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# IMPACT AREA STRATEGY

## Right to Health

*Final Draft – April 20, 2021*

## Executive Summary

**CARE remains committed to ensuring the universal right to health**. The Right to Health Strategy aims to support 50 million people of all genders in realizing this right, including enabling 30 million women and girls to realize their sexual and reproductive health rights (SRHR), by 2030. CARE's strategy to advance the right to health focuses on building resilient, equitable, and accountable health systems that can respond to shocks and crises and ensure sustainable access to quality health services for all.

Globally, the right to health is undermined by persistent economic and social inequities, as well as ongoing threats to health security posed by increases in the number, scale, scope, and duration of humanitarian disasters. Restrictive gender norms and gender inequalities are replicated and reinforced in health systems, contributing to gender inequalities in health and lived experiences. Even before the onset of the COVID-19 pandemic, many health systems were struggling to adequately meet the health needs, particularly the sexual and reproductive health needs, of the populations they were meant to serve. The COVID-19 pandemic's impact has further strained these systems and put hard-won gains in health equity and gender justice at risk. The current global COVID-19 pandemic is generating unprecedented global attention to, and resource allocation for, health-systems. We and our partners have a unique opportunity to leverage political will and investments to ensure fair and efficient epidemic control measures. This is also a once-in-a-generation opportunity to

leverage this momentum to build more resilient, equitable, and accountable health systems overall. It is also critical that we proactively work to prevent investments in the COVID-19 response from derailing other essential health services, or building vertical, disease-specific infrastructure.

Our 2030 vision and strategy are powerfully shaped by the COVID-19 pandemic. We are witnessing an unprecedented global focus on health systems; as a diverse set of stakeholders we are investing in mitigating the wide-ranging economic, social, and political impact of COVID-19 as well as in preparing for the next pandemic. CARE and our partners have a "once-in-a-generation" opportunity to leverage this momentum not only to ensure fair and efficient epidemic control and vaccine delivery, but also to "build back" resilient, equitable, and accountable health systems. It is also critical that we proactively work to prevent investments in the COVID-19 response from derailing other essential health services, or building vertical, disease-specific infrastructure.

At the global level, we will shape the priorities of agenda-setting global health partnerships and policy-making bodies working in both stable and crisis-affected settings. We will shape the policies and investments of key bilateral and private donors, as well as shaping national and regional health policies and budgets. We will also work to ensure transparent and inclusive governance of health systems from grassroots to national, regional, and global levels – with a focus on ensuring leadership of locally rooted women's groups, youth groups, and civil society organizations.

CARE's Right to Health Strategy catalyzes three interrelated domains of change that are aligned with the gender equality framework. We seek to: (1) build assets and agency of women, girls, and other groups facing injustice; (2) change the power relations to enable collective voice and well-being; and (3) transform health systems and structures to enable universal access to health. We do this with the deliberate focus of strengthening health systems anchored in community health ecosystems. We unleash the power of frontline health care workers as change agents. In keeping with our values, our approach towards gender equality is community-driven and based on reflective dialogue to build consciousness of existing inequality, gendered social norms, and build skills for collective actions to challenge and change inequitable gender norms and power dynamics. The reflection, analysis, and action processes are applied at all levels (individual to structural) and are accomplished through meaningful engagement and leadership of program participants at all levels. This approach towards gender and inclusion is cross-cutting across the emergency to development continuum.

**CARE's Right to Health Strategy has four thematic areas of focus. These include the following:**

1  **Strengthen local health systems and community-based organizations** to ensure equity, access, and quality of health services, explicitly seeking direction from our partners including community-based organizations, governments, and citizens. Our strategy calls for a shift to localization at a minimum, and to push for decolonization of health programming including mindset and approaches in all systems and processes.

2  **Support marginalized population groups, especially adolescents, to exercise their right to health** through holistic programming that optimizes their health, rights, and voice. Our programs ensure that adolescents of all genders, (including underserved groups experiencing injustice) are supported by the people and systems that surround them.

3  **Increase access to quality health services, including sexual and reproductive health and rights services, in humanitarian and fragile settings**, to support resiliency over the long term and sustainability. Our nexus approach ensures agility to respond to emergencies while building back and strengthening resilience of the health system in fragile settings to support communities when the situation stabilizes.

4  **Prepare and respond to public health emergency preparedness** by leveraging our long-term relationships with the government, frontline health workers, and communities. We work with partners to quickly mobilize and respond to public health emergencies and ensure that preparedness and response efforts address the gendered dimensions of health before, during, and after emergencies.

Coordinated and aligned advocacy, from the grassroots to the national, regional, and global levels, is a critical pathway for CARE to transform health systems and achieve impact at scale. At the global level, we will shape the priorities of agenda-setting global health partnerships and policy-making bodies working in both stable and crisis-affected settings (such as Gavi and FP2030). With our partners, we will shape the policies and investments of key bilateral and private donors, as well as shape national and regional health policies and budgets.

Partnership is central to our effort to ensure that people of all genders can realize their right to health. Our partnerships are also pathways to scale. We provide accompaniment and capacity enhancement to national governments to scale proven approaches and interventions in the health sector. We also work with community and civil society partners to ground health interventions in the rights and needs of the community and ensure accountability. We document and share lessons and good practices via regional and global networks and partners. Finally, we use advocacy and influence global, multilateral, and regional coalitions to strategically influence priorities and agendas of policy-making bodies. Coordinated advocacy with partners – from the grassroots to the national, regional, and global levels – will enable a transformation of health systems and achieve impact at scale.

Our approach to partnership is informed by our values. We seek to embody the principles of equity, collaboration, complementarity, mutual accountability, transparency, and humility. We acknowledge CARE's history and complicity in contributing to an industry and aid system that is deeply inequitable with harmful power and privilege imbalances. We commit to re-imagine and deploy mechanisms for enabling more equitable partnerships between CARE and our implementing, learning, and influencing partners. We seek opportunities to accompany and act as allies to partners – especially grassroots, rights-based, and women- and youth-led civil society organizations—in accessing funding and decision-making spaces directly.

The Right to Health Strategy is co-led by CARE India and CARE USA. There is a Strategic Advisory Group leading the process of developing and implementing the strategy, including a process to put in place more permanent governance structures. Also, a resource development plan to finance the strategy which will require significant support from teams across CARE.

