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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 equality 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.

Acronyms

| | |
|-------------------|----------------------------------------|
| COVID-19 | Coronavirus Disease |
| CVA | Cash and Voucher Assistance |
| FGD | Focus Group Discussion |
| GBV | Gender-based Violence |
| HIV | Human Immunodeficiency Virus |
| IDP | Internally Displaced Person |
| IPV | Intimate Partner Violence |
| KII | Key Informant Interview |
| MISP | Minimum Initial Service Package |
| NGO | Non-governmental Organisation |
| RGAs | Rapid Gender Analysis |
| SARS-CoV-2 | Novel Coronavirus |
| SRH | Sexual and Reproductive Health |
| STI | Sexually Transmitted Infection |
| TPID | Temporary Protection Identity Document |
| UN | United Nations |
| UNHCR | The UN Refugee Agency |
| WHO | World Health Organization |





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Introduction

First declared a pandemic by the World Health Organization (WHO) in March 2020, the novel coronavirus, SARS-CoV-2, continues to cause unprecedented global impacts more than one year on. Many countries, still grappling with the immediate public health emergency created by the rapid and ongoing spread of coronavirus disease (COVID-19), are now contending with a lack of availability, equitable access to, and distribution of vaccines, particularly in the Global South.

GENDERED IMPLICATIONS OF COVID-19

Public health emergencies affect women, girls, boys, men, and persons of all genders differently. As the global crisis has evolved, CARE has worked to understand the pandemic's gender implications, including by adapting its Rapid Gender Analysis (RGA) toolkit to implement a Global RGA on COVID-19 and by conducting RGAs covering 64 countries. Since 2015, CARE has led 57 projects in 20 countries to fight the spread of epidemics such as cholera, Ebola, and Zika. CARE's work in these responses, lessons learned from past public health emergencies, and RGAs since the onset of the pandemic show that the impact of COVID-19 in resource-poor contexts and humanitarian and fragile settings is disproportionately affecting women and girls in virtually every facet of their lives, particularly their health and protection.⁷ In previous public health emergencies, governments and health care actors have diverted resources from routine health services towards containing and responding to the outbreak or epidemic, constraining already limited access to SRH services, such as clean and safe deliveries, contraceptives, and pre- and post-natal care for women and adolescent girls.⁸ Past experience, including with the Ebola epidemic in West Africa, demonstrates that as access to critical services—including family planning and maternal health care—is restricted or sidelined, total deaths from other health

⁷ CARE, "Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings", March 2020.

⁸ Gender in Humanitarian Action (GiHA), "The COVID-19 Outbreak and Gender" (date unknown).

concerns can outnumber the direct deaths from the epidemic itself.⁹

During times of crisis, the prevalence of GBV increases due to multiple risk factors created by the emergencies themselves, as well as their effect on pre-existing gender inequalities within households, communities, and societies.¹⁰ Domestic violence may be the most common type of violence that women and girls experience during emergencies,¹¹ particularly where movement restrictions, including lockdown measures, can trap women and girls with their abusers, as in the case of COVID-19.¹² However, at a time when many women and girls need GBV services more than ever, evidence suggests that those services are likely to decrease as resources are diverted to the health crisis response and/or accessing any available services becomes more difficult due to movement restrictions.¹³

FORCED DISPLACEMENT AND COVID-19

More than one year into the pandemic, evidence is growing of its impact on immediate humanitarian needs and longer-term outcomes for people in vulnerable situations and marginalized populations, significantly setting back hard-won gains and magnifying inequalities. As part of its Women Respond Initiative, CARE has gathered stories of how the virus and the way societies have responded to it have pushed already marginalized people into further risk and vulnerability.

Among the most vulnerable to both the health emergency caused by COVID-19 and the parallel socio-economic crisis are the more than 80 million people worldwide affected by forced displacement, approximately half of whom are women and girls.¹⁴ The majority of forcibly displaced people live in resource-poor countries with weak public health and social protection systems, and economies that are unable to cope with the enormous strains of COVID-19. The UN Refugee Agency (UNHCR) has warned that COVID-19 containment measures have disproportionately affected refugees and forcibly displaced people, pushing them deeper into poverty, reducing incomes and job opportunities for those working in the informal economy, and constraining their ability to access durable solutions.¹⁵

However, to date there has only been limited research around the unique ways in which women and girls on the move are affected by the pandemic or how service providers can meaningfully adapt their programming to address the new and different vulnerabilities, needs, and risks that these women and girls face. 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: 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. CARE chose health and protection as the specific themes, given past learning on how their outcomes and service access and utilization are particularly impacted during public health emergencies and because of the pre-existing vulnerabilities that women and girls on the move experience in relation to being protected and staying healthy.

⁹ CARE, *COVID-19 Adaptation & Response Strategy (May to December 2020)*, May 2020

¹⁰ CARE, *Gender-Based Violence and COVID-19: The Complexities of Responding to the Shadow Pandemic*, May 2020.; See also CARE, "A Framework for addressing Gender-Based Violence in Emergencies", April 2019.

¹¹ International Rescue Committee (IRC), *Private Violence, Public Concern*, January 2015.

¹² United Nations (UN), *Policy Brief: The Impact of COVID-19 on Women*, April 2020.

¹³ CARE, "Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings", March 2020.

¹⁴ UNHCR statistics.

¹⁵ UNHCR, *COVID-19 Supplementary Appeal*, December 2020. See also UNHCR, "UNHCR's Global COVID-19 Needs", February 2021.

AFGHANISTAN

After 40 years of war, recurrent natural disasters and crises, humanitarian needs show no signs of abating and poverty is deeply entrenched. There are more than 3.5 million conflict- and disaster- induced IDPs in Afghanistan with some 97,000 people newly displaced in 2021 as ongoing conflict, a deteriorating security situation, and drought-like conditions in parts of the country once again drive people from their homes and leave people in need of life-saving support. Since the COVID-19 pandemic began, a record number of undocumented Afghan refugees—an estimated 824,000 people—had returned from Iran and Pakistan as of November 2020. Returns have continued in 2021, with UNHCR recording more than 103,000 undocumented Afghan returnees in March.

As of May 2021, there were more than 64,000 confirmed COVID-19 cases and 2,700 deaths in Afghanistan, although the true scale of the pandemic is likely to be significantly higher. CARE Afghanistan's 2020 RGA noted the significant impact of COVID-19 containment measures on the socio-economic situation in the country, the inability of the weak health system to cope with the pandemic response, and the impact of COVID-19 on the delivery of humanitarian assistance. A projected 18.4 million people are in need of humanitarian aid in 2021, more than two-thirds of whom are predicted to be in "catastrophic" or "extreme" need. COVID-19 has had significant consequences on incomes and, combined with ongoing conflict, food insecurity is now on par with the 2018-2019 drought. As a result, Afghanistan has the second-highest number of people experiencing emergency food insecurity in the world.¹

ECUADOR

Throughout 2020 and early 2021, Ecuador was in the midst of an acute economic and political crisis, aggravated by the pandemic. The Venezuelan crisis has also significantly impacted Ecuador, with more than 431,000 Venezuelan migrants, refugees and asylum seekers sheltering in the country as of April 2021. Of these, only an estimated 8% have received residency permits or regular stay and just 0.2% have been recognized as refugees by the Ecuadorian government. UNHCR estimates that 50% of all Venezuelans in Ecuador currently live in an irregular migration situation. In July 2019, the Ecuadorian government introduced new measures that made it more difficult for Venezuelans to legally enter the country, pushing more migrants and refugees to enter irregularly and making them more vulnerable to all forms of exploitation, abuse, violence, discrimination, smuggling, trafficking, and negative coping mechanisms. The changes also limit Venezuelan migrants' and refugees' access to social services, health, education, protection, and sustainable livelihoods. In January 2021, the government further set back migrants' and refugees' rights, including by broadening the grounds for deportation under revisions to a previous law. Despite these challenges, UNHCR estimated that 450–500 Venezuelans were entering Ecuador daily through visible paths during working hours in April 2021. UNHCR has also noted population movements of Venezuelans from Ecuador to Colombia due to the lack of livelihoods and people having exhausted all sources of humanitarian assistance.¹

As of May 2021, there were more than 412,000 confirmed COVID-19 cases and 19,000 deaths in Ecuador.¹ CARE RGAs, including one national and one regional, demonstrated the multi-faceted impact of COVID-19 on displaced and vulnerable host communities. Migrants and refugees are competing for very scarce resources to access formal employment, housing, health and education services. Sixty-eight percent of migrants/refugees that CARE surveyed at the end of 2020 had not received any form of humanitarian assistance.

