Tapash Paul / CARE

WOMEN AT THE LAST MILE:

How investments in gender equality have kept health systems running during COVID-19

FLAGSHIP REPORT

AUTHORS: Anushka Kalyanpur, Dr. Ihlas Altinci, Dr. Emmanuel Ojwang, Dr. Ikhtiar Uddin Khandaker, Sandya Ganesan, Emily Janoch, Pari Chowdhary

EXECUTIVE SUMMARY

Jennifer Bosel / CARE

Even before COVID-19, investments in health systems—and especially female health workers—were too low. In 2019 the world had a gap of 18 million health workers.[i] **Two years and 15 million deaths later, we have at least 26 million fewer health workers than we need.**[ii,iii] This leaves us severely underprepared for future pandemics and other major shocks to the health system, including conflict and climate change. We must invest in health systems that don't just meet the needs of today, but that are also resilient in the face of future shocks.

Pandemic preparedness requires gender equality: equal recognition, support, and fair pay for ALL health workers. Globally, 70% of health workers are women, but half of their work is unpaid.[iv] We must do more to support these health workers. **The glimmers of success in COVID-19 built on previous investments in women health workers, their skills, and equality in health systems.** Pre-existing investments in equality helped systems respond to COVID-19. Increased investments will build better resilience for the crises that come next.

WOMEN AT THE LAST MILE PROVIDE AND FACILITATE ACCESS TO HEALTH SERVICES.

They include women who are connected to formal health system (such as midwives and community health workers) and those outside the formal health system (such as community volunteers, and women leaders who help hold health systems accountable). Together, they create a health ecosystem for their communities.

This report highlights case studies and lessons learned from 20 countries during COVID-19. The evidence shows that we must invest in gender equality in health systems to prepare for and respond to the next pandemic. Health worker training is not enough. Focusing only on health workers working within the formal health system is not enough.

We need to work for equality.

Gender equality raises life expectancies across entire countries.[v] Investments in health workers could provide a $10 return for every $1 invested in the system.[vi] **In COVID-19, previous investments in gender equality made an important difference for women at the last mile to continue critical services in the pandemic.** There are three common areas for investment that led to success were. First, support women's skills, leadership, and confidence. Second, connect women to each other and to men, leaders, and others in their communities. Third, ensuring equal systems—from access to leadership roles to accessible childcare to social norms that support women's mobility.[vii]

Fair Pay is gender-equal, context-specific, tiered, multi-sourced compensation. This includes salaries for those part of the formal health system and at minimum livelihood, private sector, or social entrepreneurship models for those that operate outside of the formal health system.

HOW HAVE WOMEN KEPT SYSTEMS RUNNING?

By building on investments that came before COVID-19, women have found innovative ways to keep systems running, continuing—and sometimes increasing—health services during COVID-19 and other overlapping shocks to the health system. Some common ways in which women are contributing to resilient health systems are:

- **Providing services and information.** Women in savings groups in Myanmar used their own savings to become first responders and midwives during COVID-19 lockdowns so they could still get health services even when they couldn't reach formal health services. In Bangladesh, Skilled Health Entrepreneurs became certified vaccinators to get COVID-19 vaccines to the last mile.

- **Innovating with technology.** In Syria, health workers used telemedicine consultations to provide sexual and reproductive health services. In Cameroon, peer educators stepped up and provided consultations and services for HIV+ people using WhatsApp, SMS, and other online platforms.

- **Holding systems accountable.** In Malawi, women and young people used Community Scorecards to advocate for an *increase* in the national budget for sexual and reproductive health, even as most countries were cutting those budgets to make room for COVID-19 response. In Niger, women in solidarity groups negotiated for lower rates for women's services at health centers so that the economic impacts of COVID-19 didn't prevent refugee and host women from getting the services they needed most.

- **Building solidarity.** In Colombia, women worked to get mental health services to health workers who were suffering from burnout and other impacts of COVID-19. In Tanzania, health workers focused on building trust with community members—especially young people—to ensure that people got services. In Benin, women in savings groups supported adolescent brides and survivors of GBV to access health and legal services.

RECOMMENDATIONS

Investment in gender equality particularly women health workers must be considered a core preparedness action.

1. Demand a more inclusive definition for Frontline Health Workers (FLHW)
2. Co-design programs, policy, and practice with and for women FLHWs, including Community Health Workers (CHWs) leaders
3. Respect, protect, and fairly pay FLHWs
4. Invest in gender-transformative, multi-dimensional empowerment approaches
5. Develop and prioritize equity and inclusion-based local partnerships led by affected communities, particularly women, refugees, and key populations
6. Scale people-centered, inclusive, and accessible technology solutions
7. Expand market-based approaches for health system resilience

Asafuzzaman Captain / CARE

Background

The COVID-19 pandemic compromised health systems worldwide, and it has had especially devastating effects on the availability and accessibility of sexual and reproductive health including gender-based violence, child health, and mental health services. Diverting health resources towards pandemic response, increased burden and burnout for health workers, lower mobility, growing economic insecurity, and fears of contracting the virus all lowered access to routine health care during COVID-19.[viii] As a result, about 12 million women have been unable to access family planning (FP) services, 86% of countries have reported less access to contraceptive care, and 92% of countries have reported a decrease in institutional births.[ix,x] There are also concerns about the malnourishment of mothers (went from 1 in 20 to 1 in 5 during 2020), increased reports of domestic and gender-based violence against women, and decreased rates of child health and childhood immunizations.[xviii]

The severity of COVID's impact on countries' health systems has varied, but in almost all cases women and girls are disproportionately affected. Even in the United States, one in three women had to delay or cancel visits to health care providers because of COVID-19.[xi] Similarly, in Australia 22% of women reported unmet SRH-related needs, including access to general practitioners, SRH specialists, pharmacies, hospitals, and counseling services.[xii] Studies have shown a 50% decline in family planning use in Bangladesh, decreased rates of contraceptive use in Colombia, and a significant reduction in availability of family planning services, postnatal care, and routine childhood immunizations at primary health centers in Nigeria.[xiii, xiv] In Nepal, the number of young children being treated for severe acute malnutrition (SAM) has fallen by over 80%, and rates of childhood DPT3/Penta3 vaccination have declined in India (-33%) and Pakistan (-66%).[xv] Contending with reduced access to SRH and child health services in addition to the pandemic has placed women at a higher risk of experiencing adverse mental health effects (stress, anxiety, or depression). 63% of women said mental health care was their biggest need by February of 2022.[xvi] Several studies have shown disproportionate mental health impacts among female health workers as compared their male counterparts, and exacerbated mental health issues for pregnant women during the pandemic compared to pre-COVID.[xvii]

When women leaders, including FLHWs, have been able to build on pre-COVID investments and programs in gender equality that developed their technical and leadership skills, agency, and support networks, they have been able to take on key roles to support the resilience of their communities and health systems through the pandemic. Despite these critical roles played by women, investment in them is largely limited to technical trainings as midwives, nurses or community health workers. Furthermore, investment in their agency and pay, recognition by their communities and formal leadership and health structures is severely restricted.

Women leaders at the last mile are often the first—and sometimes only—line of defense against health crisis. Whether they are health workers, members of the farmers' association, or the primary family caretaker when someone gets sick, they are intrinsic to health care. Furthermore, globally, women account for 70% of the health and social care workforce, and provide essential health services for an estimated 5 billion people.[xviii] Primarily serving in nursing and midwifery roles, their services range from sharing health information, to delivering babies, to providing mental health counseling in a crisis. As both formal health professionals and informal community volunteers, women also provide referrals for everything from hospitals to safely give birth, to places for survivors of violence to get support, justice, and care services. Overall, women take on an immense amount of work to ensure that their health systems are not overwhelmed, even though most health systems are massively under-resourced and under-staffed.

EVEN BEFORE COVID-19, INVESTMENTS IN HEALTH SYSTEMS—AND ESPECIALLY FEMALE HEALTH WORKERS—WERE TOO LOW.

In 2019 there was an estimated shortfall of 18 million health workers, primarily in low- and middle-income countries.[xix] Investments in community health workers have been unstable and declining steadily since 2007 for survivors of GBV to access health and legal services.[xx] COVID-19 increased the burden on health workers dramatically, without corresponding investments in increasing or supporting the health workforce. Of 71 World Bank loans to support COVID-19 response and vaccinations, only 11% allowed for hiring surge staff, only 4% paid health worker salaries, and only 7% allowed for hazard pay.[xxi] ACT-A recommends investing $5 billion in health worker training and protection, but that only covers 21% of the number of health workers WHO recommends.[1,xxii] Moreover, women health workers contribute $3 trillion dollars to the global economy every year, but HALF of this work is unpaid and unrecognized.[xxiii] Where they do get paid, they make 28% less than their male counterparts.[xv]

COVID-19 IS PUTTING THE FUTURE OF THE HEALTH WORKFORCE AT RISK.