# CARE's Impact Area Strategy for the Right to Health

## Rationale
### Relevance and contributions to CARE's global vision and mission

In calling for stronger rights-based approaches and more localized and diversified networks of partners, CARE's 2030 vision embraces shifts in power at a global, national, and individual level, including through decentering power from northern to southern actors. The strategy for the Right to Health Impact Area is rooted in this vision of power shifting. It aims to empower individuals, transform relationships, and bring about fundamental changes in power and privilege within the systems and structures that promote health and well-being. Healthy lives and well-being are essential to each of the strategic impact areas, and to achieving CARE's 2030 goals. Climate change is inextricably linked to health, as it affects the social and environmental determinants of health, including clean air, safe drinking water, sufficient food, and secure shelter.[1,2] The achievement of the right to health means that all people are able to complete their education, to engage in livelihoods that will enhance their economic prospects, participate fully in both private and public decision-making, and can invest in themselves, their families, and their communities.

## Context analysis

Our 2030 vision and strategy are powerfully shaped by the COVID-19 pandemic. We are witnessing an unprecedented global focus on health systems; as a diverse set of stakeholders we are investing in mitigating the wide-ranging economic, social, and political impact of COVID-19 as well as in preparing for the next pandemic. CARE and our partners have a "once-in-a-generation" opportunity to leverage this momentum not only to ensure fair and efficient epidemic control and vaccine delivery, but also to "build back" resilient, equitable, and accountable health systems. It is also critical that we proactively work to prevent investments in the COVID-19 response from derailing other essential health services, or building vertical, disease-specific infrastructure.

At the global level, we will shape the priorities of agenda-setting global health partnerships and policy-making bodies working in both stable and crisis-affected settings. We will shape the policies and investments of key bilateral and private donors, as well as shaping national and regional health policies and budgets. We will also work to ensure transparent and inclusive governance of health systems from grassroots to national, regional, and global levels – with a focus on ensuring leadership of locally rooted women's groups, youth groups, and civil society organizations.

Despite progress towards the Sustainable Development Goals (SDGs), at least half the world's population, many of whom suffer financial hardship, compounded by the COVID-19 pandemic, are still without access to essential health services.[3] If current trends continue, up to five billion people will lack adequate health care by 2030.[4] Vulnerable populations face greater illness and premature death from preventable and treatable causes. Climate change is likely to continue to exacerbate the inequitable effects of poor health on communities already experiencing injustice. Protracted crises, often driven by armed conflict and climate change, are already the new normal.[5] By 2030, two-thirds of the world's poorest people will live in fragile or conflict-affected settings.[6,7]

The gaps and inequities cited above threaten the achievement of all SDGs and human security itself. Systematized racism, sexism, ableism, colonialism, and other forms of bias and discrimination have enormous impact on global health and development, and are institutionalized in both formal and informal structures and systems, including in national health systems and in international aid.[8] Efforts to acknowledge and address such institutional discrimination, and to decolonize health systems and international development, are urgently needed.[9] This bias and discrimination underpins unjust disparities in health that have persisted for decades within and across regions, nations, and communities. Feminist principles inspire and direct us. We aspire to partner more deeply and more thoughtfully with feminist groups, social movements, and civil society leaders to tackle health injustice. However, we recognize shrinking political space creates risks and barriers for them. CARE's Right to Health Strategy recognizes these urgent challenges and daunting complexities but aims to be a humble learning partner on the journey to tackling them.

An important trend to note is the global commitment to Universal Health Coverage (UHC). Supported by a group of government stakeholders, multilateral and civil society organizations, UHC2030's mission is to *create a movement for accelerating equitable and sustainable progress towards universal health coverage.*[10] UHC2030 provides a platform at global and country levels on strengthening health systems across five dimensions: equity, quality, responsiveness, efficiency, and resilience. The goal is to ensure that efforts to promote UHC don't just improve the national averages, but address gaps in inequalities that affect the poorest and most marginalized. Although the current global COVID-19 pandemic has led to a dramatic loss of human life worldwide, and has exacerbated existing health inequities, this crisis also presents an opportunity to build back resilient, equitable, and accountable health systems, and to ensure fair and efficient epidemic control and vaccine delivery.

**CARE's capacities and added value**

CARE and partners promote the right to health and well-being by catalyzing fundamental changes in power and privilege within systems and structures. The recent expansion of this outcome area from a focus on sexual and reproductive health and rights (SRHR) to a broader goal of a right to health better reflects the full range and focus of CARE's global work in health. CARE remains fully committed to quality SRHR programming, and this work remains a central pillar of the health outcome area.

CARE's added value is its equity and rights-based approach to health and health systems. CARE's application of rights-based approaches to health programming and advocacy empowers people to know and claim their right to health, increases accountability of health systems to the communities they serve, and works to prevent discrimination and ensure equitable access to health information, services, and products by expanding access and quality of services for those hardest to reach, or who face hurdles in accessing health care services.

CARE has deep roots at community level as well as relationships with leaders at higher levels of the health system and government ministries, which leverages a unique capacity to promote resilient community health ecosystems by strengthening accountability between health systems and communities. CARE's approaches bring communities and duty bearers together to develop more accountable, resilient, and responsive health systems that, in serving those who are underserved better, also provide improved services for all. Along with social accountability, CARE's approaches promote shifting social norms at community level, with deep expertise in supporting shifts in gender power and privilege within health programming as reflected in our work around the world using Social Analysis and Action (SAA), which shows that shifting community gender and power norms improves health outcomes. CARE's emphasis on right to health and strengthening the public health sector means that CARE primarily works with and alongside government and local civil society partners. We recognize that embodying CARE's partnership principles[11] of humility and complementarity is required to fully unleash our ability to achieve our Right to Health goals. A critical focus of our partnership effort is supporting frontline providers in government health services to improve accessibility, availability, acceptability, and quality of primary health care services, making sure that sexual and reproductive health and rights are an integral part of those services. CARE's health programs focus on strengthening health systems, frontline health workers training and supervision, and strengthening community and facility preparedness for emergencies.

CARE works with community groups and leaders and local health authorities to catalyze community-led collective action and mobilize public demand and build institutional commitments and to change institutional practices and policies. As noted below in the section on Market-Based Approaches, CARE has limited but important partnerships with private sector providers where public services cannot reach. Our advocacy to influence health policies, programs and budgets of governments and other decision-makers continues to grow.

Another added value that CARE brings is its "nexus" approach that supports the provision of lifesaving services in acute emergencies through emergency preparedness activities and strengthens shock-affected health systems to either return to or exceed pre-crisis levels of performance. This mitigates the impact of humanitarian disasters, increases resilience to future shocks and stressors, including disease epidemics. In fragile and humanitarian settings, CARE supports public health facilities to deliver essential primary health services with a focus on SRH, because these services are often neglected in humanitarian response. CARE also supports community-centered models of preparedness, including risk communication and community engagement to support disease prevention and community-based surveillance to enhance rapid detection of disease outbreaks.

## What the Right to Health Strategy Aims to Achieve
**Definition of *right to health***

At CARE, we envision a time when people of all genders attain the highest standard of physical, mental, and emotional well-being across development and humanitarian settings.