TURKEY

For the past six years, Turkey has hosted the world's largest refugee population with more than 3.6 million Syrian refugees under temporary protection and close to 330,000 refugees and asylum seekers from other nationalities in 2021.¹ The vast majority of Syrian refugees reside in urban areas (98%), living in shared or rented housing and, to a lesser extent, temporary or informal settlements. The high concentration of Syrian refugees in urban centers has created a supply and demand imbalance with many facing difficulties in meeting their basic needs, accessing income-generating and employment opportunities, and stretching already taxed social services. An estimated 1.8 million Syrian refugees (45%) live below the poverty line with extreme poverty more common in female-headed households (10%) than in male-headed households (4%).

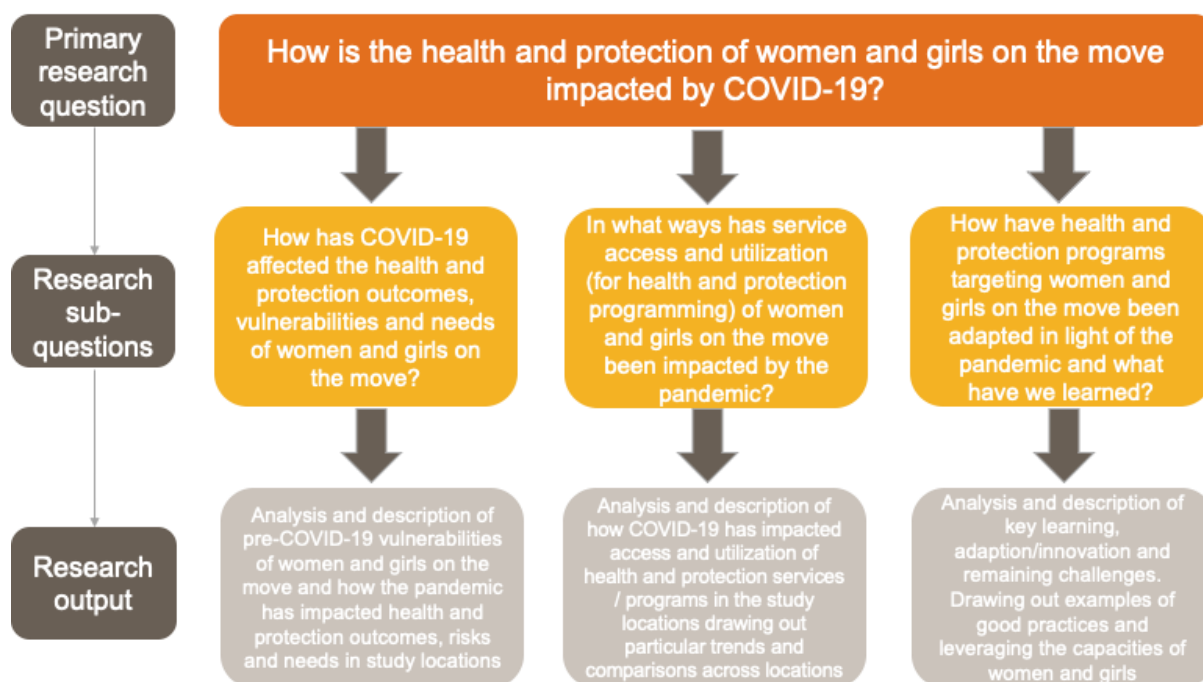
As of May 2021, there were more than 5.1 million confirmed COVID-19 cases and 45,000 deaths in Turkey. At the time of writing, Turkey was grappling with another wave of infections and had reintroduced movement and other COVID-19 restrictions. CARE assessments, including the COVID-19 Impact Assessment and RGA, demonstrated the impact of COVID-19 on Syrian refugees' ability to meet their basic needs as income earning opportunities and informal work were further constrained. The European Union-funded Emergency Social Safety Net (ESSN) multi-purpose cash transfer scheme remains a lifeline for many Syrian refugees in Turkey with recent assessments noting that around one in five female-headed households had no income source other than the ESSN or humanitarian assistance.



Methodology

CARE USA undertook new research in April and May 2021 to examine how COVID-19 has affected the health and protection of women and girls on the move, with the goal of informing programming, policy, and future research. The health and protection research focus areas were guided by CARE's broader gender in emergencies research and approach and learnings from prior public health emergencies.

RESEARCH LOGIC



PRIMARY DATA COLLECTION

The primary data collection was conducted in collaboration with CARE country offices in Afghanistan, Ecuador, and Turkey using a mixed-methods approach including surveys, FGDs, and KIIs.

| COUNTRY | QUANTITATIVE | QUALITATIVE |
|----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Afghanistan 4 provinces (Kabul, Kandahar, Herat, Balkh, including both urban and rural locations) | <ul style="list-style-type: none"> • 88 surveys with women (72% IDPs/returnees) • 89 surveys with adolescent girls (73% IDPs/returnees) | <ul style="list-style-type: none"> • 24 FGDs with women/adolescent girls (221 participants – IDPs and host communities, rural and urban) • 12 KIIs with external stakeholders • 6 KIIs with CARE staff |
| Ecuador 4 provinces (El Oro, Imbabura, Manabi, Pichincha – all urban locations) | 206 surveys with women on the move (refugee and migrants) | <ul style="list-style-type: none"> • 1 FGD with women (11 participants) and 1 FGD with adolescent girls (13 participants, aged 13–17 years) • 5 KIIs with external stakeholders • 3 KIIs and 1 FGD (8 participants) with CARE staff |
| Turkey 3 provinces (Gaziantep, Kilis, Şanlıurfa – all urban locations) | 648 surveys with women (49% Syrian refugee women) * <i>*Subset of a wider household survey of 1,055 households, 53% refugee and 47% host community; 61% women</i> | <ul style="list-style-type: none"> • 5 FGDs with Syrian refugee women (44 participants, aged 18–24 years) • 10 KIIs with external stakeholders • 8 KIIs with CARE staff |

LIMITATIONS

The primary information collected for this research complements and build on data CARE gathered in the three countries before and during the COVID-19 pandemic, including existing comparable data used to avoid gathering new data where appropriate. This was particularly the case for Ecuador, given the extensive quantitative and qualitative data already available. Where this limits the comparability of the data across the three countries, this is noted.

CARE sought to survey adolescent girls (aged 10–19 years) for this research, to better understand how the age of the respondent intersects with their gender to affect need. For various reasons, including COVID-19 movement restrictions, CARE could only accomplish this in Afghanistan. However, CARE collected complementary qualitative data with young Syrian refugee women (aged 18–24 years) in Turkey and migrant and refugee adolescent girls (aged 13–17 years) in Ecuador.

Finally, the scope of the research called for a focus on stakeholders, including humanitarian partners and health and protection service providers such as international, national and local non-governmental organizations (NGOs), UN agencies, national governments, and local authorities. In total, CARE conducted 27 KIIs with stakeholders across the three countries, although these were mostly from local partners/NGOs, national governments, local authorities and line ministries, including authorities with responsibilities towards women, public health, and refugee/displacement. While CARE asked partners questions about program adaptation and learning, in some cases there was a lack of sufficient detail to highlight this research sub-question in the report. To complement this, CARE conducted 19 KIIs and FGDs with CARE program and field staff to draw out adaptations, learning, and good practices during COVID-19. Case studies in this report show how CARE has adapted programing to respond to new and growing needs.