By 2021, even in the US, 62% of frontline health workers said they COVID-19 has had a negative impact on their mental health. For workers under the age of 30, that number jumps to 75%, and 70% of younger health workers say they are burned out.[xxiv] Health workers in at least 10 countries, from the UK to India, to Zimbabwe and Democratic Republic of Congo, had on strike by April 2021 over the pay, conditions, or support that they failed to receive in COVID-19.[xxv] In the US, 20% of health workers left their jobs during COVID-19.[xxvi] As workers, especially young workers, burn out and go on strike, the health system further erodes, making the risks of the next pandemic much higher. The International Council of Nurses estimates that at least 13 million nurses will be needed by 2030 because of COVID-19 related burnout and the reluctance of new people to enter the workforce if COVID-19 conditions prevail.[xxvii] Up to 87% of health workers in Africa are reporting burnout,[xxviii] and in the Egypt alone, 25% of nurses intend to leave the profession.

If the trend continues, by 2030, the world will have between 25 and 34 million fewer health workers than we need.[2]

GENDER INEQUALITY FURTHER BURDENS WOMEN AT THE LAST MILE.

Gender and social norms and community expectations also result in women health workers working twice as hard as men at work and at home. Unpaid care burdens are dramatically higher for women than they are for men.[xxix] Furthermore, women health workers are often clustered into lower-status and lower-paid (often unpaid) roles, and are further disadvantaged by horizontal occupational segregation with limited investment in leadership/agency training or opportunities for them to step up. For example, of 71 World Bank COVID-19 grants, 90% referred to gender equality in general and all of them included technical trainings for FLHWs. However, only one of them included self-care training and another one required women in leadership. Overall, while they invested in technical trainings, none of the invested in leadership or gender transformative support to FLHWs themselves.

While it is widely acknowledged that women play an integral role in health systems worldwide, they are severely under-represented in health leadership positions. Only 24.7% of the world's health ministers and 25% of senior leaders of global health institutions are women.[xxvi] This has put women-specific health needs at risk of being overlooked, especially with the reshuffling of priorities, policies, and funding to tackle the COVID-19 pandemic. The lack of recognition, protection against discrimination, and decision-making power that women in the health workforce face not only undermines their own well-being and livelihoods, but also negatively impacts delivery of quality care and health system resilience.

[1] WHO recommends 4.45 doctors, nurses, and midwives for every 1,000 people to achieve SDG health goals.

[2] This is calculated updating WHO workforce estimates from 2016, with 2020 numbers from the International Council of Nurses, who estimate that COVID-19 related burnout and deaths will create a gap of 13 million nurses.

Mirwais Nasery / CARE

Methodology

CARE triangulated data from three of its studies to identify and verify programmatic innovations that were developed in response to the pandemic. **This approach intended to gather programmatic evidence and learning from COVID-19 to make the case for greater investments in gender equality, specifically in women leaders including FLHW's agency and pay, relations and recognition with and by their communities and transforming structures as a core preparedness action to ensure continuity of essential health services and facilitate health system resilience.**

1. CARE conducted a rapid landscape analysis of projects that fit the following criteria: a) evidence of an adaptation to ensure continuity of health services that build on investments in gender equality and b) adaptation's demonstrated impact through data on continuity of essential health services including SRHR, Child health, GBV and MHPSS. Identified activities and programs were further categorized into sub-themes: providing services and information; innovating with technology; holding systems accountable and building solidarity.

2. The She Told Us So series synthesized and elevated women's voices from across 38 global, regional and country-specific rapid gender analyses (RGAs) conducted during the pandemic (between March 2020 and February 2022).[xxiv,xxx]

3. 'The Impact of COVID-19 on the Health and Protection of Women and Girls on the Move' report (June 2021), helped to validate preliminary findings from the rapid landscaping.[xxxi] These studies were validated against a literature review conducted by CARE to assess the impacts of health system disruptions as a result of COVID-19.

Results

While not the norm across health systems, the examples in this paper make it evident that pre-COVID investments in agency and technical skills for women FLHWs at the last mile was critical to minimizing the disruption in health services during the pandemic. Investment not only in these women as individuals, but also in gender equality in their communities, transformed the way community members recognized and rewarded health workers, found new ways to ensure last mile health workers got paid, and helped them build networks with each other. They also changed the way health systems operated—from reducing the cost for women to recognizing informal workers as a critical part of the system. Systems that equally paid, protected, and respected women health workers allowed them to leverage their skills to contribute to more resilient health systems during COVID-19.

Learning from this section has critical implications for emergency preparedness and health system resilience across humanitarian and development settings. CARE supported continued access to SRHR services for 2.1 million people between March 2020 and July 2021 as a result of supporting women's leadership and gender equality at the last mile. For example, in CARE Bangladesh, previously capacitated community-based Skilled Health Entrepreneurs in Bangladesh stepped in when COVID hindered clinic-based health-seeking, increasing service provision by 125% for deliveries by skilled birth attendant, 98% for postnatal care, and 162% for referrals between February-May 2020.[xxxii]

This section highlights the key ways in which women leaders mitigated the disruption of health services including SRHR services such as skilled birth attendance, family planning and HIV services, along with childhood immunization, MHPSS and GBV services in locations that had pre-COVID investments in gender equality were made. These include:

1. Women leaders providing surge support to **provide essential services and information** to reduce the burden on the formal health system by leveraging community-based solutions by and for skilled members of affected communities at the last mile.
2. Women **innovating with technology** to provide online medical consultations, awareness raising and referrals in collaboration with global and local women and key-population-led partners.
3. **Women holding systems accountable** by leveraging existing community structures such as adolescent leader girl groups and Village Savings and Loans Associations to ensure rights-based, affordable access to essential services and supplies.
4. Women **banding together and building solidarity** through a variety of approaches to support one another and their communities for mental, psychosocial and physical support while facing the harsh realities of COVID-19.

1. PROVIDING SERVICES AND INFORMATION

Building on pre-pandemic investment in gender equality, during the COVID-19 lockdown, women provided surge support and ensured the resilience of their health systems during crises. They were able to provide services to thousands of people who would not otherwise have had access to primary health care during COVID. With small investments in adaptation and support of these women leaders such as provision of PPE, training on COVID-19 mitigation and management guidelines and additional support to frontline health workers in some contexts through insurance schemes, women leaders were able to leverage their technical skills, community leadership, and COVID-19 knowledge and skills required to step in at the last mile and reduce the burden their local health systems faced during the height of the pandemic.

Emerging core themes of pre-COVID-19 investments that health workers built on to continue providing services and information include:

- Training for women leaders including FLHWs in both technical skills development and leadership.
- Recruiting and supporting women from local communities, which facilitates trust building and familiarity from community members and health providers from similar cultural, socio-economic and other backgrounds.
- Women leaders' contributions being recognized by their communities and by the formal health system.

Existing investments in women leaders, particularly health workers—often dating back more than five years—provided the critical foundation for more resilient health systems that were able to provide services and information well. Some models that made this possible are:

TRUSTED WOMEN HEALTH WORKERS AS ENTREPRENEURS.

At the height of the first COVID-19 lockdown in Bangladesh, access to health care dropped 50%. During this gap, 410 women Skilled Health Entrepreneurs (SHEs) provided health services for 2.8 million people.[xxxiii] They increased post-natal care visits by 98%, skilled birth attendance by 125%, and referrals to formal health services by 162% compared to pre-COVID levels. 100 SHE's even became trained COVID-19 vaccinators to reach people who were not getting shots. This was possible because these women were established, trusted members of their communities—particularly because they share socio-economic, cultural, and geographic backgrounds with their clients. Even when patients were reluctant to call a doctor for help because they thought it would be bothering an important, high-status person, they trusted the SHEs enough to call and ask for advice. SHEs built on 8 years of investments, skills training, and formal recognition from the government of Bangladesh to operate as small health care businesses, as well as a track record of previous success. Between 2012 and 2018, SHEs' work resulted in reductions in neonatal mortality (-9%), infant mortality (-32%), and under-5 mortality (-45%), as well as increases in delivery by skilled birth attendants (24%), ANC (17%), and PNC within two days of delivery (21%). When COVID-19 hit, minor investments—like the provision of PPE, insurance coverage, COVID-19 training--helped ensure local communities could access maternal and child health services.

GBV CHAMPIONS AND COMMUNITY VOLUNTEERS TAKE ON COVID-19 MESSAGING AND EMERGENCY REFERRALS.