CARE's Right to Health Strategy aspires to articulate and implement a rights-based and justice-oriented framework. It is rooted in principles and commitments to gender justice, decolonizing international aid, including commitments to address racism, cultural imperialism, and white supremacy in CARE's programming, localization, with efforts to center decision-making and resources locally, inclusive of diverse stakeholders that represent groups marginalized from the mainstream; incorporating meaningful participation of partners and program participants and ensuring accountability to these voices and the above principles.

The right to health means that everyone has the right to:

- **Self-determination,** including the right, without any form of discrimination, stigma, coercion, or violence, to have control over and make free and informed decisions about one's own body; sexuality and sexual pleasure; gender identity and expression; if, when, and with whom to partner, or marry; if, when, and how to have children, to practice self-care and pursue wellness in a way that keeps alive one's culture, community, and connections to others; that nurtures physical, mental, emotional, and spiritual health.

- **Equitable, resilient, and accountable health systems** that uphold rights-based, gender- and age-responsive care across the humanitarian to development continuum.

- **Social, economic, and political equality** as a fundamental pre-condition to health; health must be enjoyed without discrimination on the grounds of gender, race, age, ethnicity, ability, or any other status.

## Impact goal, targets, and theory of change

By 2030, CARE will support 50 million people of all genders to exercise their right to health; among those 50 million, 30 million will be women and girls who will realize their right to sexual and reproductive health. In the next three years, our target is to support impact for an average of 6 million people each year, reaching a total of 18 million by the end of 2024. We view these targets as dynamic.

The Right to Health Impact Area contributes to several SDGs. It contributes to SDG 3 (Ensure healthy lives and promote well-being for all at all ages), SDG 5 (Achieve gender equality and empower all women and girls), and SDG 17 (Partnerships for the Goals).[12]

The Right to Health theory of change envisions an interconnected set of three domains of change needed to achieve the right to health. In the first, individuals and families experiencing injustice promote their own health and well-being. In the second, communities build more equitable relationships at family and community levels. Civil society organizations with links to social movements collectively create more responsive, accountable, and inclusive health care services. In the third, policymakers, powerholders, and health systems decision-makers act to ensure that health systems are equitable, responsive, accountable, and resilient to shocks. The graphic further illustrates how CARE and partners' approaches and actions contribute to these outcomes which underpin the ultimate objective, which is that all people achieve their right to experience the highest possible standard of health and well-being.

Box 1. Right to Health Theory of Change
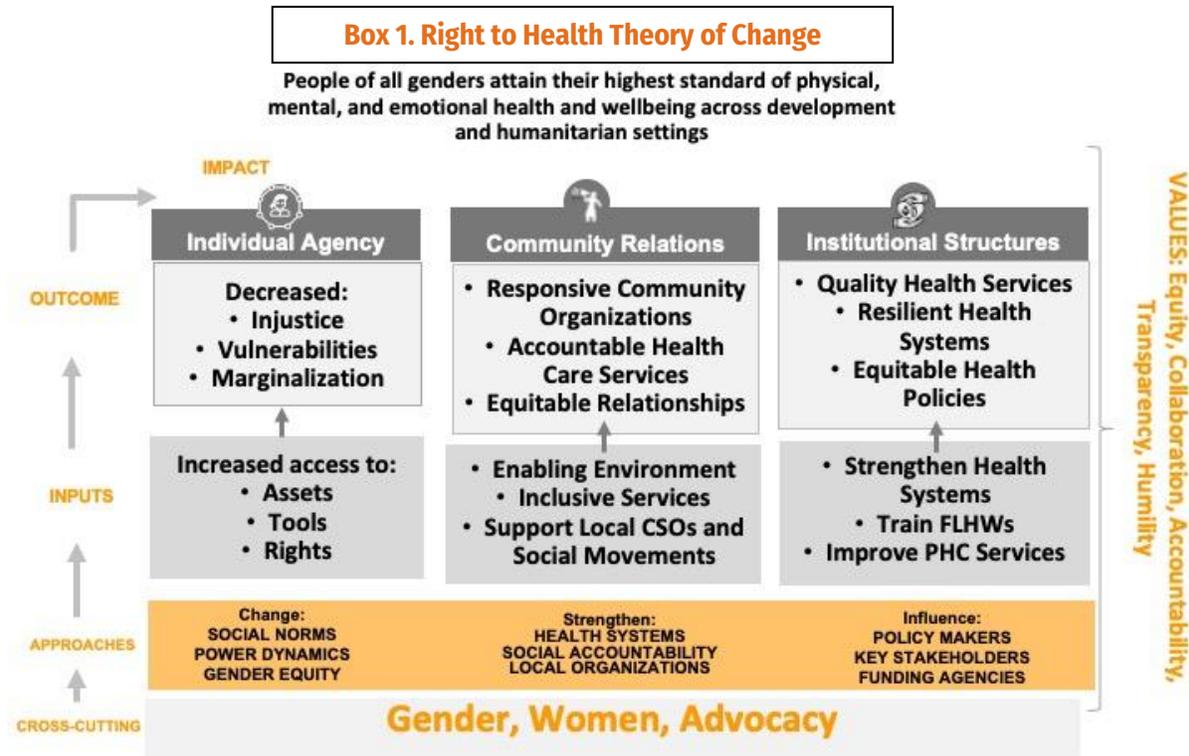
## Areas of focus

CARE's Right to Health Strategy has four thematic areas of focus. Central to each thematic area is CARE's deep-rooted commitment to transforming and promoting equitable, gender-transformative social norms, and meaningfully engaging communities in support of rights-based health care for all.

### 1    Strengthen local health systems and community-based organizations

CARE's approach to strengthening health systems puts communities at the center to ensure meaningful engagement and participation of women, youth, and other marginalized groups in planning, delivery, and monitoring of health services and resources. We work with communities to shift social and gender norms that impede access to health information, services and products, and to hold health providers and other duty bearers accountable by bringing them together to identify problems and their solutions; revitalizing community health committees to oversee health resources; and accompanying community-based groups led by women, girls, and other marginalized populations, to directly advocate for their rights and needs, shape the policies and programs that affect their lives, and drive accountability. CARE works to ensure that high-quality health services are both available and accessible. This is achieved by: (1) enhancing the knowledge, attitudes, and skills of frontline health workers through on-the-job training, skills assessments, and coaching/mentoring; (2) supporting the continuous collection, analysis, and use of health and stock inventory data by key stakeholders to improve service delivery and utilization; (3) increasing the health system's readiness and capacity to withstand, adapt, and recover from shocks so that essential services are available during a crisis; and (4) advocating at multiple levels for policies, resources, and accountability systems that ensure equitable access to rights-based health care.