Impact of COVID-19 on Access to Health

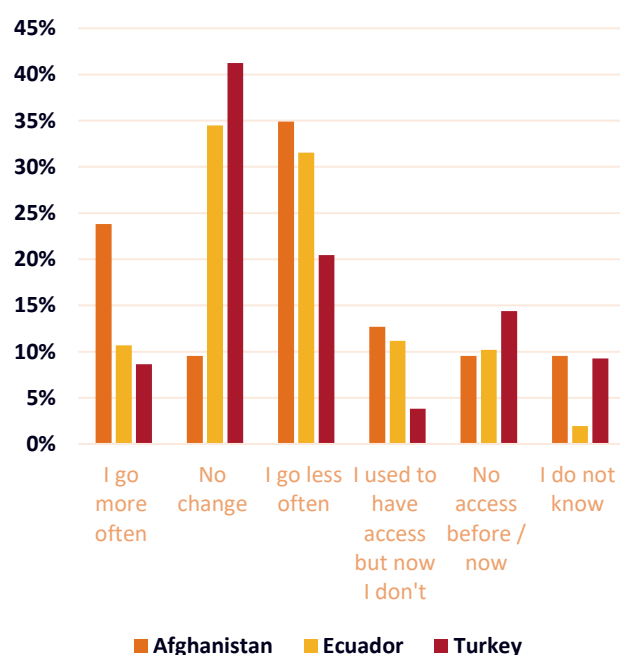
ACCESS AND USE OF HEALTH SERVICES DURING COVID-19

Across all three countries, COVID-19 has significantly impacted access to and utilization of health services for women on the move.

Almost 4 in 10 women on the move across Afghanistan, Ecuador, and Turkey (an average of 38%) reported having “less” or “used to have access but can no longer access” regular health check-ups and other health services since the pandemic began (48% in Afghanistan, 43% in Ecuador, and 24% in Turkey). Women with less or no access to health services are likely to have been in that situation for more than one year, given the onset of the first waves of COVID-19 in each location by March 2020.

These figures are stark—in terms of the potential impact on health outcomes for women on the move—but are even worse when looking at access in general. On average, an additional 11% of women on the move across the three countries reported not having had access to health services before the pandemic and that they were still not able to go during the pandemic (10% in Afghanistan, 10% in Ecuador and 14% in Turkey). Comparable data between displaced and host populations in Afghanistan and Turkey demonstrates

Impact of COVID-19 on access to health services



the increased vulnerability of women and girls on the move, with COVID-19 compounding their already limited access to health care.

Even before the pandemic, displaced and host communities in Afghanistan faced significant challenges accessing adequate health care, given that the system is weak and overburdened.¹⁶ Cultural norms and limitations on women's freedom of movement, including the practice of a male family member accompanying a woman when she leaves the house, further strain women's and adolescent girls' ability to access health services.¹⁷ IDPs, particularly those living in rural informal settlements, have the most significant access challenges. Twenty-one percent of rural IDP women reported no pre-pandemic access to health care and 52% reported less access, or that they were no longer able to access health care during COVID-19. This means that a staggering 73% of rural IDP women have had less or no access to health services during the pandemic. In Afghanistan, the only country where survey data was collected among adolescent girls, 43% of IDP adolescent girls reported that they had less or no access to health check-ups and other health services now (slightly lower than the 48% found for women on the move in Afghanistan), and 12% had no previous access (compared with 10% for women).

“The biggest challenge in our community is that we still do not have health clinics. For treatment we go to mobile clinics which rarely go to our village. We need a health clinic at our village level.”

Rural IDP woman living in Balkh, Afghanistan

KIIs with government health officials in Balkh, Herat, Kabul, and Kandahar provinces confirmed that health systems across the country, already unable to provide adequate services in rural locations, are similarly unable to cope with the additional burden created by COVID-19.

In Ecuador, health care access is highly gendered and variable for women on the move. A previous study conducted by CARE found that 88% of migrant and refugee women who reported needing health care were unable to access it.¹⁸ Barriers included lack of money to cover costs of care or medicines; discrimination and xenophobia (including health care personnel refusing to provide services); lack of documentation; and lack of information on how to access medical services. In data gathered for this research, 43% of migrant and refugee women said that during COVID-19 they accessed health care services less often or could no longer access previously available services, demonstrating the significant impact of the pandemic on already limited access to health services.

KIIs with local partners in Ecuador confirmed that the pandemic is challenging the health care system. One partner running a health center noted that they are receiving referrals from the public health centers more often during the pandemic and that this is putting services under increased pressure with detrimental impact

“My daughter was sick; she got a fever and was unconscious and I had to take her to hospital. She had access [to the health care services] because of her father, who is Ecuadorian, but later I had problems when we changed hospitals because she was a foreigner, and they did not want to receive her because she did not have a foreigner code. I had a very difficult time.”

Venezuelan migrant mother in Ecuador

on morbidity and mortality rates. When asked whether migrant and refugee populations were included in government response plans, partners told CARE that government plans were still developing. In some

¹⁶ CARE Afghanistan, *Rapid Gender Analysis COVID-19*, July 2020.

¹⁷ Oxfam, “A New Scourge to Afghan Women: COVID-19 Briefing Note”, April 2020.

¹⁸ CARE, *An unequal Emergency: CARE Rapid Gender Analysis of the Refugee and Migrant Crisis in Colombia, Ecuador, Peru and Venezuela*, June 2020.

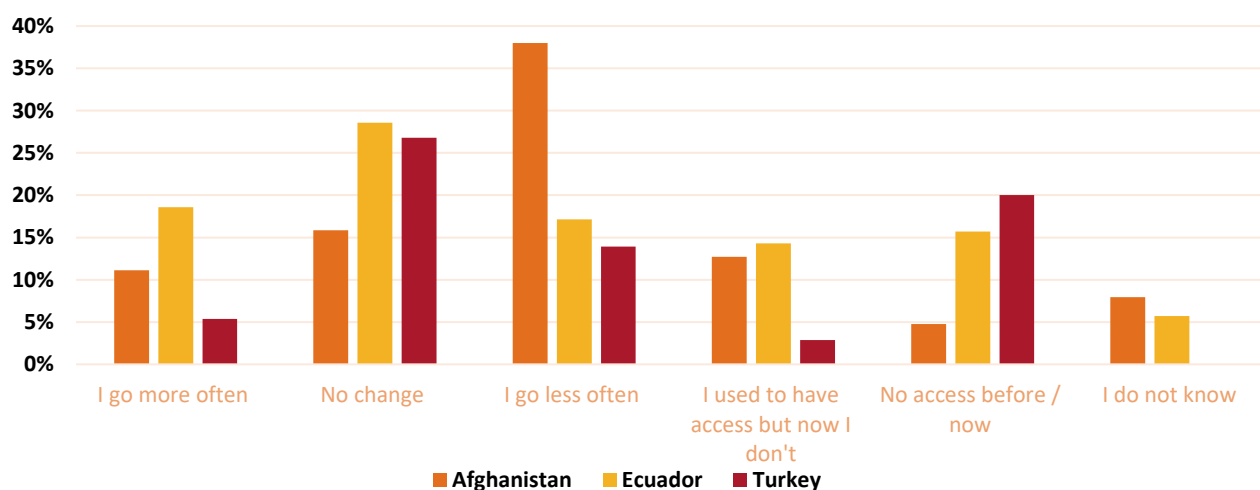
locations, older migrants are being included in response plans; in others, partners noted that it is humanitarian organizations like CARE that are mostly responding to the needs of migrant and refugee populations.