In Borno State in NE Nigeria, CARE and its partner HEDCAF worked with mobile clinics, staffed by local female service providers to increase ANC and home delivery services for women and girls during the COVID-19 lockdown. The mobile clinics also provided referrals to health facilities and hospitals, and even invested in ambulances and supplied drugs and medical equipment for patients they had referred to these static facilities. Community volunteers provided services and information to more than 19,000 people. This success built on pre-pandemic investments in the development and training of local community leaders as "GBV champions" and tasked them with conducting community awareness sessions, monitoring GBV risks and incidents, and providing GBV survivors with referrals for medical care, support, and legal reporting. When the pandemic spread to Nigeria, the GBV champions received trainings on COVID-19 precautions. As trusted community leaders, they addressed myths and misinformation to share accurate information on the virus, all while scaling up community-based individualized GBV care services that ensured the continuity of support from the health system for GBV survivors.

WOMEN PROVIDING CARE WHEN HEALTH CENTERS CAN'T.

During the early months of COVID-19, when most public facilities had severely scaled down or shut down service provision, 36 urban Community Health Workers (uCHWs) in Afghanistan continued to provide essential services such as counseling on ANC, PNC, and childhood immunizations, and actually increased their patient-load from 7,964 in the three months prior to the second COVID lockdown (Oct-Dec 2020) to 9,915 in January-March 2021.[xxxiv] Community members were more likely to continue or even improve their health seeking behaviors in areas with the uCHW home-based health post model during the COVID lockdown. For example, uCHWs reported increased utilization of maternal and child immunizations (679%), diarrhea treatment for children (117%), and referral services to health facilities (457%) during the early months of lockdown in comparison to the 3 months prior to the start of COVID-19.[xlii] This built on 15 years of piloting, adapting and scaling up a model of establishing health posts inside the homes of local Community Health Workers in urban areas and training them with the technical skills necessary for maternal and child health care. Their success was based on strong pre-pandemic efforts to invest in gender equality not only in uCHW skills but also in trust and recognition that was developed in their communities over time, including links with local community councils as well as formal recognition in local community centers.[xxxv] The CARE team in Afghanistan was able to quickly provide uCHWs with personal protective equipment and build capacity on WHO protocols for COVID-19 screening, detection, and referral of cases as well as risk communication and community engagement. Together, this approach supported mitigation of more severe impacts of COVID-19 on access to health care during a time when the larger health system was being overwhelmed.

"Considering the knowledge, experience, and respect that I received during this period, I feel like I have a responsibility to my community to carry forward all my training in a useful way. I really want to volunteer to provide response to needy people."

—FLHW, Afghanistan

EMPOWERED FLHWS EXPAND ADOLESCENT-RESPONSIVE PROGRAMMING EVEN DURING OVERLAPPING CRISIS.

Building on pre-COVID investments in FLHWs and community-centered health system strengthening programming by CARE and local Syrian partner, Violet since 2019, FLHWs in the Amal Hospital in Ariha in Idleb, NW Syria, not only withstood relocation of their hospital to Azaz city in Aleppo Governorate in March 2020 and the impacts of COVID-19 but also expanded adolescent-responsive programming.

Prior to COVID-19, CARE and Violet had built capacity of midwives, PSS and CHWs to implement AMAL including technical topics, facilitation and leadership and community-centered gender and social norms. Between October 2021 and March 2022, these workers expanded from focusing only on adolescents themselves to also targeting community and health providers. As a result, they increased adolescent family planning service uptake by 55%. Overall, women were 2.7% more likely to get antenatal care, 21% more likely to access family planning, and 8% more likely to have a delivery by skilled birth attendant.

Violet is one of CARE's several local partners who is currently implementing the AMAL Initiative, an approach designed to improve sexual and reproductive health and well-being of crisis-affected pregnant adolescents and first-time mothers through advancement of inequitable gender, power, and social norms. The AMAL Initiative seeks to create an adolescent-enabling context in its implementation areas by increasing agency and leadership of adolescent girls, improved relations with community and health providers, and transforming structures through adolescent-responsive services and environments.

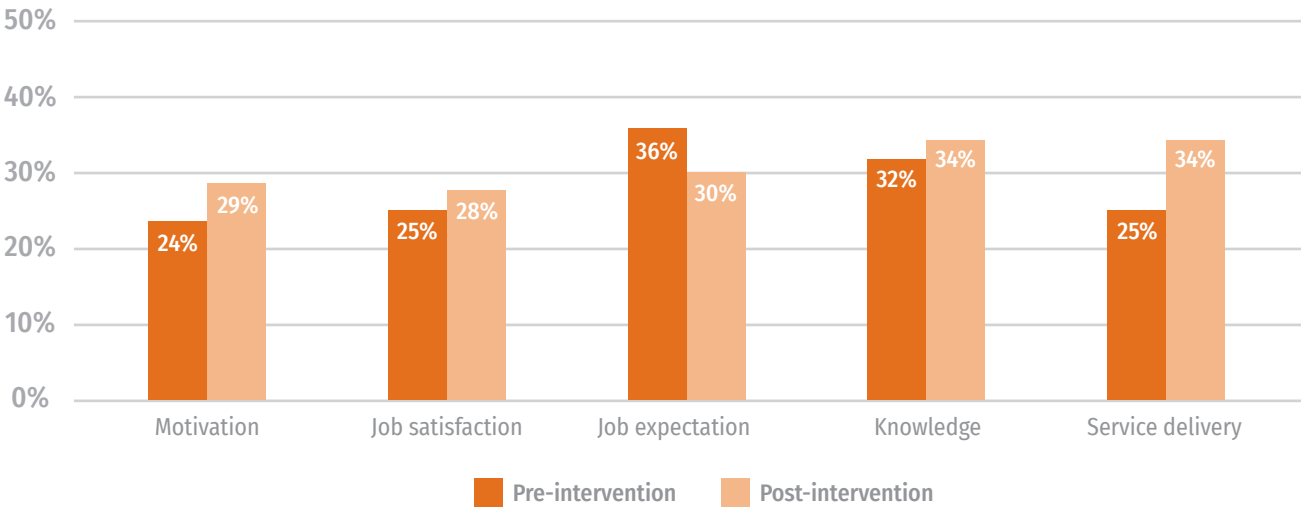
INVESTING IN EMOTIONAL WELL-BEING AND RESILIENCE OF FLHWS SUPPORTS WOMEN LEADERS AND IMPROVES FAMILY PLANNING UPTAKE IN THEIR COMMUNITIES.

Health workers in the state of Bihar in India increased family planning referrals from 36 to 41% between November 2020 and April 2021, even as the COVID-19 second wave was raging out of control. They increased family planning services for newlyweds by 17%, and dialogues between mother in laws and daughter in laws by 8%.

This success built on more than 10 years of work with Accredited Social Health Activists (ASHAs) in the health system in Bihar. Recognizing the valuable work and the growing demands and adverse impacts of COVID-19 on this cadre of workers, CARE India and CorStone collaborated to pilot a program to build the emotional resilience skills among front line workers (that complements years of investment in technical trainings of this by CARE and the government of Bihar). Between November 2020 to April 2021, this initiative designed a curriculum that rolled out trainings to approximately 23,000 ASHAs covering topics including resilience building, goal setting, listening skills, managing difficult emotions, character strengths, assertive communications complemented by skills such as problem solving, integrating mindfulness and relaxation techniques and managing challenging situations. These trainings were delivered through WhatsApp, Google Meet for small groups to demonstrate and practice and other additional technology-based techniques such as Mentimeter increase interest and participation.

As a result, 68% of ASHAs were more likely **to be optimistic about their work and were 4.5 times more likely to have high self- esteem.** 41% of ASHAs were **more likely to be satisfied with their job and 32% were more likely to provide services.** However, 21% had lower job expectations. This investment in FLHWs resilience and well-being was complemented by programmatic interventions between Jan-March 2021 to enhance recognition of family planning as an important life-saving intervention that helps to reduce maternal and infant deaths.

