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MAGNIFYING INEQUALITIES AND COMPOUNDING RISKS

The Impact of COVID-19 on the Health and Protection of Women and Girls on the Move





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Executive Summary

More than one year into the coronavirus disease (COVID-19) pandemic—with some countries seemingly on their way out of the crisis while others enter new waves—evidence of its impact is growing. COVID-19 is increasing short-term humanitarian needs and negatively affecting longer-term outcomes for marginalized populations and people in vulnerable situations, significantly setting back hard-won development gains, magnifying inequalities, and compounding risks. Among those worst affected are the more than 80 million people worldwide—approximately half of whom are women and girls—who have been forcibly displaced by drivers such as persecution, conflict, generalized violence or human rights violations.¹

The majority of forcibly displaced people live in resource-poor countries with weak public health and social protection systems, and economies that have been hard-hit by the pandemic.² Yet, to date, there has only been limited research around the unique ways in which women and girls on the move are affected.³ This despite predictions of significant impacts on access to, and use of, basic health services—including for sexual and reproductive health (SRH)—and the overall protection environment, including increases in prevalence and risk of gender-based violence (GBV).

Placing gender at the center of its humanitarian and development responses, CARE undertook new research in Afghanistan, Ecuador, and Turkey between April and May 2021 to better understand how COVID-19 is impacting the health and protection of women and girls on the move. The three countries represent different types of forced displacement across multiple regions: internally displaced persons (IDPs) and refugee returnees in Afghanistan; more recent migrants and refugees due to the Venezuelan crisis in Ecuador; and longer-term Syrian refugees living under temporary international protection in Turkey. The primary data collected for this research included more than 1,000 surveys with women on the move and from host communities, to allow comparison; 31 focus group discussions (FGDs) with women and adolescent girls; and 45 key informant interviews (KIIs) with government actors, health and protection service providers, humanitarian organizations, and CARE staff.

¹ United Nations Refugee Agency (UNHCR) statistics.

² UNHCR, *COVID-19 Supplementary Appeal*, December 2020. See also UNHCR, “UNHCR’s Global COVID-19 Needs”, February 2021.

³ For the purposes of this report, CARE uses the term “on the move” to include different persons affected by forced displacement including internally displaced persons (IDPs), asylum seekers, refugees, migrants and refugee returnees.

KEY FINDINGS AND IMPLICATIONS

Access to and use of health services: Half of all women on the move in Afghanistan, Ecuador, and Turkey have had less or no access to regular health check-ups and other basic health services since the start of the pandemic. In Afghanistan, 48% of IDP and refugee returnee women reported “less” or “used to have access but can no longer access” to basic health services during COVID-19 compared to 43% in Ecuador and 24% in Turkey. This has likely been occurring for more than a year now, given the onset of the first waves of COVID-19 in each country by March 2020.

While the ongoing pandemic has had an impact on access to health care worldwide, new research for this report demonstrates that it is compounding previous access challenges and therefore likely worsening the health outcomes for women and adolescent girls on the move, particularly compared to host communities. For example, in Turkey, an additional 14% of Syrian refugee women, compared to just 3% of Turkish host community women, reported that they did not have access to health services before COVID-19, and that lack of access continued during the pandemic with pre-existing challenges around government registration, language barriers, and lack of financial resources to cover paid services. In Afghanistan, 10% of IDP and refugee returnee women reported no previous and continued lack of access to health services compared to 4% of host community women. IDPs in rural settlements were more likely to lack access than those in urban settlements, due to having no available health care services in their area and the need to travel long distances, compounded by the requirement that many women across Afghanistan must have a male family member accompany them when leaving the house. In Ecuador, migrant and refugee women reported that discrimination and xenophobia were negatively affecting their access to health services, and that COVID-19 had magnified this issue. Across all three countries, many women on the move told CARE that they were not utilizing any available health services because they feared stigmatization and/or contracting the virus.

Access to and use of SRH services: Almost half (46%) of women on the move in Afghanistan, Ecuador, and Turkey had less or no access to safe maternity care since the start of the pandemic. In Afghanistan, 51% of displaced women reported “less” or “used to have access but can no longer access” since the start of the pandemic; an additional 5% reported no previous and continued lack of access. In Ecuador, 31% of women reported less or no access and an additional 16% reported no previous access while in Turkey, 17% of women reported less or no access during COVID-19 and an additional 20% reported no previous access.