In Turkey, more host community women (43%) than Syrian refugee women (24%) reported less or no access to health services. However, this should be contextualized: 14% of refugee women reported that they had no pre-pandemic access to health care services, compared to 3% of host community women. This indicates that many refugee women faced greater challenges in accessing health services than Turkish women prior to the onset of COVID-19. In general, Syrian refugees with temporary international protection can access the Turkish public health care system. However, refugee women reported that lack of a Temporary Protection Identity Document (TPID)—government refugee registration—language barriers, and financial resources to afford paid services in health facilities were some of the barriers that prevented them from accessing health services before the pandemic.¹⁹

ACCESS AND USE OF SRH SERVICES DURING COVID 19

Research findings demonstrated significant and dangerous impacts on access to SRH services for women on the move during COVID-19 in all three countries.

Impact of COVID-19 on access to safe maternity care



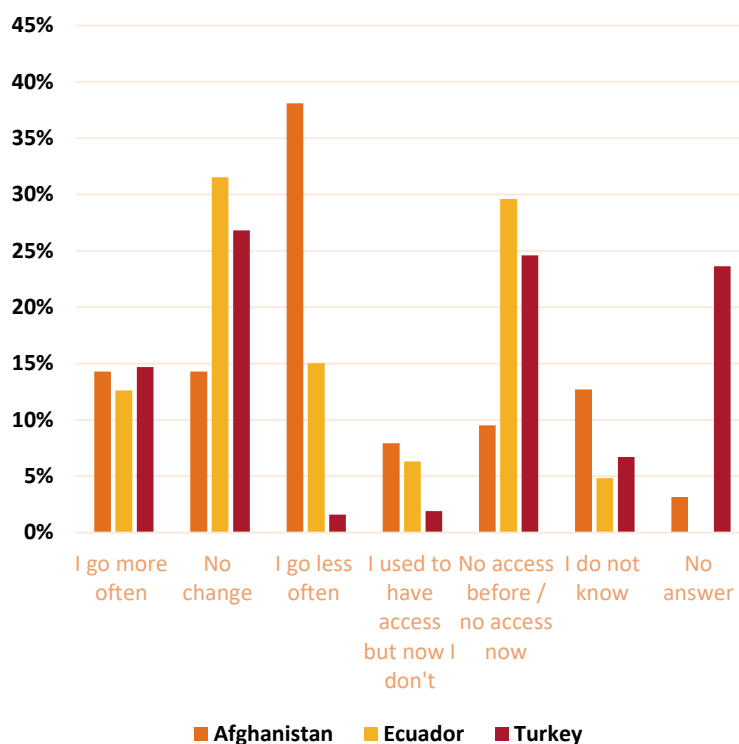
On average, one-third of women reported that they go less often or no longer have access to safe maternity care with women and girls reporting worse impacts in Afghanistan (51%) and Ecuador (31%) compared to Turkey (17%). As with general health data, these figures should be considered in terms of totality of access, with an additional 20% of women in Turkey, 16% in Ecuador, and 5% in Afghanistan reporting that they had no access to maternity care before COVID-19 and were still not able to access maternity care during the pandemic.

In terms of family planning counseling and SRH services in general, 46% of women in Afghanistan, 21% in Ecuador, and 4% in Turkey reported having less or no access at the time of data collection. The Turkey data should be read considering both the high number of women who reported not having access before the pandemic and still not being able to access SRH services during the pandemic (25%), as well as a high proportion of women choosing not to respond (24%).

¹⁹ CARE Turkey, *Rapid Gender Analysis MENA – Turkey Program*, April 2020

Across the three countries, women on the move in Afghanistan reported the most significant changes in access to SRH services during COVID-19 with 51% reporting less or no access to safe maternity care and 41% reporting less or no access to family planning and SRH services in general. Among adolescent girls on the move in Afghanistan, the trend is slightly lower with 17% reporting less or no access now to SRH services, although this figure should be caveated with the fact that 34% of adolescent girls chose not to respond to this question. In general, IDP and refugee returnee women reported more significant negative changes to their access to safe maternity care and family planning and SRH services during the pandemic than women in host communities (51% compared to 40% for safe maternity care; 46% compared to 40% for family planning). The lack of functioning health services and long distances affect women’s access to maternity and family planning services, particularly in rural settings, and raise significant concerns that COVID-19 could lead to increased rates of maternal and newborn morbidity and mortality.

Impact of COVID-19 on access to family planning and SRH services



In Kandahar, Afghan women in IDP settlements told CARE that they are no longer able to access contraceptives, a devastating revelation after the gains made around family planning counseling in a traditional culture. In Balkh, women mentioned that COVID-19 had left them “away from everything. We stay in our homes always and therefore we cannot get [SRH/family planning] awareness and instructions... We have no access to the health centers and most women give birth in their homes.”

IDP women living in informal settlements in Afghanistan

In Ecuador, the picture was slightly different—higher proportions of women on the move (30%) reported pre-existing access challenges around family planning and SRH services in general. These challenges have persisted since the beginning of the pandemic. A CARE Ecuador survey conducted in 2020 found that, while there is widespread knowledge of contraceptive methods, only 53% of migrant and refugee women were able to access contraceptives.²⁰ More women aged 18 to 24 years reported less or no access to safe maternity care (38%) during COVID-19 than 28% of older women. This reduced access is having devastating consequences related to unwanted pregnancy in Ecuador, which has the second highest rate of adolescent pregnancy in South America.²¹ Recent complementary CARE research concluded that issues with SRH service provision are further compounded for migrants and refugees; in previous KIIs, government and other service providers noted that

²⁰ CARE, *An unequal Emergency: CARE Rapid Gender Analysis of the Refugee and Migrant Crisis in Colombia, Ecuador, Peru and Venezuela*, June 2020

²¹ See: <https://elpais.com/sociedad/2021-04-29/el-constitucional-de-ecuador-despenaliza-el-aborto-en-casos-de-violacion.html>.

women on the move were unaware of their rights or available services and how to access them.²²

In Ecuador, an adolescent migrant girl told CARE about her frustrations in trying to access SRH counseling during the pandemic and being told that she had to make an appointment. When she tried to make an appointment over the telephone, she was told that it was full, and she had to go to another center. Migrant and refugee women in Ecuador also talked about access to gynecological checkups and the distribution of contraceptive supplies and not being able to afford some medicines which were previously available free of charge and now have to be paid for.

Venezuelan migrant/refugee women and adolescent girls in Ecuador



²² CARE Ecuador, Project Without Borders – Baseline Assessment, December 2020

Finally, in Turkey, while just 4% of Syrian refugee women reported that they accessed family planning and counseling less often or not at all during COVID-19, a higher proportion of women reported that they had no access to family planning and counseling (25%) and safe maternity care (20%) before the pandemic. However, unlike respondents in Afghanistan and Ecuador, 24% and 31% of women chose not to answer these two questions, potentially indicating the cultural sensitivities around family planning and SRH in the Syrian context.

With a high proportion of Syrian refugee women and Turkish host community women not responding, it is difficult to determine reliable trends in terms of displacement status. It is worth noting that FGDs conducted with young Syrian refugee women found that Syrian refugees in general did not access family planning and SRH services, apart from maternity care, before the pandemic.

“The suffering of access to health services in general is the same for [SRH] services. Many Syrians go to private hospitals even though the cost is more because the treatment is better. In the hospitals sometimes they complain about the number of children Syrians are giving birth to and tell us we should do family planning,”
21-year-old Syrian refugee woman living in Gaziantep, Turkey

These figures are stark and, in Afghanistan and Ecuador in particular, reflect the threat of important gains in SRH awareness raising, access to, and utilization of services being rolled back as a result of the pandemic. In Afghanistan, Ecuador, and Turkey, KIIs with a variety of external actors, including government authorities and health service providers, confirmed that SRH service provision has diminished due to the priority given to the COVID-19 health response. These findings are echoed by others, with one regional organization in the Americas noting that COVID-19 could erase more than 20 years of progress in reducing maternal mortality and increasing access to family planning.²³

²³ Pan American Health Organization (PAHO), ‘COVID_19 Causing Devastating Impacts on Women Says PAHO Director’, 26 May 2021.

