
CARE Bangladesh

LEAVING NO ONE BEHIND

Designing a rights-based, community-centered response to COVID-19

The COVID-19 pandemic has created an unprecedented crisis on an enormous scale.

At CARE, we believe that achieving the "leave no one behind" aspect of Universal Health Coverage (UHC) is paramount to achieving the Sustainable Development Goals. When COVID-19 hit, we were guided by the principle that the efficacy of our responses depends on understanding how marginalized people are affected, in all their diversity, across contexts, and over time.

As women's needs are routinely overlooked without deliberate efforts to fill persistent gender data gaps, we sought the advice of experts – **women and people in crisis-affected communities** – through rapid gender analyses (RGAs). We recognized several cross-cutting themes from our RGAs in 55 countries, but some of the most striking were that women all over the world were expressing concern over **losing access to sexual and reproductive health services** and **experiencing increased levels of gender-based violence (GBV).** Women are nearly twice as likely to report challenges accessing quality health services as a challenge than men are, and 27% of women respondents rated this as one of their top concerns. Women face social limitations on their mobility, rely more on public transportation, often need a man's permission to get health care, and spend more time on unpaid care work than men — all of which can restrict their access to services.

Fourteen percent of women and 11% of men reported that issues around GBV and safety were among the biggest COVID-19 impacts in their lives. We found in our own research and from other sources that nearly all countries reported rising GBV, increased calls to hotlines, and more demand for GBV services. Lack of trust in health the system and diversion of female health workers away from their regular jobs to COVID-19 services has sharply reduced access to services for sexual, reproductive, and maternal health including family planning. Seventy-three percent of women surveyed in Afghanistan told CARE they now have no access to family planning. (For more information, see the synthesis of the RGA findings in CARE's She Told Us So report).

Findings of the RGAs have been key to informing our COVID-19 health response which focuses on four critical objectives to curb the effects of the pandemic's impact.

1. Protect and support healthcare workers. Over 70% of frontline health workers worldwide are women. Most receive lower pay than their male counterparts and have seen a huge increase in their care responsibilities at home and at work, while also being at disproportionate risk of contracting COVID-19 and experiencing stigma and harassment in their communities. We are working with partners to institute infection prevention and control measures to provide some measure of safety to health workers and offering psychosocial support through digital tools and social media platforms where possible so they can continue their lifesaving work while maintaining their wellbeing.

2. Use evidence-based public health communication techniques to slow the spread of COVID-19. Countering rumors, misinformation, fear, and stigma – which are abundant in these times – is critical to keeping people safe in a pandemic. We use risk communication and proven behavior change approaches to improve sanitation and hygiene practices in the communities where we work. To strengthen the critical link between individuals in the community and the health facility, we are developing and supporting new protocols for community-based surveillance (identifying and referring suspected COVID-19 patients and tracing contacts). In places experiencing lockdowns and physical distancing requirements, we are testing remote and digital/mobile phone strategies for getting accurate and timely messages out.

3. Ensure continuity of critical sexual and reproductive health services. During the West Africa Ebola outbreak in 2013-2016, deaths due to causes *other than Ebola* outpaced those from the pandemic illness itself because access to critical health services, including family planning and maternal health care, were restricted or sidelined. We are advocating for the provision of personal protective equipment to frontline health workers and are supporting health center managers and leaders to develop adaptive strategies such as separating COVID-19 patients from those needing maternity services; implementing low-touch or no-touch protocols for antenatal and prenatal care; using mobile phone triage for assessment, diagnosis, and management; and increasing access to self-managed family planning methods through pharmacies. We are also collaborating with partner agencies in the Inter-agency Working Group for Sexual and Reproductive Health in Crisis Settings (IAWG) to develop and disseminate guidance on provision of lifesaving sexual and reproductive health services in line with the MISP, adapted to COVID-19.