**2     Support marginalized population groups, especially adolescents**

Our programs ensure adolescents of all genders, including those experiencing social isolation, are supported by the people and systems that surround them. In close partnership with adolescents themselves, CARE and partners work to create an enabling and equitable environment, underpinned by supportive social norms where young people can realize their full health and potential and lead the change that they desire for themselves and their communities. For example, across multiple contexts in development and humanitarian settings, CARE has deep expertise in working with adolescents. CARE's programming provides a wrap-around programming model that includes health support systems that are integrated with skills-based education, financial literacy, civic engagement, community mobilization, and other issues important to this group. CARE also works to strengthen and mobilize resources for youth-led advocacy organizations and networks and broker entry points for youth to advocate for their rights and needs directly with decision-makers at the local, national, and global levels.

**3     Increase access to quality health services, including sexual and reproductive health and rights services, in humanitarian and fragile settings**

Our nexus approach ensures agility to respond to emergencies while building back and strengthening resilience of the health system in fragile settings. CARE works to accelerate localization and incorporate a gender lens across all elements of this focus area. Under this focus area, CARE and partners: 1) enhance preparedness through capacity building of government, local partners, and other humanitarian actors, influencing policy, and strengthening coordination mechanisms across actors; 2) enable agile, rights-based, people-centered, gender-sensitive emergency response efforts guided by the Minimum Initial Service Package for SRH in crisis-settings; 3) strengthen government health systems that have been weakened by protracted or chronic crisis to deliver comprehensive health services and unlock access to the most stigmatized SRH services; and 4) lead in global and regional advocacy platforms to ensure universal access to health rights in crisis-affected settings.

**4     Prepare for and respond to public health emergencies**

CARE leverages historical relationships with governments, frontline health workers, and communities to quickly advocate, mobilize, and respond to public health emergencies such as the Ebola crisis and the COVID-19 pandemic. We work to ensure that preparedness and response efforts address the gendered dimensions of health before, during, and after crises. During disease outbreaks, we focus on protecting and supporting health providers to institute national infection prevention and control measures; strengthening community engagement systems for promoting healthy practices and integration with water and sanitation interventions; collaborating with ministries of health to support community-based surveillance and contact tracing; and ensuring continuity of essential health services including lifesaving SRH services such as emergency obstetric and newborn care and clinical management of rape. CARE is responsive to the changing environment, leveraging its last-mile reach to deliver critical services in emergencies. Examples include supporting the roll-out of COVID-19 vaccines, risk communication and community engagement (RCCE), and support to frontline health providers. CARE is also advocating for global and national policies and funding that ensure equitable vaccine delivery, including fair pay and supportive work conditions for the (70% women) health and care workers who will deliver the vaccine to the last mile. Our COVID-19-related advocacy will leverage the unprecedented investments currently being made in COVID-19 response to "build back" resilient, equitable, and accountable health systems that are prepared for the next pandemic. We will also use grassroots, national and global advocacy and accountability to proactively work to prevent investments in the COVID-19 response from derailing other essential health services, or building vertical, disease-specific infrastructure.

Results/Indicators: CARE is expanding to a broader mandate to strengthen health systems and structures that deliver on the right to health for all, from a strong foundation in sexual and reproductive health and rights. To accommodate an expanded mandate, we note the need to adapt both *what* we measure and *how* we focus our

learning efforts. We propose adding one new priority indicator that is widely regarded as a marker of health system strength and responsiveness[1] to the existing PIIRS priority indicators from our 2020 Program Strategy that speak to the foundational right to sexual and reproductive health and rights.

These are shown below in Box 2.

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Box 2. Priority Right to Health core indicators for PIIRS

*Existing core indicators:*
- Births attended by skilled health personnel (%) [SDG indicator 3.1.2]
- Women of reproductive age who have their need for family planning satisfied with a modern contraceptive method (%) [SDG indicator 3.7.1]

*New core indicator:*
- Children aged 12–59 months who have received three doses of the combined diphtheria, tetanus toxoid and pertussis vaccine (DPT3) as a percentage of all children aged 12–59 months (%) [SDG Indicator 3.b.1]

*Key Supplemental Indicator (under development):*
- Persons who have completed the approved COVID-19 vaccine regimen as a percentage of the population eligible to receive the vaccine (%)

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To date, PIIRS indicators are not designed to collect data about *how* changes are achieved (e.g., shifting power), but rather to document the outcome achieved (i.e., health outcomes). We commit to working with collaborators across the organization to develop additional supplemental indicators and invest in qualitative, participatory methods that better capture elements of how and what changes happened, including patient-centered quality care, and disparities and inequities inherent in health and community systems. We also commit to better capturing gender, ability, age, and socioeconomic status-disaggregated data. Groups who experience social marginalization from the health system may have health needs that go unnoticed if data are not disaggregated to illuminate these inequities.

It is important to acknowledge that, as the world continues to adapt to the COVID-19 pandemic, and as resources are diverted to a COVID-19 response, progress in CARE's foundational indicators will be at risk. Indeed, there is already evidence of initial backsliding in reproductive health indicators. We anticipate that sustaining the hard-won gains of the last decade could be a substantial achievement in and of itself.

### Learning

Learning plays an important and central role in our Right to Health Strategy. We aim to connect people and ideas; generate, translate, and share evidence; and nurture a culture of learning. Four important principles underpin our approach to learning. First, we commit to prioritizing equity analyses in our work to better identify and understand where our programs are falling short of our commitment to the right to health for all people, but particularly for groups who are marginalized from health systems. We commit to applying the learning from our work on gender equality to inform our approaches to this work.[13]

Second, we recognize the need to seek input and engage in more meaningful stakeholder engagement at every stage of our learning processes. We seek to strengthen data for decision-making processes by investing in collaborations with public health officials where CARE works and southern-based, indigenous researchers and stakeholders, centering decision-making where the impact of those decisions will be most immediately felt and

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[1] Becker, L., Pickett, J., Levine, R. (2006). Measuring Commitment to Health: Global Health Indicators Working Group Report. Washington D.C.: Center for Global Development.

appreciated. We commit to sharing our findings first and foremost with those who contributed to the learning efforts and with those they will benefit.

Third, we embrace approaches that aim to tell the story of impact and describe both how and why change happened, and what didn't happen. We invest in building skills in feminist research and documentation methods that center experiential narratives and stories of those closest to the work, acknowledging that CARE's research and documentation approaches in the past have tended to prioritize who are "knowers," what is "known" and what and how information is "shared," in ways that were staunchly positivist and often, biased towards the Global North. This needs to change.