HEALTH WORKERS' SATISFACTION AND SKILLS INCREASED



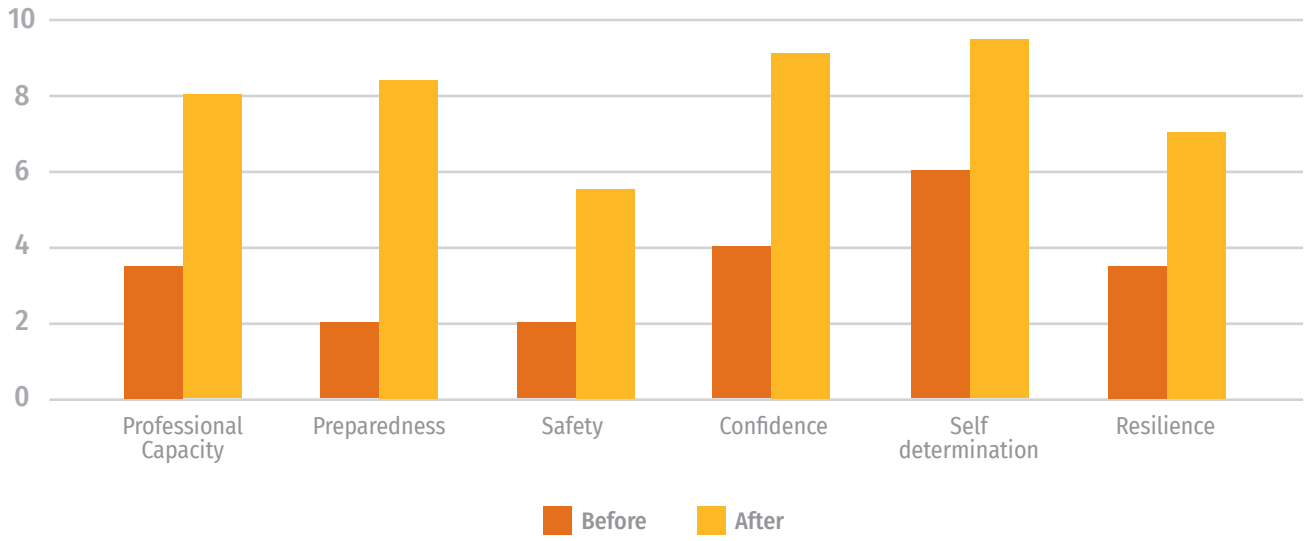
Barbara Rodriquez / CARE

Rosa Panggabean / CARE

BUILDING ON CONFIDENCE AND LEADERSHIP TO EXPAND HEALTH CARE.

In Afghanistan, Colombia, and Uganda, 1,700 frontline health workers reached 109,484 people with COVID response, supported 8,065 new contraceptive users, got prenatal care to 17,934 pregnant women, and got general care visits to 87,290 people.[xxxvi] They did this partly because they were twice as confident in their technical skills, 4 times more prepared, and 30% more likely to feel they had self-determination than prior to this intervention. That helped them deliver services in contexts of overlapping and extreme crisis.

FRONTLINE HEALTH WORKERS' SELF-ASSESSMENT OF FACTORS CONTRIBUTING TO EMPOWERMENT BEFORE AND AFTER PARTICIPATION IN THE CARE-ABBOTT PROGRAM, USING A SCALE FROM 1 TO 10



As part of this initiative, CHWs got trainings in technical skills like COVID-19 prevention, on risk communication and community engagement. They used their new skills to raise their status as community leaders for COVID management and gradually became trusted sources of information and healthcare. All training topics and performance targets were determined with the involvement and input of CHWs, providing them with an additional opportunity to develop their leadership and agency.

The project also focused on investments to motivate health workers—from financial stipends in Afghanistan to special dignity kits for health workers in Uganda. The project also connected health workers to each other so they could build professional skills, influence policy, and help design training packages.

LEVERAGING PRIVATE SECTOR PARTNERSHIPS.

In Bangladesh, CARE identified that garment workers, most of whom are women, couldn't leave work to get vaccines, which meant they weren't getting vaccinated at all.[xxxvii] Building on pre-COVID investments in gender equality among factory owners and garment workers, CARE connected the government to the garment factory owners to extend vaccine training to healthcare staff and women's groups working at garment factories, so women were able to get vaccines without taking time off from work at the factory. CARE was able to leverage existing relationships with the garment factories, private sector and the government. Now other garment factories are replicating this model because it worked so well.

Voices of Frontline Health Workers (FLHWs)

"Compared to before, I'm more skilled at diagnosing and helping people, more trusted and encouraged by the community, prouder of myself, and am earning some money. This program has shown me what I am capable of, and I want to take my ability even further."
—FEMALE FLHW, AFGHANISTAN

"Before COVID, the community didn't really pay attention to us. Now we have a lot of power to make change— when we talk, people listen. It's completely changed how we are perceived and treated." —FEMALE FLHW, UGANDA

"Skills aside, I have learned how to adapt to change. I feel like a stronger person. With all the supports I received, I'm hopeful about what I'll be able to accomplish for myself in the future."
—FEMALE FLHW, COLOMBIA

"Early on, it was scary to be a frontline health worker for many reasons. Fear of getting infected, of being avoided by people, of not knowing what to do to help patients. I lacked the confidence, but with the continuous mentorship from CARE and all the training, I learned how to protect myself and serve others when they needed it."
—MALE FLHW, UGANDA

2. INNOVATING WITH TECHNOLOGY

Women leaders at the last mile used technology to ensure their communities could access information and services—not only on COVID-19 but also on other essential services. Women developed, adapted, and scaled up telemedicine consultations; leveraged existing relationships with health facilities and providers; and used new communication platforms developed for COVID-19 messaging to include pre-recorded messages and hotlines for SRHR, GBV and mental health topics and referrals. Key success factors include:

- Build people-centered, inclusive social media-based outreach using platforms people are already comfortable with (for example, Meta applications like WhatsApp, Facebook and Instagram);
- Center trusted local women leaders, including frontline health workers;
- Build parallel investments in trusted people and offline interactions to complement technology, particularly to reach and impact the most marginalized of groups.

COMBINING TRUSTED LOCAL EXPERTS AND SOCIAL MEDIA.

CARE partnered with Meta to disseminate key messages on COVID-19 to 476 million people in 20 countries. As a result, 8.6 million people likely experienced a positive change in their knowledge, attitude and/or behavior towards the COVID-19 vaccine and/or preventative measures to protect against the virus. "Trusted messengers"—including women health workers and CARE staff—**were one of the biggest drivers** of engagement and attitude changes. Posts with women doctors were by far the most popular, and people were more than 300% more likely to share messages that featured those women.[3] In Somalia, Haiti and Mali, CARE staff were seen as trusted messengers with Haiti's video having a 26% engagement rate for utilizing these messages.

Another key success factor in using technology was taking advantage of health experts' knowledge to focus on specific people, understand their needs, and provide options to connect to new resources. For example, CARE Turkey personalized messages to Refugee Mothers, reached female refugees of child-bearing age. Those messages inspired 6,300+ Taps to "Call Now" encouraged them to get more information through their existing emergency hotline. Women who saw those messages were 3.6 percentage points more likely to feel vaccines were safe—which was a major concern among pregnant women in Turkey. CARE Guatemala translated their video into four Mayan dialects, which drove more engagement and higher share rates than the video in Spanish, particularly in regions like Izabel and Alta Veraoaz with reach hard-to-reach indigenous populations.

USING PREFERRED PLATFORMS TO ENCOURAGE VACCINES AND COVID-19 SAFETY.

After getting messages on TV, WhatsApp, text, and Facebook, 67% of people in Jordan's Unilever-UKAID Promoting Safer Hygiene Practices for Women and Girls project registered for COVID-19 vaccines and 98% of people increased their commitment to COVID prevention behaviors. People who changed their plans cited these messages as a key factor in their decision. The impacts reached many aspects of health care; 33% of people said they used new techniques to manage their stress and self-care because of what they learned from the project which improved mental health. Those messages were successful because the team worked with local Women Leadership Councils to create and disseminate accurate information and host special interviews with the Ministry of Health including on COVID-19 and produce videos that represented all walks of life in Jordan, using baseline research to focus on people's major concerns—especially mental health. CARE Jordan used **multiple formats,** collaborated with a variety of stakeholders including media companies and took an inclusive approach to share information including games, radio, TV, face to face visits, recorded health messages called Mobile Doctorini, and social media to share health messages. They also filled technology gaps by paying for data bundles on phones for some project participants so they could get better access to information through the project.

[3] This is 300% higher than the standard benchmark for social media campaigns.

ADDING TECHNOLOGY TO EXISTING SYSTEMS.

With support from Syria Relief & Development (SRD), 900 Health Personnel, Community Health Workers, Case Managers, adolescent and youth leaders switched to telemedicine options at the beginning of the pandemic, and increased uptake of antenatal care services by 34%, post-natal services by 205%, and family planning by 24% at the height of the pandemic. They were able to reach more than 5,327 people even in the height of lockdown by combining digital and mobile outreach. 98% of patients said they'd recommend telemedicine services to a friend, and 94% were satisfied with the service. Despite the fluctuation and lack of predictability in strength of internet access, 97% of respondents reported relying on their smartphones for available services in the area and 98% indicated that WhatsApp was their most used and favorite app for text and audio messages.

While online consultations are not a substitute for face-to-face consultations, they offered an alternative solution to facilitate critical access to women during COVID-19 facing other overlapping barriers such as restricted mobility due to gender norms, double burden of work and household chores, among others. **29% used the service because it was easy access and relieved the burden of transportation. 27% of people said it made them less afraid to contract COVID-19,** 17% being too ill to leave their homes and others reporting not wanting to leave their children alone, work engagements and having nobody to accompany them.