Findings are similar in relation to family planning counseling and SRH services; 46% of women in Afghanistan, 25% in Turkey, and 21% in Ecuador reported less or no access during the pandemic. This has immediate consequences on the health of women, including mothers, and their children, but also on communities at large. COVID-19 risks rolling back important gains in SRH awareness raising, access and utilization of services in Afghanistan and Ecuador in particular, while stalling further progress in Turkey.

Compounded impact of the economic crisis on women: Access barriers to health, including SRH, services are compounded by the massive impacts of the pandemic on household income and many people’s inability to meet basic needs—67% of women on the move in Afghanistan and 70% in Turkey reported that their household income decreased during COVID-19. In complementary data from Ecuador, 67% of migrant/refugee women said their income sources had been “completely” affected. The economic effects of the pandemic are pushing displaced households deeper into poverty and to a breaking point, reducing health care expenditures and increasing food insecurity. For example, 100% of IDP/refugee returnee women in Afghanistan reported that households in their community are relying on less expensive/less preferred food, 63% reported sending children under 18 to work, and 67% reported reducing expenses on medication, hygiene items, and clothing. Food shortages are felt even more acutely by women, who are most often held responsible for providing and preparing the family’s food, putting women under additional stress.

Risk and prevalence of GBV: According to the women on the move interviewed, COVID-19 is increasing GBV risks, including of intimate partner violence (IPV) and child marriage of adolescent girls. Across all three countries, between 16% and 39% of women on the move reported that the risk of violence and abuse of women and girls in their communities had increased. In Afghanistan women almost exclusively (up to 88%) said that male unemployment had driven the increase. In FGDs across all three countries, women and adolescent girls were more likely to discuss GBV risks in the context of their families and homes (i.e. domestic violence), rather than discussing GBV as occurring more generally in their communities. On average, more than half of all women

across the three countries said they had spent 10 or more days at home in the past 14 days, potentially trapped with their abusers and often in substandard and overcrowded shelters. Mothers and adolescent girls also spoke about the long periods of online learning when many girl (and boy) learners faced barriers to participate in distance/remote learning and lost the safe space created by schools.

Exclusion and access to GBV response services: Greater risks and reports of increased prevalence of GBV come on top of increased feelings of exclusion from services with almost half (45% on average) of women on the move reporting that they feel more excluded during COVID-19 than they did before the pandemic. While the availability of GBV prevention and response services differs across countries, a common theme during FGDs with women in all three countries was a reduction in access since the onset of COVID. CARE protection staff reported that, in general, it has been more difficult to access women in need and ensure they can be referred to appropriate medical, psychological and legal services during the pandemic.

Compounded impact of reduced access to registration and civil documentation: More than a quarter of women on the move across the three countries (26% on average) reported increased challenges in accessing registration and legal and civil documentation, which are vital for displaced persons to secure legal stay and often to access essential services, such as health care. In particular, in Turkey, valid refugee registration is required to make appointments for government health services; in Ecuador, registration and documentation can help women and girls on the move push back against the discrimination and xenophobia that migrants often experience when trying to access public health services.

KEY RECOMMENDATIONS

CARE's research confirms that women and girls on the move have been and continue to face grave challenges to their health and overall protection. National governments and the international community must act urgently to ensure that COVID-19 and other humanitarian response and recovery efforts are gender-responsive, women-led, and focused on preventing women and girls on the move from losing further ground in the fight for gender equality.

