sectors, not only from access but also from exercising their right to self-determination in their reproductive lives.
Allocate funding and resources to local women centres, shelters and community-led initiatives to ensure unimpeded access to comprehensive sexual and reproductive health services and gender-based violence assistance during the remainder of the pandemic.	Utilize public funding to strengthen the capacity of women's centres and community-led initiatives to effectively assist in cases of gender-based violence and sustain sexual and reproductive health services during the remainder of the COVID-19 pandemic.

<p>Establish COVID-19 protocols for prenatal and postnatal care.</p>	<p>Given the heightened risk of infection during and after pregnancy, health protocols, especially at community health centres, must be established to ensure that proper and compassionate prenatal and postnatal care are prioritized during the remainder of the pandemic.</p>
<p>Develop inclusive and accessible modes and mechanisms for reporting gender-based violence.</p>	<p>Providing alternatives to hotlines and app- or web-based reporting mechanisms, such as toll-free SMS-powered reporting, is crucial to address the unequal access to the internet and other technology.</p> <p>Government hotlines must be toll-free, consolidated and survivor-centric.</p> <p>Develop reporting mechanisms that allow migrant women and women in ethnic minorities to safely report concerns without fear of detention or violence.</p>

Inclusive information, education and communication strategies and building safe online spaces

<p>Establish effective information, education and communication campaigns in marginalized communities.</p>	<p>Analyse how local channels of communication, such as chat applications or social media groups, are used by marginalized and vulnerable communities to gather and consume information. This will help to effectively implement information, education and communications campaigns and eradicate misinformation on COVID-19 and to provide reliable resources on gender-based violence and sexual and reproductive health services.</p>
<p>Build and strengthen partnerships with community leaders and organizations with their agency, knowledge and expertise on community needs at the centre of any information, education and communications campaign.</p>	<p>Employ a participatory approach in the development of education and information campaigns, positioning marginalized communities as empowered agents in addressing the gendered impacts of COVID-19.</p>
<p>Create a safe space for online learning, and promote digital literacy and resilience.</p>	<p>Ensure that legal frameworks and national policies for gender-based violence cover virtual spaces and strengthen reporting mechanisms by building partnerships with government ICT agencies, private ICT companies, civil society organizations and law enforcement agencies.</p> <p>Raise awareness among students on the manifestations of online sexual abuse and exploitation, and develop digital literacy among parents and guardians that is grounded on the Feminist Principles of the Internet (Association for Progressive Communications, 2016) to ensure a safe learning environment.</p>

Gender-responsive development interventions

Develop a gender-responsive, inclusive and multisector COVID-19 response framework.	Position gender analysis and a multisector lens as a central approach in national and local government response frameworks.
Develop a gender-responsive disaster risk reduction framework.	Revisit disaster risk reduction frameworks to advance a multi-risk and gender-responsive standard and approach.
Develop and employ data collection and analysis that examine and address power and gender relations in diverse environments.	<p>Use gender-, age-, ethnicity- and sector-disaggregated data in analyses that shape development interventions.</p> <p>Re-examine the <i>household</i> as a unit of analysis, especially in the case of migrant women, internally displaced persons and hidden households.</p>

Addressing the “crisis of care”

Recognize, reduce and redistribute care work to inform national policy frameworks and development interventions (Duragova, 2020).	<p>Include unpaid care work in national accounting systems to recognize its centrality in sustaining and reproducing productive work.</p> <p>Introduce flexible work arrangements for those in the formal sector and parental leave policies that include increased leave allocations for paternity leave and carers’ leave.</p> <p>Scale up community care initiatives organized by women-led organizations by building partnerships with local governments, civil society organizations and community leaders.</p> <p>Build, strengthen and fund care infrastructure, such as day-care centres.</p>
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