This success built on 8 years of previous investments in local health workers—especially women. Since 2012, CARE has worked closely with Syria Relief & Development (SRD) and UNFPA to significantly invest in women leaders and local health workers. When COVID-19 hit Syria, SRD started implementing online telemedicine consultations in communities hosting locals and IDPs in Idleb and Aleppo Governorates (Abin, Mills, and Azmarin), where SRD-supported frontline health workers to support SRH services in primary healthcare facilities and mobile clinics.

Other projects saw similar success scaling telemedicine. Tanzania's Tabora Maternal and Newborn Health Initiative (TAMANI) ran from 2017-2021 with support from Global Affairs Canada to improve gender-equitable access and quality of reproductive, maternal and newborn health services across health facilities and communities. When COVID hit, CHWs used COVID-19 communication platforms to provide free FP/SRHR counseling and referrals through 211,224 mobile phone calls.

[4] Key populations are defined groups who, due to specific higher-risk behaviors, are at increased risk of HIV, irrespective of the epidemic type or local context. Also, they often have legal and social issues related to theirbehaviors that increase their vulnerability to HIV (WHO). They usually include sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs, and people in prisons and other enclosed settings (USAID).

3. HOLDING SYSTEMS ACCOUNTABLE

A variety of CARE's programs demonstrate that investing in gender equality and feminist principles of localization by and for affected populations results not only in more relevant and responsive programming but also in more accountable health systems. Whether in the context of relatively stable settings of Cameroon or Malawi or in refugee-response scenarios of Ecuador and Uganda, it is clear that centering the voices and leadership of CBOs led by key populations[4] including People Living with HIV, refugees or migrants and LGBTQ populations are critical to developing successful and innovative models for continued access to essential services during crisis. Furthermore, social accountability approaches such as the Community Score Card or utilizing an Ombudsperson model not only allows for elevating key barriers to access and solutions from these unique perspectives but also demonstrates to affected communities that they have the right to accountable health systems.

YOUTH GROUPS LEAD COVID-19 ADAPTATIONS AND ACCOUNTABILITY.

Despite the obstacles of COVID-19 and the way it diverted resources from primary health care, youth groups and community-based leaders in Malawi found ways to successfully advocate for **increasing** the national Family Planning budget to ensure people could still access reproductive care during COVID-19. These groups found virtual solutions to replace in-person stakeholder meetings. Based on what they learned in these virtual meetings, SMS and WhatsA pp conversations, the groups successfully worked with local, district, and national government officials to identify and resolve critical issues to improve Malawi's vaccination campaigns, identify and train last mile health surveillance assistants, provide more training for health workers, and get access to much needed supplies like PPE and family planning supplies.

This success is rooted in nearly 20 years of investments in locally-led accountability and building community networks to improve health services. CARE Malawi has been collaborating with communities in particular youth and women's groups to amplify the marginalized voices to hold health systems accountable utilizing the Community Score Card (CSC) since 2002. By bringing together groups of community members, as well as providers (NGOs, government officials and parliamentarians), unique viewpoints are brought to the table to identify gaps in service delivery. Specifically, groups that are more likely to be marginalized, including women and youth within the community, become amplified and are given equal consideration. Groups create and deliver an action plan that meets community needs and builds health system accountability.

BUILDING CONNECTIONS FOR ACCOUNTABILITY.

Launched during the COVID-19 pandemic, the Ombudsman model in Uganda's Pagirinya refugee settlement model helped 5,155 crisis affected women and girls get access to information and accountability. Women were able to band together and feel empowered to make changes to the health system that they themselves were using as part of local Community Councils. Local women and girls felt a sense of ownership and take in the accomplishments of the Community Council. For example, one woman representative said:

> **"I feel good to be a member of this project... we were able to present the issues facing women, especially ANC services where women complained they were being harassed. We followed it up and it has improved access to ANC by women."**
>
> – Women's Representative at Pagirinya Refugee Settlement, Uganda

The Community Council has collected and reviewed over 50 SRHR-related complaints about quality of SRH services, discrimination when seeking services, and lack of acceptable information about SRHR among adolescents. Based on council recommendations, improvements such as increased distribution of menstrual hygiene kits to adolescents and improved access to HIV treatments even in the middle of the pandemic have been implemented by government executives, and there has been a commitment by the Ugandan government to changing sub-county by-laws to include improving adolescent SRHR and preventing early forced marriage.

Even before the start of the COVID-19 pandemic, more than 500 women and girls were dying during pregnancy and childbirth everyday due to a lack of quality SRH services in countries with emergency settings. Creating programming to increase overall accountability and quality of health services was especially important in the context of the pandemic in order to decrease the dual burden of COVID-19 and poor-quality SRHR. Between March 2020 and June 2021, CARE Uganda partnered with the Center for Reproductive Rights to address gaps in accountability for SRHR in Pagirinya refugee settlement in northern Uganda. An innovative and participatory accountability model grounded in human rights law and principles was piloted; a diverse nine-member Community Council for SRHR, including advocates from the disability and adolescent community would collect, review, and respond to SRHR-related complaints in order to improve SRH services.

ACCOUNTABILITY FOR AFFORDABLE SERVICES.

In Niger, women who were part of the Women Lead in Emergencies project successfully advocated for cheaper maternal health care. In MainéSoroa, many women gave birth at home—without any support from a health worker—because they could not afford health center costs. Women's groups advocated to the District Medical Officer, and the head of the hospital—and achieved a considerable reduction in the cost of access to the hospital, increasing the number of center-based births.

César López Balany / CARE

4. BUILDING SOLIDARITY

CARE programming has revealed several examples of women banding together and building solidarity through a variety of approaches to support one another and their communities for mental, psychosocial and physical support while facing the harsh realities of COVID-19. These have often been as a result of building individual skills and leadership prior to COVID, leveraging existing networks and community structures to identify evolving needs and develop community-based solutions to respond with agility.

COMMUNITY GROUPS PLAN FOR CRISIS.

In Myanmar women health workers were able to achieve 80% coverage for immunization against polio, 30% increase in knowledge of HIV prevention, and 602 individuals completing midwifery training—despite the impacts of COVID-19 and political instability. They bridged gaps in healthcare in hard to reach areas by providing critical information and services. Building on the strong community-level platforms and women's leadership, with support from CARE Myanmar, members of Village Savings and Loan Associations, originally designed and formed to facilitate savings practices within the community and provide a platform of community-led resilience to sudden shocks, redirected some of their funds to undergo training on first aid and immunization provision. VSLA members then supplemented the COVID-19 prevention efforts of community health workers and government staff by serving as an additional workforce for health messaging, first aid and immunization provision within their communities. To ensure continued access to reproductive healthcare, a subset of VSLA members and CARE-GSK community health workers completed a separate midwifery training and served as auxiliary midwives (AMWs). They received an auxiliary midwife kit to support their ability to provide essential maternal and child health services including antenatal care, delivery, and postnatal care. AMWs additionally supported COVID-19 response efforts by reducing unnecessary burden on health facilities by identifying and referring only high-risk pregnancies for case management to facilities.

This success built on investments in Frontline Health Workers starting in 2011 in partnership with CARE and GlaxoSmithKline.

The Frontline Health Worker Initiative established platforms, networks and health service capacity-building that served as a catalyst for CARE to pivot towards the response to the COVID-19 pandemic quickly in the communities where these projects exist.

The initiative included multi-pronged interventions focused on FLHWs including building their capacity to deliver primary healthcare, raise awareness on disease prevention and encourage uptake of RMNCAH services, distribute sanitary/safety supplies, basic health commodities including contraceptives and connect people with health facilities and personnel at formal health structures.

SOLIDARITY AND LEADERSHIP AMONG CIVIL SOCIETY GROUPS LED BY WOMEN AND PEOPLE AT RISK.

In Cameroon, 14 community-based organizations led by women or people with HIV/AIDS not only kept health systems open—they improved health access for high-risk patients. Using their skills and creativity, they increased the number of clients on HIV preventative care by 59%, increased the access to self-testing HIV kits by 54%, and increased the number of patients on ARVs by 21%, providing a total of 32,076 services between April and June 2020. That was in the face of incredible obstacles, as fears of contracting COVID-19 at health facilities and drop-in centers, diversion of labs from HIV-related use for viral load testing to COVID-19 testing, and exacerbated stigma against these key populations severely hampered their ability to continue seeking life-saving HIV services.