Fourth, we invest in cooperative and complementary learning with other impact areas and teams at CARE. We recognize, for example, that our work in fragile; conflict and public health emergencies must be informed by and contribute to learnings from program participants and the wider humanitarian spaces and that our efforts to strengthen adolescents' access to health services should be informed by best practices in promoting gender equity.

Over the next three years, we will prioritize learning across each of our four areas of focus in alignment with our theory of change and to understand and demonstrate **how gender equality contributes to the realization of the right to health**. Some specific learning questions that have been identified to date include the following:

- **Agency**
  - How can we facilitate girls, women, individuals of all genders who are marginalized, so that they are able to meaningfully engage, participate, and lead, to ensure their access to and utilization of high-quality, sexual and reproductive health information and services?
  - How can we specifically address the needs of adolescents' rights to health and reproductive health in ways that engage, motivate, and empower them?

- **Relations**
  - What are effective community engagement approaches to address social norms and social determinants of health to create an environment that allows people of all genders to exercise their right to health?
  - How can CARE and partners tackle barriers to individual and community behavioral change, mitigate the impact of public health emergencies, and support the continued utilization of essential services?

- **Systems**
  - What approaches are effective at addressing common shortcomings of health systems including weak provider performance and motivation, poor accountability, persistent inequities, restrictive provider attitudes, behaviors, and norms, and high susceptibility to shocks and stresses?
  - What models are effective at delivering health services, particularly essential sexual and reproductive health services, in fragile settings or during public health emergencies, while supporting equity and inclusion?

## How the Right to Health Strategy Aims to Achieve its Goals

### Gender equality at the heart

We gratefully acknowledge the work of hundreds of women's rights movement activists and groups, feminist scholars, and researchers, who have successfully been pressing for attention to gender equality in policy and practice for decades.[14,15] Pervasive gender inequality, and restrictive gender norms have translated into a range

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of negative health outcomes for all people, especially for women and girls.[16] There are numerous pathways and contributing elements of gender equality to better health outcomes.[17] Research shows how inequitable health systems can be re-shaped to reduce gender inequalities through better social and economic policies, and through community accountability mechanisms.[18] CARE's Right to Health Strategy will focus on contributing pathways, some of which are listed below and detailed in the programmatic models that follow. These are cross-cutting across the emergency to development continuum.

**1      Approaches for influencing gendered social norms and attitudes at the household and community levels.**

In keeping with our values, and our understanding that pathways to health include an enabling environment at home and at the community level, our approach is community driven. CARE's proven tools use reflective dialogue to build consciousness of power and privilege, and to critique the expectations that come from gendered social norms. The reflection, analysis, and action steps of SAA build skills for collective action to challenge and change inequitable power dynamics and expectations. These build an enabling environment in the ecosystem that includes individuals, families, and communities.

**2      Community accountability mechanisms.**

Our decades of experience have shown that community accountability mechanisms can be a successful pathway to more inclusive and responsive health systems and services. Community accountability processes provide a space for meaningful participation of women and girls, and groups experiencing injustice such as LGBTQI, in defining, monitoring, and shaping health and other services. More details are shown under CARE's models.

**3      Approaches that improve access to quality care and reduce gender and other bias in health care delivery.**

We work with partners to transform health structures, with a deliberate focus of strengthening health systems anchored in community health ecosystems. We unleash the power of frontline health care workers as change agents. CARE's approach in addressing gender and other barriers in health care delivery uses reflection, analysis, and action steps similar to those at community level, in order to build consciousness and capacity of providers and the systems in which they operate, thus systematically unblocking gendered and other social barriers within health care, whether in service delivery, how health care providers are recruited, supported and paid, in governance and decision-making, or how health care systems and services are financed.

CARE has decades of experience in these approaches, which have been shown to be effective. Yet, we recognize there are also opportunities to deepen our work. We acknowledge that CARE's health programming could go further, by addressing gender inequality more systematically, and to expand to tackle other forms of systematic bias and discrimination in health systems. We commit to making efforts to explore how to better address these, including systemic bias among health care providers and bias within health systems, including how people affected by marginalization – including people with disabilities, indigenous and ethnic minority groups, trans, intersex, and queer people – are included in health systems in general and SRHR programs and services in particular. We also commit to addressing other systematic forms of bias and discrimination, including racial, ethnic, religious, and caste-based power and privilege, and how health systems can reduce barriers and discriminatory practices towards indigenous groups and people of varying abilities.

This strategy aligns with key organizational frameworks such as the adolescent empowerment framework that highlights meeting the holistic needs of adolescents through integrated approaches; CARE's Humanitarian Directions that emphasizes localization and gender in emergencies through nexus approaches; and Health Policy Plus frameworks for advancing equity through strengthening health systems.

**Core programmatic models**

CARE seeks to promote scalable and sustainable change globally. The models for doing so require a close working partnership with local communities and organizations, and a commitment to ongoing learning from

and leveraging the best of local partners' and CARE's rights-based programmatic experiences. The following five program models highlight examples of CARE's tools, while also noting that some tools for such models will emerge under the leadership and direction of our local partners.

**Models for power-shifting, addressing social norms, and achieving more gender-equitable relationships**: With gender transformation at the heart of our work, we strive to support communities, health care providers, and other stakeholders to critically explore and transform power dynamics and achieve the right to health. For example, SAA provides a tested and evidence-based platform for communities to collectively explore and implement ways to tackle gender and other barriers to health, both at the household and community levels. We use SAA with service providers to reflect on their attitudes, values, and biases, as well as the power dynamics with clients and its impact on acceptability and accessibility of services. In addition to working in close partnership with communities, we also focus on and partner with frontline health care workers, most of whom are women, aiming to strengthen their skills to challenge and address stigma and inequality affecting them and those that affect marginalized clients. There is significant potential in expanding SAA or similar approaches, as developed and led by others, across the emergency to development continuum.

**Models for social accountability**: We adapt, leverage, and scale models to promote social accountability. These provide scaffolding for ensuring meaningful participation of groups experiencing injustice in defining, monitoring, and shaping health and other services. Many social accountability models developed around the world show promise. One example of a proven social accountability tool that has the capacity to elevate community needs, shift power dynamics at local and district levels, and promote community-generated solutions is CARE's Community Score Card (CSC). CSC or other social accountability tools have the potential to improve services in disaster/conflict-affected communities or with particular groups marginalized from health services, such as adolescents.

**Integration of gender, health, equity, and rights in emergencies**: There is a need to strengthen programming that integrates gender with health in emergency settings. Some tools that can be applied in the development of such models may include CARE's Rapid Gender Analyses and implementation of the SRHRiE Minimum Commitments for Gender and Inclusion. These tools build on mutually reinforcing efforts across teams in CARE and external partners. Other promising approaches have emerged from pilots that tested an integration of SRHR elements in the *Women Lead in Emergencies* model, which focuses on increasing the voice, leadership, and power of women and girls in crisis settings.

