ADB COVID Centre of Excellence Working Paper:

How CSOs address gender inequity in times of COVID

Swasti THE HEALTH CATALYST

ADB

Table of Contents

1 Introduction

The COVID-19 pandemic was like none other in living memory, given its scale and intensity. As communities, governments, civil society partners and individuals collaborated to mount a response, they essayed stories of resilience, and simultaneously, of challenges and lost opportunities. It is opportune to coalesce these myriad experiences and learnings and understand the causes and contours of the success and failures, towards establishing a template for future response and improved disaster and pandemic preparedness. Given that the worst ravages of this disease were experienced by vulnerable populations who, ironically, had the least culpability in contributing to its early spread, it is vital that our future actions effectively incorporate the theme of equity and we pivot our response by keeping these groups at the core of our focus.

Within the spectrum of vulnerability, we need recognise that women, transgender and persons with non-binary gender identities were perhaps amongst the worst affected by the pandemic. Women in the crosshairs of poverty, sickness, disability, exclusion and displacement found themselves bearing the maximum brunt of this situation. Available evidence is witness to the fact that the pandemic has had a differentiated impact on men, women and other genders. According to the Centre for Monitoring Indian Economy (2022), despite constituting a mere 9% of the total urban workforce in the country, women have accounted for 76% of the total job losses in urban India since the pandemic. The changing dynamics of work – work-from-home – did not benefit this cohort as anticipated. Instead as the struggle for economic opportunities scaled, women bore a disproportionate number of losses [1]. Within homes, instances of domestic violence, including intimate partner violence (IPV), reportedly doubled [2]. As per the National Family Health Survey-5 (NFHS-5, 2019-21), only 54% women have access to a mobile phone and 33% use the internet [3] and technology exclusion compounded their vulnerability, limiting their ability to register their grievance or even bring it into the national gaze. Technology was also one of the identified barriers to vaccination.

Statistics on certain categories of women, such as the elderly, disabled and migrants are limited, as is data on transgender and other non-binary persons. A medicalised COVID-19 response did not necessarily account for the varied realities and circumstances that negatively affect the ability of these communities to access healthcare services and social protection during the pandemic. While anecdotal evidence in the national and provincial media contains snippets about their woes during the pandemic, their virtual erasure from the public discourse has meant that there has been insufficient discussion and an even more scant response towards dealing with their pandemic-related plight. For those whose concerns went under-represented and subsequently, unaddressed, the disaster does not have a very 'clear end point [4].'

The events of the past two years have reinforced the social determinants of health and given currency to a multi-disciplinary approach to providing vulnerable communities knowledge and services related to health, livelihoods and social protection to build their resilience to humanitarian crises. Learnings from service delivery generated at the local level are perhaps as vital as macro-level learnings and trends, since grassroots planning and action often bridges the gap between policy and implementation and ensures last-mile delivery of critical care services. Small and localised actions when planned effectively can lead to meaningful changes.

With this context the Center of Excellence (CoE) on COVID-19, jointly established by Swasti[1] and the Asian Development Bank (ADB) emerged out of a need to review successful on-ground actions and develop a need-based and comprehensive repository of learning materials which can guide the planning of future mitigation strategies, with a central focus on equity. This is critical to counteract the bleak realities of disasters, as well as a welcome a timely prelude to much-needed policy change, especially in gender mainstreaming.

This working paper, a part of the CoE learning series, provides an incisive case of the critical role Civil Society Organisations (CSOs)[2] play in addressing structural inequities exacerbated by the pandemic and enabling gender mainstreaming. Through the experience and learning of a large, pan-India COVID-19 response initiative, the #COVIDActionCollab (CAC), it further spotlights the need for collaboration to ensure inclusion of vulnerable groups that might otherwise be left out of life saving service delivery perpetrated by a pandemic.

2 CSO role in COVID-19 response

It was clear from early on in the pandemic that vulnerable populations, particularly women and gender minorities, would need special redress from its impacts. Experiences with COVID-19 were neither linear nor were they uniform across communities and geographies. It was crucial that vulnerable people within their different local contexts were adequately represented in a holistic response. A "one-size fits all" approach to building the COVID-19 resilience of marginalised communities would be unproductive; and innovative, context-specific solutions and the alignment of technologies for meeting people's diverse needs were pressing priorities for ensuring last-mile delivery.

Given this context, CSOs played a critical and leading role in working with vulnerable and marginalised communities to ensure their well-being. Being privy to the special challenges faced by a number of these groups in accessing services, grassroots organisations were able to leverage their on-the-ground experience to rapidly identify the needs of marginalised communities and adapt their services accordingly. The spread of informal activism—forms of self-organisation aimed at practical problem solving – has perhaps been the most striking trend in civil society as many such organisations reshaped themselves around more practical types of community action since COVID-19 first emerged.

Community action was also critical to complement government initiatives. Governments shared messages on COVID-19 and designed many specific COVID-19 schemes for the benefit of the poor and marginalised communities. Existing entitlements were also sources of support to enable these groups to tide impacts on their health and livelihoods. Yet, the government had limited wherewithal to ensure last-mile delivery, and the most vulnerable remained at risk of being left out. The CSO actors were the ones armed with human and financial resources to reach the unreached and support government efforts.

[1] Swasti is a health catalyst that supports people and communities, particularly the marginalised, to make the right choices and lead healthy lives.

[2] Given varied perspectives in literature, for the purpose of this working paper civil society organisations are defined as not-for-profit organisations and community based organisations.