CSOs found ways to keep services running. They started community and home-based delivery of HIV services (including testing, counseling, provision of ART and a new type of PrEP at their home or near their home), collaboration with other HIV actors to support home-based collection of blood samples for viral load testing. They also intensified follow-up through virtual counseling, phone calls and case manager-supported counseling through WhatsA pp, Zoom and Skype. Local groups provided key populations with a list of low-risk health facilities as well

as support for safe transportation to health facilities. All of this was possible because of a strong network of online peer mobilizers from community-based organizations who used Facebook and WhatsApp to reach these groups in virtual Hotspots. Not only was this platform used for COVID-19 prevention messaging and accelerating COVID-19 vaccinations, but also for reinforcing key STI and HIV messages and linking people living with HIV to peer counselors for additional support.

This success built on four years of investments in locally-led health systems. Since 2015, CARE in collaboration with Johns Hopkins University (JHU), Metabiota, Moto Action, and six local community-based organizations (CBO) have been implementing the USAID-funded *Continuum of Prevention, Care and Treatment (CoPCT) of HIV/AIDS with Most-at-risk Populations in Cameroon (CHAMP)* project that was far exceeding ambitious PEFPAR targets. CHAMP works to support and leverage the networks and capacities of 14 CSOs that are either women-led or key population-led, most often by and from the highest burden HIV positive communities in Cameroon.

BUILDING SOLID COMMUNITY RELATIONSHIPS, TRUST, AND CONFIDENCE.

In Tanzania's Tabora Maternal and Newborn Health Initiative project (TAMANI), women leaders contributed to implementing COVID-19 prevention, increasing availability of soap and water in the region from 43% to 57% between 2020 and 2021. They also improved access to essential services. Even with COVID-19's impacts, the National Newborn Mortality Ratio dropped 9 percentage points, and maternal mortality dropped 6 percentage points. There was a 12 percentage point increase in the number of women who gave birth with a Skilled Birth Attendant. Follow up for pregnant women improved by 68%. **Family planning more than doubled overall, and quadrupled for adolescent girls.** In the words of community health worker Esther Malisha *"Us CHWs have been acting as a bridge between community and health facilities."*

When COVID-19 hit, leveraging ongoing programming, with the support of Bloomberg philanthropies, CARE implemented adaptations not just for COVID-19, but also for other infectious diseases. We focused on further building local capacity of women leaders on infection prevention control, household hygiene, disease surveillance, and response to gender-based violence. These efforts utilized existing platforms and workers, including community health workers, community groups, and government health management committees.

One worker describes the difference like this: "[people] have confidence in me, they believe in the education I provide, they don't doubt me. So even today if I say that I am calling for a meeting, a lot of people will be coming, and I'm so proud of that." It's not just health workers who notice the difference. A teenage girl says, "[Health workers] are good indeed, they educate nicely and in case you haven't understood something you can tell them and they will explain again. They are charming." A boy says, "When you see a nurse on the street you just feel you want to greet them just because they are the person who you live well with."

This was possible because TAMANI prioritized training and mentorship of frontline health workers both at the facility and community-levels, even before COVID-19. The project ran from 2017-2021, and invested not only in the technical and leadership skills development of FLHWs, but also their recognition and appreciation by the community and addressing underlying gender and social norms at the community level. The project looked beyond core health skills to the broader enabling environment.

COMBINING REFUGEE LEADERSHIP AND CASH SUPPORT.

In Ecuador, Alas de Colibrí and Diálogo Diverso worked with CARE to **scale up** key interventions to ensure continuity of essential primary healthcare, SRHR and HIV services in a context where 43% of Ecuadorans were reporting less or no access to health care due to COVID-19 constraints.[xxxix] CARE and its partners were able to reach more than 5,131 people with vouchers that helped them access health services—and 55% of the vouchers went to support sexual and reproductive health care. They also kept health services running by focusing on local leadership and providing resources, workshops adapted with and for migrant and LGBTQ communities on SRH, GBV and

HIV prevention and inclusive-services held for public and private services providers so they could hold them virtually. They continued virtual workshops and provided referrals to access the public health system supported through case managers, particularly for especially high-risk people. This was possible because of investments that started in 2019, and partnerships with refugee and LGBTQ-led CSO networks.

SUPPORTING CHILD BRIDES AND GBV SURVIVORS.

Despite the impacts of COVID-19, local youth leaders in Benin collaborated with VSLA and other community members to contribute to a 50% drop in early and forced child marriage rates and adolescent birth rates between 2018 and 2021.[xxxviii] When COVID-19 hit, PROJEUNES issued additional grants to two new local youth organizations, Yon Ba ROAJELF and Ensemble Artistique et Culturelle des Enfants du Bénin (EACEB) to support COVID-19 adaptations. These included integrating accurate information on COVID-19 messaging through the well-recognized PROJEUNE comic book publication, working with existing in and out of school youth clubs to purchase and distribute chlorinated handwashing devices, providing additional trainings for health personnel that included both ASRH and COVID-19 mitigation and management measures. The project built on previous community dialogues with religious leaders and leveraged structures such as VSLAs to address and question social norms that govern adolescent girls' and youth lives particularly around access to SRHR and GBV services to keep services moving in COVID-19. With their additional skills and some small grants, Village Savings and Loan Associations (VSLAs) provided support and services to survivors of early and forced child marriage in targeted villages.

SUPPORTING HEALTH WORKERS' MENTAL HEALTH.

When the pandemic hit in Colombia, frontline health workers who were already responding to growing health needs of both Venezuelan refugees and migrants and host communities were required to further adapt and scale up service provision in a demanding workplace with long hours and a high number of patients. 300 frontline personnel received psychosocial care services, and as a result were able to ensure the continuity of care delivery of essential health services to 13,350 individuals who accessed the Colombian health system.

CARE Columbia

This mental health support was critical so that health workers could continue to deliver services. Given the disproportionate gendered burden of COVID-19 on women health workers as caretakers in the home and service providers in their workplace at facilities resulted in significant stressors and burn-out, also isolating them from their social support networks and communities. CARE Colombia and their partner GENFAMI recognized both the importance of women health care workers to the functionality of the Colombian health system, and the need for increased psychosocial support for women health workers to mitigate concerns regarding COVID-19. They invested in frontline health workers at the last mile by providing them with psychosocial support through virtual support groups and courses, and ensured that women had the self-care practices and coping tools they needed in order to continue providing high-quality care during the pandemic without experiencing burnout. Specific emphasis was placed on providing support to healthcare staff that provide SRHS to adolescents and women, and staff that worked with migrants and refugees. The support groups offered frontline workers an opportunity to share their experiences with one another and build solidarity so that mental health support could be offered at a peer level moving forward. Those investments will continue to pay off long after the COVID-19 pandemic abates.

"Being on the frontline, not just of the pandemic but of the risk and stigma and challenges that came with it, was a huge learning experience. After going through that and receiving training, skills-building, and other supports I see myself in a new light and as part of a bigger effort in my country. I believe myself capable of much more and want to continue to be a reliable and empathetic source of care for my community." —Female FLHW, Colombia

CREATING PERSONAL PROTECTIVE EQUIPMENT (PPE).

Even women with no formal connection to health services played a critical role in keeping health systems functioning. Across savings groups in West Africa, women entrepreneurs banded together to support their communities during COVID-19. Leveraging their business and community mobilization skills, women in Burundi, Ethiopia, Mali, Niger, Nigeria and Uganda produced and distributed thousands of masks to mitigate the transmission of COVID-19. In both the first and second-round surveys (September 2020; March 2022), VSLA members reported engaging in awareness raising campaigns to help encourage handwashing, social distancing and mask wearing among VSLA members and the broader community. Across the six countries, 41% of women reported taking part in information dissemination—the rate ranges from 25% in Uganda to 80% in Mali. In Burundi, women in VSLAs took the initiative to construct handwashing centers in their community and encourage community members to regularly wash their hands. VSLAs in Niger and Mali responded to a market opportunity by producing masks and soap, turning a dire situation into a business opportunity. VSLA members have also worked with community health extension workers and the local governments to curb misconceptions about COVID-19 within their communities. Furthermore, in Burundi, Ethiopia, Mali, Niger and Nigeria, a large majority of VSLAs (70%) are using the group social fund to support members to buy food and hygiene materials, to cover education expenses for their kids, and pay hospital expenses for the household, demonstrating the significant impact of solidarity between women leaders at the last mile and their communities.