ECONOMIC IMPACT COMPOUNDING HEALTH OUTCOMES

The economic effects of the pandemic are contributing to poorer health and food security outcomes, particularly for women and girls on the move. Already vulnerable to economic shocks, COVID-19 is pushing forcibly displaced people worldwide deeper into poverty. Particularly affected are those who work in the informal economy and whose incomes, according to UNHCR, are projected to drop by 82% in the countries where most forcibly displaced people are located.²⁴ As a result, displaced households in Afghanistan, Ecuador, and Turkey are resorting to negative food security coping mechanisms and reducing household health care expenditures, compounding the diminished access to basic health care already described.

In Afghanistan and Turkey, data collected for this research shows that 67% and 70% of women on the move, respectively, reported a decrease in household income during COVID-19. In complementary data available for Ecuador, when migrant/refugee women were asked about the extent to which the pandemic had interrupted their current sources of income, 67% said “completely” and 31% “partially.”²⁵

“Our main concern is food shortages ... People have nothing to eat during this time and many times we are having to sleep hungry... We have not received support from anybody.”

IDP woman living in an informal settlement near Kabul, Afghanistan

“A woman is also affected by the emotional part because she has to perform miracles with food and ensure her children eat every day. We women have the hardest part, we must make food work for the whole family.”

55-year-old Venezuelan migrant/refugee in Ecuador

CARE'S COVID-19 PROGRAM ADAPTATION – AFGHANISTAN

With funding from the in-country UN Office for the Coordination of Humanitarian Affairs (OCHA) Humanitarian Fund, CARE resumed its mobile health response in Balkh province during COVID-19. This was important given the pre-existing barriers to accessing basic health care that IDPs, refugee returnees, and vulnerable host communities faced, barriers that were compounded by COVID-19 movement restrictions. In addition to regular services—such as pre- and postnatal care, family planning, and routine vaccinations—the team included COVID-19 response activities, surveillance (referrals), and community-level awareness raising. Through its three mobile health teams, CARE Afghanistan reached more than 37,000 vulnerable women, girls, men, and boys with basic health care and COVID-19 prevention and response activities.

CARE also deepened its approach to community-based health services, recruiting community health workers (CHWs). With more than 32 CHWs now in place, these women are continuously raising awareness about COVID-19 and providing basic health care to communities that would otherwise struggle to access services. CARE has also set up health shuras (councils), and Community Health Action Groups consisting of 12–15 women) to further support a community-based response, including provision of information and referrals.

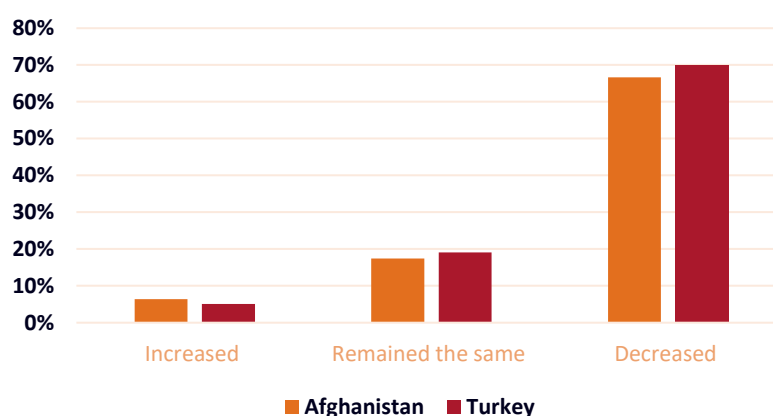
²⁴ UNHCR, “UNHCR’s Global COVID-19 Needs”, February 2021.

²⁵ CARE Ecuador Post CASH and Food Distribution Monitoring, April – December 2020

In terms of ability to meet food needs, 75% of women on the move in Afghanistan and 40% in Turkey reported that the situation had worsened during the COVID-19 pandemic. In Ecuador, 69% of refugee and migrant women reported to CARE that they did not have enough resources to buy food during the previous month.²⁶ More than half of women in Afghanistan and 11% in Turkey also reported a reduced ability to meet health care needs.

To cope with reduced income during the pandemic, women reported that displaced households in their communities had adopted a range of negative coping mechanisms regarding food security, spending savings, and selling assets.

Changes in household income as a result of COVID-19



| SELECT COPING STRATEGIES | AFGANISTAN | TURKEY | ECUADOR* |
|---------------------------------------------------|------------|--------|----------|
| Relying on less preferred and less expensive food | 48% | 36% | 35% |
| Reducing number of meals eaten in a day | 17% | 15% | 42% |
| Spending savings | 22% | 16% | 13% |
| Selling assets | 13% | 5% | 16% |

* Comparable data for Ecuador gathered during CARE Cash and Food Post Distribution Monitoring (April – December 2020)

In Afghanistan, 55% of IDP and refugee returnee women reported borrowing food or relying on help from a friend or relative, 40% purchasing food on debt and 13% sending children under 18 years to work. In Turkey, 44% of Syrian refugee reported going into debt with friends and/or relatives and 37% reported going into debt with shopkeepers. In Ecuador, 54% of migrant/refugee women reported trying to keep working despite COVID-19 quarantine restrictions.

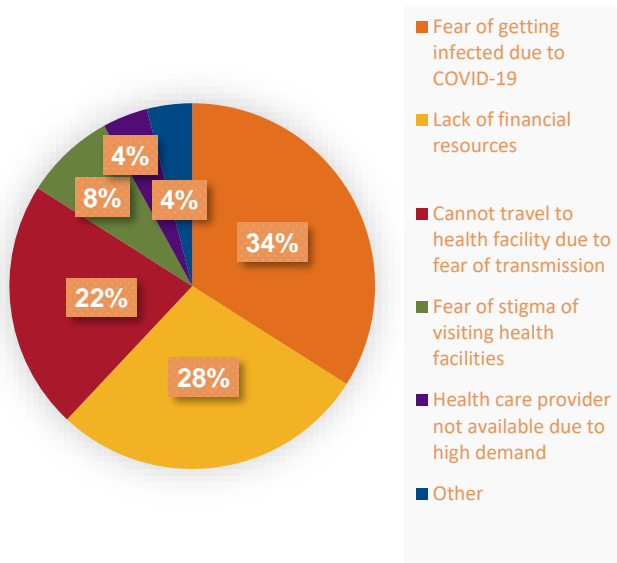
These negative coping mechanisms are stretching displaced households, particularly women, to breaking point. Food shortages are felt acutely by women, who are often held responsible for providing and preparing the family's food.

²⁶ Ibid.