**Integrated models for health and community-centered resilience**: The differential effects of the global COVID-19 pandemic on communities have shown the importance of community-centered resilience models. We see significant potential for developing piloting and evaluating models for resilience building at the community level. Several of CARE's community-based programming models provide some building blocks for such models. These include health development committees, integration with water and sanitation committees, and CARE's Villages Savings and Loans Associations. Others will emerge from the work of our local partners. These will be explored and tested as part of strengthening health systems.

**Market-based approaches to promote health**: In relevant situations where government accountability for services is less likely to be realized, such as in humanitarian settings, we set out to explore models that leverage market-based approaches for health.[19] These include engagement with private sector providers, cash- and voucher-assistance models, or social enterprise models that promote health and resiliency. In some settings, it may be appropriate to test a model for health-related savings by building on CARE's Village Savings and Loans Associations.

### Advocacy as a pathway to impact

While CARE's Right to Health programming scales through a range of pathways mentioned in the 2030 Strategy, one pathway bears calling out. Advocacy is a critical pathway for CARE to transform health systems, achieve

impact at scale, and advance the global goal of universal health coverage. CARE's Right to Health programs address a range of health issues. Our strategy to scale is to strengthen resilient, equitable, and accountable health systems that can respond to shocks and crises, and which can ensure sustainable access to quality health services for all. Where national health systems are disrupted by crisis and conflict, we will also work to strengthen humanitarian systems so that they are accountable for delivering equitable and high-quality health services as a core element of all emergency responses, including lifesaving SRH and GBV services that are often sidelined in times of crisis. CARE will also support community-driven advocacy to demand inclusive and responsive health systems, as well as engaging decision-makers at all levels – from the district to national and global levels – to adopt and implement rights-enabling policies. CARE's advocacy will be distinguished by leveraging real-life evidence to inform policy change, and ensuring meaningful leadership of women, girls, and all rights-holders to directly participate in decision-making about the programs and policies that affect their lives.

Key advocacy strategies that will contribute to the Right to Health program impact include the following:

- **Ensure fair and efficient epidemic control and vaccine delivery, but also to *build back* resilient, equitable, and accountable health systems** and prevent investments in the COVID-19 response from derailing other essential health services, or building vertical, disease-specific infrastructure.

- **Ensure high-quality, equitable frontline service delivery** with a focus on ensuring that frontline health care workers (70% of whom are women) are safe, supported, and receive fair pay so that they are able to deliver quality services.

- **Ensure well-resourced and inclusive local and national accountability systems** that enable the groups experiencing injustice – including women and girls – to fully participate and negotiate for rights-based, responsive health services, and drive accountability for full implementation of policies at the local, national, and global levels.

- **Ensure prioritization of SRHR and GBV within comprehensive primary health care in all humanitarian responses**, with continuity of essential health services in the face of crisis, disasters, and public health emergencies.

**Box 3. Examples of partners in the Right to Health Strategy**

**Program quality and delivery**

- **Ministries of Health at national and sub-national levels** to pilot, evaluate, and scale up health system strengthening interventions through public health systems via accompaniment, technical assistance, and support.

- **Civil society organizations, especially those led by people experiencing injustice**, to design, implement, monitor, and learn from programming that advances the right to health. In protracted humanitarian crises, such as conflict in northern Syria, through CARE partners with local and diaspora NGOs.

- **Centers for Disease Control and Prevention's Emergency Response and Recovery Branch** to support preparedness actions that improve rapid responses to public health emergencies (e.g., Ebola and cholera outbreaks). CARE focuses on integrating community-based surveillance to support early detection of disease and community engagement and risk communication to support prevention of disease into its community-based platforms.

- CARE is a member of the **WHO AYSRHR TA Coordination Mechanism**, to provide support to requesting governments to develop and implement SRHR policies for adolescents and youth.

- The **WHO Global Health Cluster Forum** to ensure effective and efficient coordination and response, with special attention given to SRHR, during humanitarian emergencies.

**Sharing, learning, and best practices**

- CARE is a founding Steering Committee member of the **Inter-Agency Working Group for Reproductive Health in Crisis Settings**, which is an international coalition of actors working collectively to advance SRHR in humanitarian settings.

- CARE is a member of the **Implementing Best Practices (IBP) Network**, which engages the global SRH community to disseminate and use evidence-based family planning and reproductive health guidelines, tools, and practices through its convening power and neutral platform for knowledge-sharing and collaboration.

- CARE is a long-running member of the **CORE Group**, a global knowledge sharing coalition committed to community health.

- CARE has a global MOU with **UNFPA** to advance SRHR, gender equality, and adolescent empowerment across the development-humanitarian continuum through joint influencing, collaborative programming, shared learning, linked resource mobilization, and building public awareness and visibility at multiple levels.

**Advocacy and accountability**

- **FP2020**, which is a global partnership to mobilize countries and governments to provide 120 million more women and girls access to voluntary family planning by 2020.

- **Frontline Health Workers Coalition**, which is an alliance of United States-based organizations working together to urge greater and more strategic investments in frontline health workers in low- and middle-income countries as a cost-effective way to save lives and foster a healthier, safer, and more prosperous world.

- **Gavi, ACT/COVAX**, the vaccines pillar of the Access to COVID-19 Tools (ACT) Accelerator, for a COVID-19 vaccine rollout that priorities crisis-affected, refugee and IDP populations, addresses gender barriers to immunization, and ensure the safety and well-being of frontline health workers. In the future, we will collaborate with Gavi to strengthen immunization system at the last mile and to ensure full access to immunization services in humanitarian settings.

## Partnerships

Partnership based on CARE's partnership principles[20] is central to our effort to ensure that people of all genders can realize their right to health. Our partnerships are also critical elements in our pathways to scale. We provide accompaniment and capacity strengthening to national governments to vertically scale proven approaches and interventions in the health sector. We complement that work by engaging with strategic community and civil society partners, to strengthen transparency, accountability, and improve quality. We document and share lessons and good practices via regional and global networks and partners. Finally, we use advocacy and influence in strategic global, multilateral, and regional coalitions to influence priorities and agendas of policy-making bodies. Some examples of our diverse partners at local, regional, and global levels in these areas are shown in Box 3 (see previous page).