Srinivas Panicker / CARE

Delil Souleiman / CARE

CROSS-CUTTING THEMES THAT EMERGE ACROSS THESE EXAMPLES:

- Overall, investing in gender equality at the last mile is an impactful, critical intervention for health preparedness efforts. This requires not only health skills training for FLHWs but also in their leadership complemented by recognition from their communities and the formal health system.
- Women leaders at the last mile who are from the communities they serve are the most effective not only due to proximity but also due to the trust built among people from similar backgrounds.
- An equity and inclusion lens is critical not only when selecting women-led and community-based organizations to collaborate with but also considering how to reach and respond to the unique needs of individuals via in-person or remote communication.
- Technology has played and will continue to play a crucial role in scaling health equity efforts around the world. An inclusive, people-centered approach based on collaboration with local leaders and messages featuring trusted information sources such as female frontline health workers is essential. Integrated outreach targeted to specific segments of the population in multiple formats is critical. Specifically, the most effective outreach must optimize the potential of digital reach and connectedness and simultaneously adapt and integrate with analog channels to reach less digitally connected populations.
- Leveraging leadership and perspectives of pre-existing inclusive community-based structures is core to locally led solutions and for elevating real-time feedback for timely influencing and holding decision-makers at subnational and national levels accountable during crisis.

Achuoth Deng / CARE

Rosa Panggabean / CARE

Asafuzzaman Captain / CARE

Rosa Panggabean / CARE

Recommendations

Preparing for the next crisis requires intentional investment in gender equality, particularly women frontline health workers, as a core pandemic preparedness action. This requires recognizing, counting, and compensating all individuals who contribute to health services.

1. MANDATE A MORE INCLUSIVE DEFINITION OF FRONTLINE HEALTH WORKERS

Programmers: Leverage women's existing capacity by expanding programming to include, support, and manage women leaders at the last mile across a range of skills and backgrounds. Ensure all evidence for decision-making includes data about women at the last mile.

Policymakers: Recognize the critical contributions of women leaders at the last mile by broadening your definition of FLHWs to include women leaders providing and facilitating access to health services operating both within the formal health system and outside of it, across a range of training and qualifications. Integrate all these individuals into health system counting, management, and data tracking for the health workforce.

Donors: Mandate that all health system investments include formal and informal workers.

2. CO-DESIGN PROGRAMS, POLICY, AND PRACTICE WITH AND FOR WOMEN FRONTLINE HEALTH WORKERS, INCLUDING COMMUNITY HEALTH WORKER LEADERS

Programmers: FLHWs must be treated as a specific target population for impact while also ensuring their meaningful participation along the program cycle (design to implementation to evaluation) and humanitarian program cycle (emergency to response to recovery). Co-designing programs with and for women FLHWs, including CHW leaders must be the new normal.

Policymakers: Grant women leaders seats at decision-making tables. Require local, regional, and national governments to set targets for representation of women at the last mile including FLHWs to local leadership and decision-making bodies for health policy and planning.

3. REQUIRE ADEQUATE PROTECTION, FAIR PAY AND RESPECT FOR FLHWS

Programmers: Ensure FLHWs are protected by providing personal protective equipment, access to testing and treatment, insurance schemes, mental health and psychosocial support services, gender-based violence services, and other protection measures. Increase investments in gender-equal, context-specific, tiered, multi-sourced compensation for FLHWs based on qualifications and training. Adequately compensate FLHWs for additional tasks and dangers exposed during crises, and budget to provide support towards other aspects of their lives such as childcare, rest and recuperation, etc. In addition to support for women FLHWs operating within the formal health system, integrate and connect those working outside of the formal health system with context-specific private sector, social entrepreneurship or other livelihood opportunities. women FLHWs operating outside the formal health system, integrate and connect them with context-specific private sector, social entrepreneurship, or other livelihood opportunities.

Policymakers: Ensure implementation of policies that address barriers faced by women health workers that have been amplified by the pandemic and other overlapping crises. Ensure recruitment programs in rural areas, conflict, and humanitarian contexts do not leave women behind. Women should also be supported, and their capacity built to ensure that they are able to take on more responsibilities and tasks.

Donors: Emergency funds must include a dedicated budget to protect and compensate frontline health workers for overtime, danger pay, and other considerations. They must also include equal salaries for health workers, including innovative financing mechanisms for women workers at the last mile.

4. INVEST IN GENDER-TRANSFORMATIVE, MULTI-DIMENSIONAL EMPOWERMENT APPROACHES

Programmers: In addition to professional technical health trainings, unleash the full potential of women FLHWS by investing in their leadership, interpersonal communication, teamwork, financial literacy, and entrepreneurship skills. Moreover, design programs in collaboration with local government and community groups that strengthen linkages and recognition by informal and formal structures such as the health system. Operate in conjunction with local Ministries of Health to facilitate referrals, share training resources, and improve health outcomes to ease the burden on systems and frontline workers.

Policymakers: Integrate FLHW, including CHW, roles into national systems and infrastructure. Expand the available workforce and improve a program/country's return on health investments by extending the accessibility of services and care. Work with local nursing and midwifery councils to revisit and update task-shifting policies that would allow for greater skills development and provision of essential health services by FLHWs, including CHWs.

Donors: Prioritize programs that utilize a gender-transformative lens that not only supports agency of FLHWs but also addresses inequitable relationships that shape women's lives and transform community norms and structures while improving health resilience of communities.

5. DEVELOP AND PRIORITIZE EQUITY AND INCLUSION-BASED LOCAL PARTNERSHIPS LED BY AFFECTED COMMUNITIES, PARTICULARLY WOMEN, REFUGEES, AND KEY POPULATIONS

Programmers: Map, support, and expanding equitable partnerships. Women-centered/women-led community health solutions and partners are more likely to remain with their communities during times of crisis. Providing women with leadership opportunities results in programs that are more responsive to the needs of the most marginalized groups. Recognize and support inclusive spaces that provide such leaders from affected communities the ability to co-create solutions. Fund locally-led solutions that are responsive to the unique needs of their communities. Explore innovative and trust-based solutions that leverage existing networks to improve access, particularly for stigmatized groups.

Donors: Ensure direct and dedicated funding is provided to support, amplify, and elevate work by CBOs led by affected communities, particularly women, refugees, and key populations along the humanitarian program cycle.

Ekinu Robert / CARE

LUKMEF Cameroon

6. SCALE PEOPLE-CENTERED, INCLUSIVE, AND ACCESSIBLE TECHNOLOGY SOLUTIONS

Programmers: Consider content, communication channel or form of social media, and messengers when developing targeted digital approaches. Elevating the voices of known individuals, such as frontline health workers or local leaders such as women's leadership councils, as trusted messengers online is important for achieving offline impact via social media. Furthermore, layering technology to make services more accessible results in greater reach. Equip FLHWs with people-centered, inclusive technology solutions to facilitate and scale their work. Adequately budget for the operationalization of health technology solutions, including simple ones.

Policymakers: Ensure advancements in digital health technology are accompanied by public policy solutions, particularly in terms of privacy and data use, support clients' rights and enabling public-private partnerships.

Donors: Promote adoption of digital scaling strategies that are people-centered, accessible, and responsive to the unique needs and capacities of marginalized groups, FLHWs including CHWs.

7. EXPAND MARKET-BASED APPROACHES FOR HEALTH SYSTEM RESILIENCE

Programmers: Invest in women leaders including FLHWs at the last mile to build business and livelihood opportunities as private providers of health services. Support women's economic justice approaches such as savings groups that leverage existing community structures, solidarity and trust among communities, build women's leadership, and transform social norms. Furthermore, engage with private sector companies to ensure access to essential health services are an integral part of their business continuity plans in case of crises.

Donors: Invest in scaling of women health workers' entrepreneurship models. Secure multi-year funding from ethically-geared private sector companies to support win-win solutions in gender equality that support improved health outcomes.

Sources

[i] World Health Organization. *Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health and Social Workforce.*; 2019. https://apps.who.int/iris/handle/10665/311322

[ii] *Methods for estimating the excess mortality associated with the COVID-19 pandemic.* World Health Organization; March 2022. https://www.who.int/publications/m/item/methods-for-estimating-the-excess-mortality-associatedwith-the-covid-19-pandemic

[iii] This is calculated updating WHO workforce estimates from 2016, with 2020 numbers from the International Council of Nurses, who estimate that COVID-19 related burnout and deaths will create a gap of 13 million nurses.

[iv] Sabine Freizer, Ginette Azcona, Ionica Berevoescu, Tara Patricia Cookson. *COVID-19 AND WOMEN'S LEADERSHIP: FROM AN EFFECTIVE RESPONSE TO BUILDING BACK BETTER.* UN Women; 2020. https://www.unwomen.org/en/digital-library/publications/2020/06/policy-brief-covid-19-and-womens-leadership

[v] Veas C, Crispi F, Cuadrado C. *Association between gender inequality and population-level health outcomes: Panel data analysis of organization for Economic Co-operation and Development (OECD) countries.* EClinicalMedicine. 2021;39:101051. doi:10.1016/j.eclinm.2021.101051

[vi] Dr. Bernice Dahn, Dr. Addis Tamire Woldemariam, Dr. Henry Perry, et al. *Strengthening Primary Health Care through Community Health Workers: Investment Case and Financing Recommendations.*; 2015. https://www.who.int/news/item/03-08-2015-strengthening-primary-health-care-through-community-health-workers-investment-case-and-financing-recommendations

[vii] CARE's Gender Equality and Women's Voice framework refers to these three categories as Agency, Structure, and Relations.