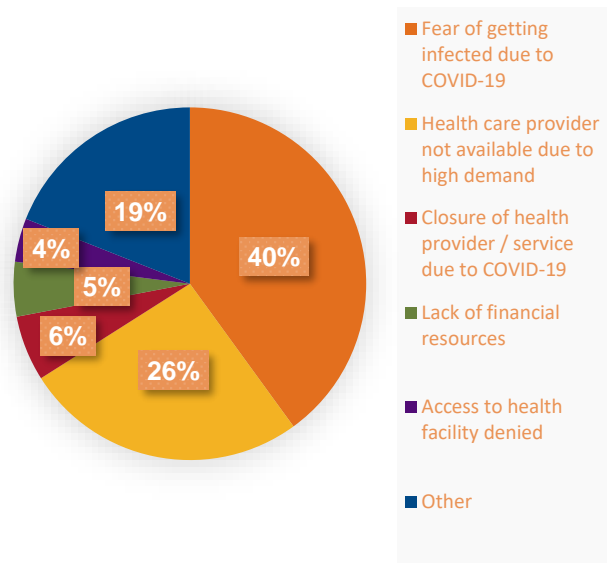
REASONS FOR NOT USING HEALTH CARE SERVICES DURING COVID-19

CARE wanted to understand why women and adolescent girls on the move were going less frequently or no longer accessing health services during the pandemic. Research revealed that COVID-19 has compounded pre-existing challenges, overburdened health services, and depleted women's and girls' financial resources for health care. Furthermore, 40% of women on the move in Ecuador and 34% in Afghanistan reported that fear of contracting COVID-19 prevented them from using available health facilities. In Afghanistan, a further 22% of women cited their fear of contracting COVID-19 if they travelled and another 8% reported fear of stigma associated with visiting health facilities as reasons for not accessing health care. This suggests that even if health care services were available, more risk communication and community engagement is needed to make women feel safe accessing services during the pandemic.

What is the reason for not being able to access health care as frequently as before (Afghanistan)?



What is the reason for not being able to access health care as frequently as before (Ecuador)?



In Turkey, researchers asked why a person was not able to access medical assistance if required during COVID-19. Syrian refugee women were more likely to report that COVID-19 response and containment measures were impacting their access to health services than women on the move in the other countries. Response and containment measures included being unable to access health services because the closest health center/hospital had shut down (18%); priority was given to COVID-19 cases (17%); and that the appointment time scheduled was too late (17%). Many Syrian refugee women reported facing additional problems accessing health care during the pandemic due to the new telephone appointment system required for Turkish citizens and registered refugees to access public hospitals and health services. Syrian refugees, government officials, and NGO representatives mentioned the universal challenges of accessing appointments due to the overwhelmed health system and priority being given to COVID-19 cases. However, Syrian refugee women mentioned that language added an additional barrier, as the system is in Turkish, which many Syrians refugees do not speak, and/or because of reduced translation support at health facilities since the onset of COVID-19. The Turkish government requirement that refugees have a valid TPID to be able to access the system and register for an appointment added another impediment to accessing health services.

“We only go if there is a necessity, especially because now we need to make an appointment through the phone. It is equal access but easier for Turkish people because they speak the language. It’s a challenge for us Syrians as we also need translators [when we speak to the doctors].”

22-year-old Syrian refugee woman in Şanlıurfa, Turkey

CARE'S COVID-19 PROGRAM ADAPTATIONS – ECUADOR

Prior to the COVID-19 pandemic, not all health—especially SRH services—were covered by the public health system and migrants and refugees faced additional barriers to accessing the system due to discrimination and xenophobia.

During COVID-19, available government-run SRH prevention and response activities have largely stopped—this includes programs aimed at decreasing or responding to teenage pregnancy, contraceptive distributions, and sexually transmitted infection (STI) screenings for sex workers. To fill this gap with the already marginalized migrant and refugee communities, CARE Ecuador stepped up its response efforts by building on its previous experience during the Zika response and its long-term HIV programming.

CARE focused on the provision of the MISP, screening and distribution of contraceptives to gay men and transgender women, and SRH rights and awareness raising campaigns. CARE also began providing CVA to vulnerable migrant/refugee and host community households to support them to purchase contraceptives and access basic health/SRH services. Since late 2019, CARE Ecuador, with two main partner organizations, has implemented a protection program using a case management approach that included vouchers for medicine and health services, mainly SRH, at public and private health facilities. The three partners formed a health commission and developed agreements with health institutions to establish a comprehensive referral mechanism and coordinate access to health services. The teams created five different voucher types, including HIV/STI screening, pregnancy tests/SRH screening, and contraceptives; the values of the vouchers were based on the costs and goods determined through local market assessments. The vouchers were paired with complementary services and distributions, including workshops on SRH and GBV as well as work with service providers to support inclusive service delivery.

CARE also prioritized staff training, so that they could continue to carry out face-to-face SRH service provision and strengthen cooperation with existing and new local partners who could access the most vulnerable populations with SRH prevention and response activities.



Impact of COVID-19 on Protection

RISK AND PREVALENCE OF GBV DURING COVID-19

CARE asked women on the move whether they thought the risk of violence and abuse against women and girls in their communities had changed during COVID-19. Thirty-nine percent of women on the move in Afghanistan and 25% in Turkey reported that the risks for women had increased. In relation to risk of violence and abuse for girls, 35% of women in Afghanistan, compared to 16% in Turkey, reported that they believed the risks had increased. Very few respondents in either country—between just 2% and 3%—thought that the risk of GBV had decreased for women and girls during COVID-19.

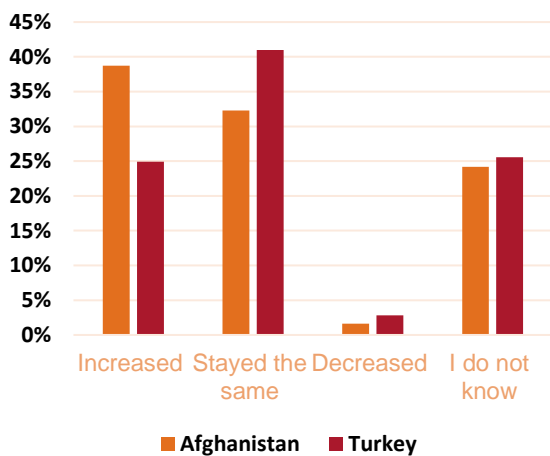
“Domestic violence cases have increased in our settlement since COVID-19 and due to movement restrictions women and girls lose their access to available services.”

IDP woman living in Herat, Afghanistan

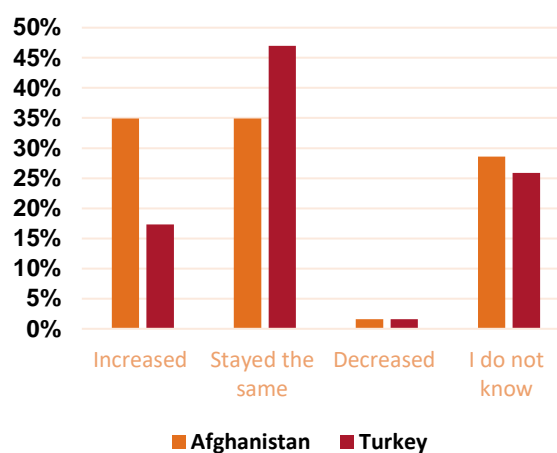
“During COVID-19, we have no jobs, we were all at home and used all the food we had. My husband was sick, and we had nothing to eat so we decided to marry our [young] girl to get food and water for eating and drinking. Our neighbors did not let us do this and helped us with food.”

IDP woman living in Balkh, Afghanistan

Do you think the risk of violence and abuse of women has changed during COVID-19 in your community?



Do you think the risk of violence and abuse of girls has changed during COVID-19 in your community?



On average, more than half (52%) of all women on the move 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. In Turkey, women on the move reported that they didn't have enough separate rooms for children/adolescents (42%), that their accommodation was too overcrowded to live in comfortably during periods of movement restrictions (41%), and that they generally lacked privacy (34%). In Afghanistan, 32% of IDP and refugee returnee women also reported having to share a shelter with another family/additional persons during COVID-19.

“The man who used to have sexist actions, at least went to work for about eight hours per day [but] now problems increase during confinement.”