- **Governments, UN led clusters/sectors, health care actors and humanitarian organizations should strengthen public health emergency preparedness in all three countries, and in forced displacement contexts in general.** This includes coordinating pandemic responses to account for the effects of emergencies on access to health services, particularly for women and girls on the move, and ensuring that all people on the move, and especially women and youth, are included in national COVID-19 vaccination plans.
- **Government agencies, local authorities, and humanitarian and development actors should prioritize the meaningful participation of women in leadership positions and the decision-making bodies responsible for COVID-19 prevention and response at all levels.** Women and adolescent girls, including those on the move, should be consulted as part of planning and response efforts and also supported to lead efforts to ensure that the needs of women and girls in each community are adequately addressed.
- **Health clusters/sectors and all humanitarian and development actors should work with governments to ensure the continuity of essential health services, including lifesaving SRH services** in line with the Minimum Essential Service Package (MISP)⁴, particularly where primary health care resources are diverted to respond to COVID-19. Actors should proactively work to ensure that the unique SRH needs of diverse adolescent girls and youth are met, and donors should fund and prioritize SRH responses during the pandemic.
- **Health care actors should invest in and scale-up adapted service delivery modalities to address movement restrictions and access barriers, particularly for women and girls on the move who face pre-existing barriers to access.** These may include support to non-facility-based health service delivery (mobile clinics, pharmacies etc.), leveraging technology for consultations and follow ups, referral system

⁴ For more information see Inter-Agency Working Group (IAWG) on Reproductive Health in Crisis, 'Minimum Initial Service Package (MISP) Resources'.

strengthening and remote approaches for mentorship and support to frontline health workers.⁵ Appropriate infection prevention and control measures should be maintained.

- Donors should significantly step-up **investment in durable solutions to displacement**, including voluntary return in conditions of safety and dignity, and with adequate socioeconomic reintegration support for women and girls.
- Donors should fully fund both basic needs and **gender transformative resilience building** (dignified livelihood options, access to safety nets, to education, etc.) in long-term, protracted displacement situations. To do so, it is critical to ensure the data gap is filled, particularly on sex and age disaggregation of data relating to IDPs.
- **Donors should increase funding for GBV prevention and response programs and require integration of GBV risk mitigation in program design and implementation across all sectors** given the increase in prevalence and risks of GBV. With findings relating to domestic violence and homes being less safe, more focus should be on engaging men and boys and raising awareness at household level including through remote means where necessary.
- **Specialized GBV service providers should scale up programming and adapt service provision** to address increased needs, access challenges resulting from COVID regulations, and gaps in local, survivor-centered GBV referral pathways and response services. Responses should be adapted to reach GBV survivors both face-to-face where possible, and through remote means where necessary, e.g., through the use of hotlines, working with community staff/outreach, and adapting standard operating procedures in the case of remote follow-up.
- **Humanitarian and development partners should advocate with host countries on the importance of regularizing status of displaced persons** including women and adolescent girls to support their access to essential services, such as health care, during the pandemic. All actors should also work with government authorities to ensure the continuity of registration and issuance and awareness about legal and civil documentation during the pandemic. Donors can incentivize this through quick impact projects providing technical and financial support to adapt systems and boost the capacity of authorities to deliver services during the pandemic.
- **Donors should increase the volume and quality (more predictable, multi-year, less earmarked and more flexible) of funding to frontline responders**, including and as directly as possible to women-led and women-rights / refugee-led and IDP-led organizations. Emergency funding is imperative to allow timely, evidence-based responses in parallel to longer-term resilience programming that elevates and enhances the expertise of women and girls on the move, local actors, and governments to prevent the further erosion of women's and girls' rights and to support gender-equitable outcomes.
- **Donors should fund, and all actors should scale up, the use of cash and voucher assistance (CVA) to improve health and protection outcomes of women and girls on the move**, building on CARE's previous research on the application of CVA humanitarian settings, including learning in Ecuador during the pandemic.⁶ CVA can be a vital tool to increase access to SRH services and in GBV prevention and response as well as to help address basic needs of women and adolescent girls.

⁵ For more information see IAWG on Reproductive Health in Crisis, 'Toolkit for Mapping of the MISP for SRH and its Adaptation for Preparedness and Response to COVID-10 and Other Pandemics and Major Outbreaks', September 2019.

⁶ CARE, *Cash and Voucher Assistance for Sexual and Reproductive Health and Rights Learnings from Ecuador, Columbia, Lebanon and Somalia*, March 2021.; and CARE, *Utilizing Cash and Voucher Assistance with Gender-based Violence Case Management to Support Crisis-Affected Populations in Ecuador*: Learning Brief, December 2019.