We recognize that there are deep inequities and injustices within the international aid system to the benefit of international actors in the Global North and to the detriment of organizations in the Global South, especially local civil society organizations led by women, youth, LGBTQI, indigenous groups, or others. Therefore, our approach to partnership aims to redress inequities by shifting power and resources to the organizations that have been excluded from the international aid system and have the most at stake and the greatest insight when it comes to social change. To achieve this, we must critically examine our own power and privilege, and actively deconstruct and transform the attitudes, practices, and structures that produce and perpetuate inequality. This will require us to rethink how and when to step back from leadership roles and distribute financial resources and decision-making power to local civil society organizations led by women, youth, and marginalized groups. It will require us to prioritize flexible, multi-year funding from donors to nurture and sustain values-driven partnerships beyond the narrow confines of the project cycle.

Partnership is a matter of principle, not of convenience. We aspire to embody feminist principles, including the principles of **equity, collaboration, complementarity, mutual accountability, transparency, and humility**. However, CARE's existing policies and procedures were designed to prioritize management of risk rather than enabling these values. Consequently, we commit to re-imagine and institutionalize mechanisms for enabling equitable partnerships between CARE and less established or conventional actors. In doing so, we commit to work towards learning how to operationalize such feminist principles into our partnerships. At the very least, these may include such examples as partnership agreements with mutual accountability mechanisms, and with less burdensome due diligence, compliance, and audit requirements.

## Funding and resourcing our programs

In the first three years of the strategy, we aim to impact 15 million people, ensuring that they are fully able to exercise their right to health, across our health programming portfolio. We estimate that this will require a collective investment of 520,000,000 USD over that time period. We derived this estimate by first estimating how many people we might need to reach directly to achieve this impact, based on our direct reach and impact reporting over the 2020 Program Strategy reporting period, and on our renewed focus and commitment to impact the lives of those we do not reach directly through systems strengthening and advocacy and policy change. We then calculated a cost per person reached across three emblematic health programs, one operating at significant scale, another providing comprehensive services at relatively small scale, and the third providing health services in a complex humanitarian crisis. Together, this gave us an estimate of the budget required to reach 43 million direct participants, impacting 15 million and proceeding on track to our collective goal of 50 million by 2030.

CARE's health programming is currently funded by large government bilateral agreements, private foundations, multilateral organizations, corporations, and high-net-worth individuals, as supported by CARE's resource mobilization and program teams across the confederation. For a successful Right to Health Strategy, we need to invest in strategic positioning and engagement with several key donors, as well as solidify and maintain relationships with our existing donors. This will require time and resources in long-term resource

mobilization efforts. Based on criteria of potential donors' alignment with CARE's values, Right to Health Impact Area Strategy goals, geographic capacities and priorities, and flexibility of design and implementation, the following key donors were identified in 2019: (1) USAID; (2) Bill and Melinda Gates Foundation (BMGF); (3) Global Affairs Canada; and (4) DFID. For these priority donors, we will invest in strategic engagement to sustain and increase funding for our health programming. This prioritization does not mean that we will pursue every funding opportunity from a priority donor, and it does not mean we will not pursue funding opportunities from non-priority donors. For the top two priority donors – USAID and BMGF – CARE will continue to build on existing action plans to strengthen our relationship and position for significant new funding in partnership with IFS and the Foundations team. Additionally, with the launch of the IAS for Right to Health, CARE will revisit this donor prioritization exercise to ensure we are capturing the top donors for our expanded mandate and focus areas, including in public health emergencies. We will continue to revisit this exercise as the broader landscape of funding for health shifts and continues to evolve, including as donors emerge outside of traditional western funding sources.

In addition to the prioritizing donors for long-term engagement, we will continue to work closely with fundraising teams and CARE member partners and entities to provide technical support to strategic proposals that support the Right to Health IAS approaches, pathway to scale, frameworks, learning questions and innovations. In new proposals, we will continue to utilize the gender marker (and other gender integration tools) to ensure application of a gender-transformative approach as central to the strategy.

Finally, looking forward towards 2030, we aim to strengthen capabilities for program design and resource mobilization for health. We recognize that to deliver on our commitment to equitable partnership with local organizations, this must be backed up by shifting power and resources to local organizations and southern-based CMPs. This may include providing technical support to country offices, southern-based CMPs, and local partners on program design, and resource mobilization for health programming; prioritizing funding opportunities that require or allow for significant funding to be shifted to local partners; and adapting existing resource mobilization tools to be shared with and used by southern-based CMPs, COs, and local partners.
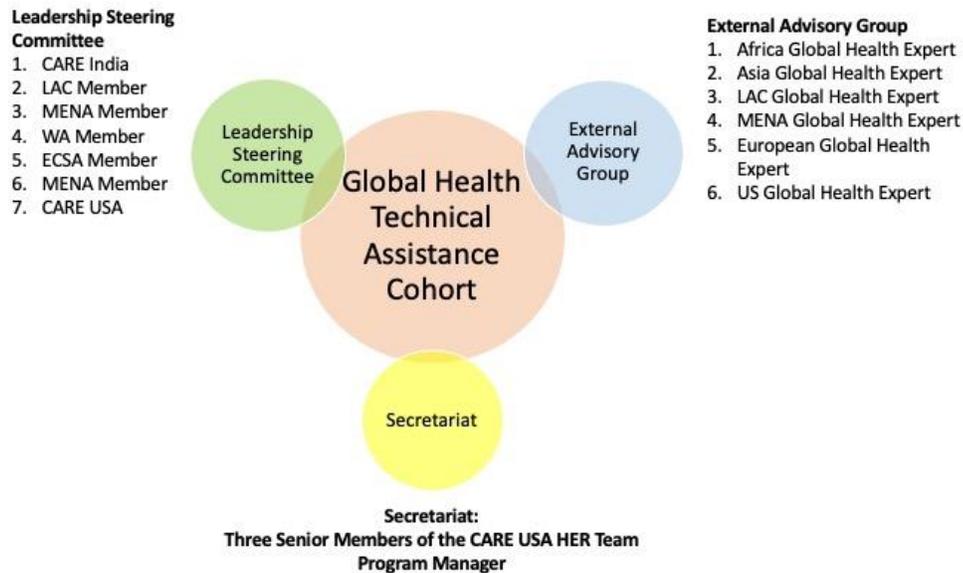
## Who will help to implement this strategy?

### Institutional arrangements and roles

CARE India and CARE USA co-lead the Right to Health Strategy. A Strategic Advisory Group (SAG) with approximately ten members from across CI came together to provide high-level guidance to CARE India and CARE USA as they set direction on behalf of the confederation. In its short history, during 2019, the SAG informed, supported, and ultimately validated the broad goals and thematic areas of the CI 2020 SRHR strategy, as well as provided input into CI Vision 2030 which expanded the sectoral focus from SRHR to realizing the right to health for all.