4. Shield and stand with women, girls, and the most marginalized. Evidence suggests that certain populations and communities are at much higher risk of severe illness and death from COVID-19, including health care workers, the elderly, and people who are immunocompromised. At the same time, this pandemic will worsen the situation and exacerbate the social exclusion of many marginalized communities — displaced people, youth, and LGBTQ individuals, for example. CARE will put our unique tools and decades of experience and relationships to work to combat harm to both the acutely vulnerable and historically marginalized.

What we've learned so far

Locally driven accountability is critical

We've found that instituting locally-driven accountability mechanisms is feasible, effective, and also critical for ensuring continuity of rights-based sexual and reproductive health programming to be responsive to all, even the most marginalized populations.

John Rutherford MICHEL/CARE Haiti

CARE is rapidly adapting and digitizing our signature social accountability tool, the **Community Score Card (CSC)**, to ensure that communities (and the most vulnerable individuals and families within them) are equitably served by their health systems during the crisis. We are working with partners and using participatory tools to combat stigma and discrimination that prevent people from accessing the health and social services they need.

In Uganda, the Center for Reproductive Rights and CARE are working with women-led community structures to address gaps in accountability between district-level duty bearers and rights holders in refugee settlements and host communities. Together, we are working to identify pressing sexual and reproductive health and rights issues and generate local solutions that inform recommendations and response plans at the settlement, district, and health system levels. Feedback collected through this process has helped to ensure health service referrals are available through COVID-19 coordination mechanisms, adapted the distribution strategies of family planning commodities among UN agencies to better meet the needs of adolescents, and built the capacity of village health teams to expand their community-based sexual and reproductive health service delivery mandate.

Girl-driven strategies to support adolescents can work

Adolescents are among the most marginalized population groups around the world, and their unique needs must be taken into account to achieve UHC. CARE recently released a paper on **Girl-Driven Change on Adolescents and COVID-19**. Related to sexual and reproductive health and rights, the preliminary data suggest that adolescents obtained fewer family planning and antenatal services overall as compared to adult women, and that these differences were particularly pronounced during periods of lockdown and restricted mobility. These data also demonstrate that at as restrictions were lifted, family planning and antenatal care service provision increased. These findings are in line with global data suggesting that disruptions related to COVID-19 are causing barriers to access and

utilization of sexual and reproductive health care. While these findings do not establish a causal relationship between lockdowns and service utilization, they do suggest that these restrictions — alongside other policy and societal changes related to the pandemic — may impact the ability of adolescent girls to obtain care.

CARE is testing innovative solutions to promote girls' health during the pandemic in Malawi using the CSC. Young people and health workers who have been involved in the CSC process in the past are pilot testing a digital version that is focused on barriers faced by adolescents as a result of the pandemic. What we learn in Malawi will be used to inform similar efforts in other countries to empower adolescents to hold service providers accountable for their health and rights. In addition, youth leaders across Malawi who participated in leadership activities supported by CARE prior to the start of the pandemic are sharing information on the needs of young people with peers and community members using existing technology.

In India, CARE has adapted one of our adolescent sexual and reproductive health projects to continue reaching married adolescents and young women with information and services, despite the pandemic. Initially, adaptations included digital and remote engagement strategies, but the project eventually was able to resume in-person household visits once health workers received personal protective equipment and were trained on proper prevention measures.

Risk communication and community engagement remains critical

CARE is instituting community-based surveillance and community engagement initiatives to monitor and respond to rumors and misinformation about COVID-19 and sexual and reproductive health. In Bangladesh, we learned that many in the Rohingya community were expressing concern that if they were to die with a foreign particle in their body (like an IUD or contraceptive implant), they would be denied a proper Muslim burial. This led to a sharp decline in uptake of long-acting reversible contraceptives and increased demand for removal. CARE is currently working with BBC media to address this situation.

Next steps

As the COVID-19 pandemic continues and vaccine distribution begins, CARE will continue to build on community-centered, rights-based health programming and advocate for positive change to ensure everyone, even the most marginalized populations across the humanitarian to development continuum, can access quality services.

For more information on CARE's COVID-19 response, contact:

Dora Curry (dora.curry@care.org)
Director, Program Delivery, Health Equity and Rights

or visit **care.org**


Ollivier Girard/CARE Niger