Venezuelan migrant/refugee woman living in Ecuador

Prior to COVID-19, 87% of women in Afghanistan already reported that they had experienced at least one form of physical, psychological, or sexual violence.²⁷ The practice of child marriage of adolescent girls was also common, according to line ministries previously interviewed by CARE.²⁸ When asked why women believed GBV risks had increased in Afghanistan, the majority cited increased male unemployment as the predominant reason (88% for risks in relation to women and 83% for risks in relation to girls). During FGDs, women and adolescent girls said they believed that domestic violence had increased in their community with men staying at home more due to movement restrictions and increased unemployment and rising tensions due to reduced income. In 3 of the 4 provinces where CARE conducted FGDs (Kabul, Balkh, and Herat), women reported increases in child marriage of adolescent girls in their communities as a coping mechanism in response to the pandemic, confirming the fears of the local authorities that CARE interviewed.

In Ecuador, prior to COVID-19, 65% of women reported having experienced violence at some time in their life, with migrant and refugee women entering Ecuador particularly at risk of sexual aggression and GBV.²⁹ The precarious situation of migrant and refugee women exposes them to trafficking in persons networks and sexual exploitation, including using transactional and survival sex as coping strategies. The proportion of migrant and refugee women who reported that they had been a victim of violence increased from 21% in December 2019 to

²⁷ Oxfam, “A New Scourge to Afghan Women: COVID-19 Briefing Note”, April 2020.

²⁸ CARE Afghanistan, *Rapid Gender Analysis COVID-19*, July 2020.

²⁹ CARE Ecuador, *Rapid Gender Analysis*, November 2019.

27% in April 2021 with the main types of violence reported as trafficking, smuggling, and GBV.³⁰ However, the proportion of migrant and refugee children who reported that they had been a victim of violence reduced slightly in the last few years, from 11% in December 2019 to 8% in April 2021, with the main types of violence being trafficking/smuggling, GBV, bullying, and extortion/threat. Additionally, during a recent baseline assessment, 19% of survey respondents reported knowing about GBV cases in their neighborhood with physical violence against women and girls (77%), emotional violence (18%) and sexual violence (5%) being the most frequently reported types of violence and abuse.³¹

In Turkey, prior to COVID-19, 38% of women aged 15–59 years had experienced IPV, according to research on domestic violence against women led by the Ministry of Family, Labour, and Social Services, although GBV is likely significantly underreported due to cultural practices, fear of stigmatization, and lack of access to information.³² When asked why Syrian women refugees in Turkey believed that violence and abuse against women had increased in their communities during COVID-19, the majority (91%) reported that it was due to more conflict in the home between husbands and wives. Seventeen percent attributed it to less freedom for women; and 17% to the increased pressure that women are under as primary caregivers and carers. Regarding girls, 70% of Syrian refugee women respondents identified girls being forced into domestic work as an increased protection concern, followed by 19% citing girls dropping out of school and spending more time on the streets; 17% noting girls are being forced to work; and 15% stating girls are being forced to marry.

“Violence is not happening in every home, and we can’t generalize. But yes, violence has increased in the home because men used to go out, change their air and spend a long time outside. Maybe some arguments used to happen, but it would not reach violence level. Men now have to stay longer at home with children and they get annoyed at the noise which has created problems in the house.”

24-year-old Syrian refugee woman living in Şanlıurfa, Turkey

³⁰ CARE Ecuador, Beneficiary Registration Tool, December 2019 to April 2021

³¹ CARE Ecuador, Project Without Borders – Baseline Assessment, December 2020

³² CARE Turkey, *Rapid Gender Analysis MENA – Turkey Program*, April 2020

LOSS OF EDUCATION AND SAFE SPACES

Around the world, COVID-19 has had massive impacts on access to education with many countries at different times suspending in-person learning and shifting to remote or distance learning. In all three countries, there were times in 2020 and early 2021 when education was disrupted.

Girl (and boy) learners living in displacement have lost even more access to education, with 63% of women in Afghanistan and 30% in Turkey reporting that their female children could not continue with their education when it switched to distance/remote learning due to COVID-19 restrictions. While figures are not available for Ecuador, a previous analysis showed that COVID-19 had deepened education inequalities with poorer children (including migrant and refugee children) facing barriers to following education online.

In all countries, educators switched to distance learning—through computers, radio, or television, for example—for extended periods in 2020. In Afghanistan and Ecuador, the primary barrier to female children continuing their learning was the lack of access to television, computers, radio and/or internet. In Turkey, language barriers were also a particular problem, given that language of instruction was Turkish but most Syrian refugees speak Arabic. Women in FGDs in Afghanistan also reported increased threats during this time in terms of child marriage while women in Turkey reported increased in risks for girls having to do unpaid domestic work or work outside the home along with child marriage.

Despite the negative impact of the pandemic on learning for displaced girls (and boys), there is a glimmer of hope in locations where learning has resumed in-person. Ninety-one percent of Syrian refugee women and 95% of IDP/returnee women in Afghanistan reported that their daughters had returned to school, as did a full 100% of adolescent girls in Afghanistan reported that they had returned. While these are not official figures, and more time is needed to analyze the situation, it shows that despite COVID-19-induced educational setbacks, students are returning to the classroom when given the opportunity. This is important, as schools can provide safe spaces for children and many displaced children have already had their education disrupted.



EXCLUSION AND ACCESS TO GBV RESPONSE SERVICES

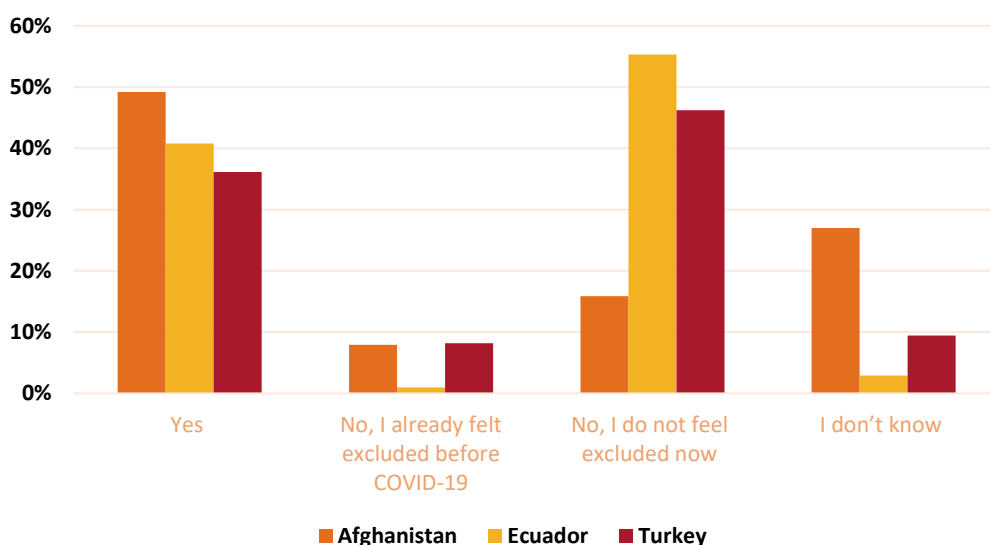
The increased risk of GBV comes at a time when women on the move across all three countries reported feeling more excluded from accessing services in general (49% in Afghanistan, 41% in Ecuador and 36% in Turkey). When combined with “I already felt excluded before COVID-19,” these figures increase to 57% in Afghanistan and 44% in Turkey.

In Afghanistan and Ecuador, women reported that they felt more excluded because of their displacement status or nationality; because they did not have accurate information on where to access services or resources; and because of physical barriers to access, including movement restrictions.