Moving forward, the CARE India and CARE USA teams will revise the governance structure to shift power to a more diverse and inclusive leadership team that more fully capitalizes on the talents and experience of CARE members from the Global South. We will iterate and finalize the structure through a consultative process over year one of the strategy. Illustrative examples of change include the following: Shifting the Strategic Advisory Group (SAG) to become a **leadership steering committee**, whose members will be drawn from the six main regions of CI, but with an emphasis on members, affiliates, and country teams from the Global South. This group will act as thought leaders to the strategy, guiding, and making decisions about strategic focus and operational form.

**RIGHT TO HEALTH: GOVERNANCE STRUCTURE**

**Leadership Steering Committee**
1. CARE India
2. LAC Member
3. MENA Member
4. WA Member
5. ECSA Member
6. MENA Member
7. CARE USA

**External Advisory Group**
1. Africa Global Health Expert
2. Asia Global Health Expert
3. LAC Global Health Expert
4. MENA Global Health Expert
5. European Global Health Expert
6. US Global Health Expert

Leadership Steering Committee

Global Health Technical Assistance Cohort

External Advisory Group

Secretariat

**Secretariat:**
**Three Senior Members of the CARE USA HER Team**
**Program Manager**

We will explore shifting the role of CARE USA's HER Team to act as a **secretariat**, coordinating and managing the activities that are prioritized by the leadership steering committee. The CUSA Health Equity and Rights (HER) Team members will have individuals assigned as regional focal points for each CARE region who support resource mobilizing, facilitating learning via online communities of practice and global webinars, and technical assistance coordination, as well as reaching out to external advisory group members.

We also envision building an **external advisory group**, consisting of leaders and activists in the health rights space, including SRHR activists, and individuals with a non-health background such as social scientists and social entrepreneurs, who will advise and help stimulate transformative and innovative programming and practices.

We will also test the feasibility of a Right to Health **global health technical assistance cohort** similar to the gender cohort and the nascent Monitoring, Evaluation, and Learning (MEAL) cohort. We also envision members of this Cohort to expand our regional communities of practice to become southern-led hubs of information and exchange, best-practice and innovation sharing, including how to implement our best work at scale. Our ultimate goal, in the first three years of the 2030 strategy, will be to significantly shift health strategy leadership and expertise to be more in proximity to problems we as CARE are seeking to solve. We estimate the cost of operationalizing the five core roles of an Impact Area Strategy, i.e., leading, learning, developing, advocating, and supporting, to be **4 million USD** over the first three years of the strategy.

## Core deliverables

Pending feedback from key stakeholders as we roll out the strategy and available resources, a critical core deliverable in the next three years will be a reorganization of the leadership and coordination mechanisms across CARE's depth and breadth of work under the strategy, such as for technical assistance, advocacy, partnerships, learning, and monitoring and accountability.

**Endnotes**

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[1] Watts, N., Adger, W. N., Agnolucci, P., Blackstock, J., Byass, P., Cai, W., … & Cox, P. M. (2015). Health and climate change: policy responses to protect public health. The Lancet, 386(10006), 1861–1914. Download at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60854-6/fulltext?referrer=justicewire.

[2] WHO Fact Sheet: Climate Change and Health. Download at: https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health.

[3] Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2017. Download at: https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/.

[4] Primary Health Care on the Road to Universal Health Coverage 2019 Global Monitoring Report. World Health Organization Download at: https://www.who.int/healthinfo/universal_health_coverage/report/fp_gmr_2019.pdf?ua=1.

[5] World Humanitarian Data and Trends: 2018. UNOCHA. Download at: https://www.unocha.org/sites/unocha/files/WHDT2018_web_final_spread.pdf.

[6] The Role of the World Bank in Fragile and Conflict-Affected Situations. 2019. Center for Global Development, International Rescue Committee, and Mercy Corps. Download at: https://www.cgdev.org/publication/role-world-bank-fragile-and-conflict-affected-situations.

[7] See also the World Bank's website on Fragility Conflict and Violence: https://www.worldbank.org/en/topic/fragilityconflictviolence/overview.

[8] Büyüm, AM., Kenney, C., Koris, A., et al. Decolonising global health: if not now, when? BMJ Global Health 2020. Downloaded from: https://gh.bmj.com/content/5/8/e003394.

[9] Clements, M. A., & Sweetman, C. (2020). Introduction: Reimagining International Development. Gender & Development: Vol. 28, Reimagining International Development, pp. 1–9. Downloaded from: https://www.tandfonline.com/doi/full/10.1080/13552074.2020.1735800.

[10] UHC2030 provides a multi-stakeholder platform that promotes collaborative working at global and country levels on health systems strengthening. For information, see webpage: https://www.uhc2030.org/.

[11] CARE International White Paper, January 2021.

[12] For full text of the SDGs, visit https://sdgs.un.org/goals.

[13] CARE's health programs have specialized in addressing gender discrimination, but we commit to expanding that to other marginalized groups as migrants, undocumented people, indigenous or pastoralist people, people with disabilities, unmarried and married adolescents, LGBTQI+ people, people with diverse gender expressions, ethnic or linguistic minority groups, and groups marginalized because of their caste or work, such as Dalits and sex workers.

[14] Htun, M., & Weldon, S. L. (2012). The civic origins of progressive policy change: Combating violence against women in global perspective, 1975–2005. American Political Science Review, 548–569.

[15] Weldon, S. L., & Htun, M. (2013). Feminist mobilisation and progressive policy change: why governments take action to combat violence against women. Gender & development, 21(2), 231–247.

[16] Sen G., Östlin P., George A. Unequal, unfair, ineffective and inefficient gender inequity in health: why it exists and how we can change it. Geneva: World Health Organization, 2007. Download at: https://www.tandfonline.com/doi/full/10.1080/17441690801900795.

[17] Heise, L., Greene, M. E., Opper, N., Stavropoulou, M., Harper, C., Nascimento, M., … & Henry, S. (2019). Gender inequality and restrictive gender norms: framing the challenges to health. The Lancet, 393(10189), 2440–2454. Download at: https://www.sciencedirect.com/science/article/pii/S014067361930652X.

[18] Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., … & Gupta, G. R. (2019). Disrupting gender norms in health systems: making the case for change. The Lancet, 393(10190), 2535–2549. Download at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7233290/.

[19] Under the strategy, we seek to ensure governments' accountability to provide responsive and inclusive health care systems for all its residents, even in emergencies. Historically, market-based approaches to health care systems have led to greater inequality, reduced access, institutional corruption, and a host of other ills that result in weakened health systems and poorer health at an overall greater cost. For more reading on this, see a recent book entitled Global Health, Human Rights and the Challenge of Neoliberal Policies by Audrey Chapman. However, CARE's experience has shown that in some specific instances, involving the private sector in a market-based approach can bridge the gap between underserved clients and a government's capacity to provide those services.

[20] CARE Partnership in CARE Paper, January 2021.