[viii] World Health Organization. *Pulse Survey on Continuity of Essential Health Services during the COVID-19 Pandemic.* World Health Organization; 2020. https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1

[ix] UNFPA, Avenir Health. Impact of COVID-19 on *Family Planning: What we know one year into the pandemic.* UNFPA; March 2021. https://www.unfpa.org/sites/default/files/resource-pdf/COVID_Impact_FP_V5.pdf

[x] UNFPA. *Pandemic Pivot: Achieving Transformative Results in the Covid-19 Pandemic.* UNFPA; 2021. https://www.unfpa.org/publications/pandemic-pivot-achieving-transformative-results

[xi] Laura D. Lindberg, Alicia VandeVusse, Jennifer Mueller, Marielle Kirstein. *Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences.* Guttmacher Institute; 2020. https://www.guttmacher.org/report/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health

[xii] Coombe J, Kong F, Bittleston H, et al. Contraceptive use and pregnancy plans among women of reproductive age during the first Australian COVID-19 lockdown: findings from an online survey. *Eur J Contracept Reprod Health Care.* 2021;26(4):265-271. doi:10.1080/13625187.2021.1884221

[xiii] Kit Catterson. *The Effects of COVID-19 on Sexual and Reproductive Health: A Case Study of Six Countries.* IMMAP; 2021. https://reliefweb.int/report/world/effects-covid-19-sexual-and-reproductive-health-case-study-six-countries

[xiv] Adelekan B, Goldson E, Abubakar Z, et al. Effect of COVID-19 pandemic on provision of sexual and reproductive health services in primary health facilities in Nigeria: a cross-sectional study. *Reprod Health.* 2021;18(1):166. doi:10.1186/s12978-021-01217-5

[xv] Zulfiqar A. Bhutta, Aatekah Owais, Susan Horton, et al. *Direct and Indirect Effects of the COVID-19 Pandemic and Response in South Asia.* SickKids, Center for Global Child Health, UNICEF; 2021. https://www.unicef.org/rosa/media/13066/file/Main%20Report.pdf

[xvi] Kalkidan Lakew, Emily Janoch. *She Told Us So (Again).* CARE; March 2022. https://www.care.org/news-and-stories/resources/she-told-us-so-again/

[xvii] Carleigh Krubiner, Megan O'Donnell, Julia Kaufman, Shelby Bourgault. *Addressing the COVID-19 Crisis's Indirect Health Impacts for Women and Girls.* Center for Global Development; 2021. https://www.cgdev.org/sites/default/files/Addressing-Covid-19-indirect-health-impacts-women-and-girls_0.pdf

[xviii] Sabine Freizer, Ginette Azcona, Ionica Berevoescu, Tara Patricia Cookson. *COVID-19 AND WOMEN'S LEADERSHIP: FROM AN EFFECTIVE RESPONSE TO BUILDING BACK BETTER.* UN Women; 2020. https://www.unwomen.org/en/digital-library/publications/2020/06/policy-brief-covid-19-and-womens-leadership

[xix] World Health Organization. *Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health and Social Workforce.*; 2019. https://apps.who.int/iris/handle/10665/311322

[xx] Lu C, Palazuelos D, Luan Y, et al. *Development assistance for community health workers in 114 low- and middle-income countries,* 2007-2017. Bull World Health Organ. 2020;98(1):30-39. doi:10.2471/BLT.19.235499 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6933433/

[xxi] *Who pays to deliver vaccines? An Analysis of World Bank Funding for COVID-19 Vaccination and Recovery.* 2021. http://www.careevaluations.org/evaluation/who-pays-to-deliver-vaccines-an-analysis-of-world-bank-funding-for-covid-19-vaccination-and-recovery/ (Analysis updated April 26, 2022).

[xxii] *ACT-Accelerator Strategic Plan & Budget: October 2021 to September 2022.* World Health Organization; 2021. https://www.who.int/publications/m/item/act-accelerator-strategic-plan-budget-october-2021-to-september-2022

[xxiii] Emily Janoch, Mariela Rodriguez, Beja Turner. *Our Best Shot: Women Frontline Health Workers in Other Countries Are Keeping You Safe from COVID-19.* CARE; 2021. https://www.care.org/news-and-stories/resources/our-best-shot-women-frontline-health-workers-in-other-countries-are-keeping-you-safe-from-covid-19/

[xxiv] Ashley Kirzinger et al. The Washington Post Frontline Health Care Workers Survey. KFF; April 2021. https://www.kff.org/coronavirus-covid-19/poll-finding/kff-washington-post-health-care-workers/

[xxv] Essex, R. and Weldon, S., 2021. *Health Care Worker Strikes and the Covid Pandemic.* New England Journal of Medicine, 384(24), p.e93. https://www.nejm.org/doi/full/10.1056/NEJMp2103327.

[xxvi] Emma Schwartz. *The Global Health Care Worker Shortage: 10 Numbers to Note.* Project HOPE; April 2022. https://www.projecthope.org/the-global-health-worker-shortage-10-numbers-to-note/04/2022/

[xxvii] *The Global Nursing shortage and Nurse Retention.* International Council of Nurses; March 2021. https://www.icn.ch/sites/default/files/inline-files/ICN%20Policy%20Brief_Nurse%20Shortage%20and%20Retention.pdf

[xxviii] Owuor RA, Mutungi K, Anyango R, Mwita CC. *Prevalence of burnout among nurses in sub-Saharan Africa: a systematic review.* JBI Evid Synth. 2020;18(6):1189-1207. doi:10.11124/JBISRIRD-19-00170 https://pubmed.ncbi.nlm.nih.gov/32813372/

[xxix] Christina Haneef, Anushka Kalyanpur. *Global Rapid Gender Analysis for COVID-19.* CARE + IRC; 2020. https://www.care-international.org/files/files/Global_RGA_COVID_RDM_3_31_20_FINAL.pdf

[xxx] Emily Janoch, et al. *She Told Us So, Rapid Gender Analysis: Filling the Data Gap to Build Back Equal.* CARE International, September 2020. https://www.care.org/news-and-stories/news/she-told-us-so/

[xxxi] Catherine Osborn, et al. *Magnifying Inequalities and Compounding Risks: The Impact of COVID-19 on the Health and Protection of Women and Girls on the Move—Final Report.* CARE; June 2021. https://www.care.org/wp-content/uploads/2021/06/CARE-Magnifying-Inequalities-and-Compounding-Risks_Final_Report_August-2021.pdf

[xxxii] Data provided by CARE Bangladesh

[xxxiii] Pari Chowdhary, Anais James, Justin Dell. *Impact, Influence, and Innovation: Reflecting on 10 Years of the CARE-GSK Frontline Health Worker Initiative.* CARE; April 2022. https://www.careevaluations.org/evaluation/impact-influence-and-innovation-reflecting-on-10-years-of-the-care-gsk-frontline-health-worker-initiative/

[xxxiv] Data provided by CARE Afghanistan

[xxxv] CBHC & private sector linkage_Guideline Final Jan 22.pdf

[xxxvi] Pari Chowdhary, Dr. Feven Tassaw Mekuria, Minerva Marquez, et al. *ON THE FRONTLINE: Lessons on Health Worker Empowerment from the COVID-19 Pandemic.* CARE; 2022. https://www.careevaluations.org/evaluation/on-the-frontline-lessons-on-health-worker-empowerment-through-the-covid-19-pandemic-response/

[xxxvii] Dr. Ikhtiar Uddin Khandaker, SM Rezaul Islam, Emily Janoch, Shefa Sikder. *How Bangladesh Is Getting COVID-19 Vaccines to the Last Mile.* CARE; 2022. https://www.careevaluations.org/evaluation/how-bangladesh-is-getting-covid-19-vaccines-to-the-last-mile/

[xxxviii] PROJEUNES - *Prévenir les mariages précoces et forcés au Bénin.* CARE; 2021. https://www.careevaluations.org/wp-content/uploads/CARE_BC%CC%A7nin_PROJEUNES_Rapport-final_Juin-2021.pdf

care.org

AUTHORS: Anushka Kalyanpur, Dr. Ihlas Altinci, Dr. Emmanuel Ojwang, Dr. Ikhtiar Uddin Khandaker, Sandya Ganesan, Emily Janoch, Pari Chowdhary

DESIGNER: Jamie Campbell

ACKNOWLEDGEMENTS: Feven Tassaw Mekuria, Anne Sprinkel, Corinne Paul, Sarah Fuhrman, Miriam Selva, Amanda Peters, Beja Turner

MAY 2022