In relation to GBV response services in Turkey, only 4 out of 11 Syrian refugee women in a FGD were aware of whether GBV services were available in their location and all of the women mentioned that people in their neighborhoods needed more GBV prevention and response awareness raising. FGDs in Afghanistan revealed that many women did not think there were any GBV response services available to them, and that the most they could do was to go to elders in their community when they faced a problem. Most women simply said that nothing could be done, and that they don’t complain or tell anyone about any problems in the home. Despite reports of increased violence in the home during COVID-19, many women in Afghanistan told CARE that they believe it remains the safest place for them. By contrast, most women participants in a FGD in Ecuador were aware of GBV response services but also that these services were overwhelmed by the number of cases. Data gathered by CARE in Ecuador in December 2020 demonstrates that significant gaps in GBV service awareness remain—31% of respondents said that they were unaware of service providers or sources of support and assistance, while 70% reported they do not know how to report or refer GBV cases.³³

During times of crisis, it can be more difficult for women to access GBV response services. CARE protection and gender in emergencies staff stated in interviews that they believe this is happening during the pandemic and that women are less likely to access GBV services, including clinical management of rape, psychological first aid, and referrals to other services. COVID-19 movement restrictions are also making it hard for humanitarians to reach women and girls in need. Furthermore, CARE case management teams reported that it is more difficult to ensure that GBV survivors can access appropriate responses due to frequent changes in referral pathways; unavailability of some responses such as psychosocial support; or the need for COVID-19 testing in order to access government services, like reporting cases to the police.

Do you feel more excluded from accessing services and resources since the onset of COVID-19?



³³ CARE Ecuador, Project Without Borders – Baseline Assessment, December 2020

ACCESS TO REGISTRATION AND DOCUMENTATION

For people on the move, refugee registration with government authorities and/or organizations like UNHCR, as well as access to legal and civil documentation, such as birth certificates, is often essential to secure legal stay and access basic services. A difficult process at the best of times, 37% of women on the move in Ecuador, 22% in Afghanistan, and 19% in Turkey reported that COVID-19 had resulted in new or additional challenges to registering or acquiring legal and civil documentation. Challenges were primarily directly related to inability to travel due to movement restrictions, the service no longer being available during COVID-19, and increased time needed to access services.

In Ecuador, these problems are exacerbated by an already difficult policy environment that can hinder Venezuelan migrants/refugees from regularizing their stay. UNHCR estimates that some 50% are living in an irregular migration situation³⁴, which severely affects their ability to earn a living and access services including health care, as discussed in the previous section. While proving legal stay is not required, in theory, to access the public health care system, migrants and refugees have reported discrimination including in relation to lack of documentation.

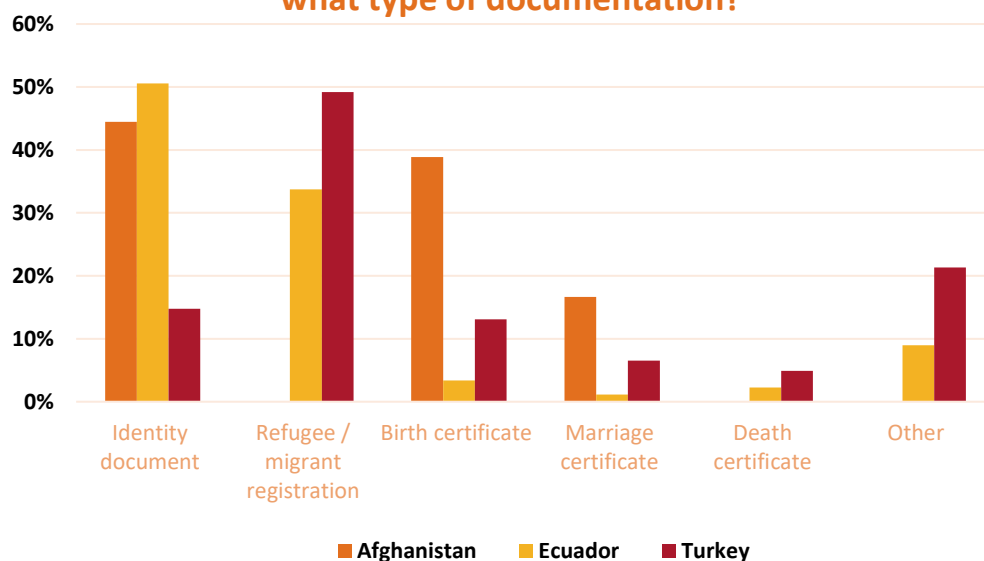


© Mary Kate MacIsaac/CARE

In Turkey, most Syrian refugees have been able to register under the temporary international protection system but must regularly go to the government department in charge of refugee affairs to update their profiles with, for example, the birth of a new child, a marriage, or during regular verification exercises. During COVID-19, the government suspended these services in full for six months. This closure negatively affected a system that, according to most reports, was already not working well and lacked clear procedures for how refugees (and the organizations trying to support them) could follow up when issues arose. Without a valid TPID, Syrian refugee women spoke of the challenges of getting an appointment via the new online health booking system.

³⁴ UNHCR, 'Ecuador Monthly Update April 2021'.

If you faced challenges accessing documentation, what type of documentation?



CARE'S COVID-19 PROGRAM ADAPTATIONS - TURKEY

In March 2020, Turkey entered its first period of movement restrictions and curfews, impacting the ability of CARE staff to continue regular programming to support Syrian refugees and host communities across southeast Turkey. While CARE Turkey undertook specific, and in many ways innovative, adaptations as programming moved to remote-based implementation, the team also decided to review the ways in which Syrian refugees could access CARE.

CARE established a national COVID-19 hotline to: (1) respond to questions, needs, and concerns amongst Syrian refugees and host communities; (2) provide immediate translation services for Syrian refugees facing barriers accessing Turkish service providers, such as health care; (3) provide information on CARE services nearby and those of other organizations; and (4) provide legal counseling to vulnerable persons at risk.

With reduced access to target communities and program participants, the hotline functioned as a way to provide information and protection responses. CARE put in place internal and external referral mechanisms that a dedicated protection staff member managed. CARE continuously updated external service mapping and referral criteria to ensure hotline operators were providing accurate information to callers on where and how to access government and other humanitarian service providers. The program team also updated its referral criteria so that operators could identify protection cases and refer them internally to case management teams for follow up and response. When the pandemic limited CARE's community protection responses, the hotline allowed CARE to continue responding to those most in need.



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Conclusions and Recommendations

COVID-19 is devastating households, communities, and countries across the globe. Yet the public health emergency and the parallel socio-economic crisis it spawned are affecting women, girls, boys, men in all their diversity differently. Among the most vulnerable are women and girls on the move who, due to the intersection of their gender and their displacement status, may face magnified inequalities and compounded risks.

CARE's research in Afghanistan, Ecuador and Turkey paints a dramatic and disturbing picture, not just for the immediate health and protection needs of women and girls, which are often going unmet, but also of the pandemic's impact on long-term outcomes. National governments and the international community must act urgently to ensure that COVID-19 and other humanitarian response and recovery efforts are gender-responsive and focused on preventing women and girls on the move from falling even further behind.

RECOMMENDATIONS

Health

- **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 MISPP³⁵, 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 strengthening and remote approaches for mentorship and support to frontline health workers.³⁶ Appropriate infection prevention and control measures should be maintained.
- **Trust building is critical during the COVID-19 response, and even more so among migrants and refugees who face discrimination and xenophobia.** Health care providers and humanitarian actors should build trust with migrant and refugee populations and engage communities including through social accountability approaches such as CARE's Community Score Card.

Protection

- **All actors should ensure that GBV prevention and response are prioritized as life-saving interventions and included in COVID-19 response plans.** Policy makers should advocate for GBV services and access to justice for survivors to be an essential component of the humanitarian response to COVID-19.
- **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.

³⁵ For more information see IAWG on Reproductive Health in Crisis, 'Minimum Initial Service Package (MISP) Resources'.

³⁶ 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-19 and Other Pandemics and Major Outbreaks', September 2019.

Response

- 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 equality 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 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 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.³⁷ 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. Where possible, CVA should be integrated into case management approaches to ensure holistic responses that include information provision and, when needed, legal and psychosocial support.
- **Development donors should require, and all actors, including governments, implementing partners and donors should work together to ensure that emergency preparedness is integrated with contingency planning** and takes into account and the specific and gendered needs of diverse people on the move.

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³⁷ 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.