Significant as the CSO actions were during the pandemic, from a national perspective these were limited given the vast geographical spread of the country, the size of the population and the multi-dimensionality of the issue. Limited resources – money, people and capacities – available to a number of these organisations prevented them from adding to their scope of work. In this panorama of response, gendered concerns were often overlooked and the 'invisible within the marginalised [5]' were subtly rendered further to the margins. It was imperative for organisations to converge and mount a response that would simultaneously target several vulnerable groups and impact fronts, with speed and scale.

3 CSO's delivery of gender outcomes during the pandemic

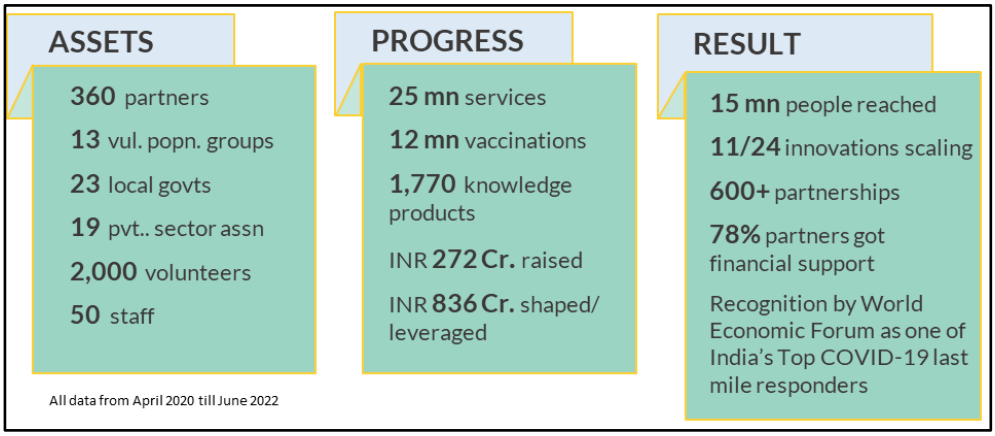
3.1 Achievement of scale

In a pandemic, speed and scale is of utmost importance and coming together to mount a response can make CSOs extension of services to the communities more effective. CSOs, engaged as they are in their areas of intervention – geographic or domain specific, require a platform to come together, to share and learn. CAC, through the concerted efforts of network building was one such initiative that, over two years of the pandemic onboarded 360 partners across 34 states and union territories of India, CAC further worked with several other organisations from the government and private sectors, organisations that preferred to lend support to the cause without joining the network.

CAC's pan-India footprint allowed it to extend support to a wide-ranging cohort of vulnerable populations, through its on the ground CSO partners. Focusing on gender and equity CAC initiative reached a range of vulnerable women including women in sex work, transgender people, migrants, women informal workers, persons living with HIV, urban poor and persons with disabilities. Such an extensive network of partnering organisations also provided greater legitimacy to the platform to engage with local governments and put forth the concerns of the vulnerable and lesser-visible sections. The comprehensiveness of its reach was opportune for CSO to exchange knowledge and build capacities of partners and extend and diversify their reach.

A snapshot of the achievements of CAC in over two years of its functioning across the pandemic is in Figure 1.

Figure 1: The scale and results of the #COVIDActionCollab



The CSO partners' commitment to band together and diligently engage with their communities through the collaborative method is directly responsible for CAC's triumphs. The motivation behind the favourable outcomes for vulnerable individuals in general and vulnerable women in particular was a number of collaboration-related factors, which are further explained in this study.

3.2 Mainstreaming gender in service delivery

The CAC collaborative approach placed vulnerable people at its core. This approach would naturally resonate with implementing CSOs whose raison d'etre was to contribute to the development of vulnerable communities.

From a gender perspective, women and the transgender and non binary (TGNB) communities, facing multi-layered social exclusion, were "the core of the core". CAC purposefully reached out to organizations led by women or dedicated to promoting equitable and socially just gender-responsive resource distribution, SEWA Bharat, Sneha and the Taras coalition of community-based organisations of women in sex work to name but a few. Through their rich and nuanced understanding of the pandemic's gendered consequences, such agencies did more than just add value to CAC's portfolio, they also enabled the platform to ensure gender equity and social inclusion in its service delivery.

During the pandemic for instance, CBOs and NGOs ensured doorstep delivery of anti-retroviral (ART) medicines to the people living with HIV (PLHIV) community in collaboration with ART clinics. Access to ART was one of the challenges of women living with HIV, constrained as it was due to the mobility restrictions imposed by the lockdown and aftermath. Many PLHIV, particularly women, hide their positive status from their neighbours, friends, and even family due to fear of stigma and backlash. Counsellors at the government operated Integrated Counselling and Testing Centre (ICTC) shared how instrumental CSOs were in helping them reach out to PLHIV and ensure that they received their life-saving medication without compromising on their dignity or confidentiality.

Similarly, the life-saving vaccine was inaccessible to many vulnerable women. For women in sex work, TGNB, PLHIV this was because the stigma and discrimination that they historically face in accessing healthcare kept them away from health facilities. For PLHIV on ART and TGNB on hormone replacement therapy it was the lack of information on potential contraindication of their medication to the vaccine.

Social norms rendered many urban and rural women with low levels of awareness of the vaccine, restricted mobility or access to technology to avail of the service. Similarly, mobility was also a barrier for the elderly and persons with disabilities. Standard national and state level programmes on awareness generation and service did not consider these exceptional circumstances in their delivery strategies. CSOs across the country stepped up to mobilise the community to bring them to vaccination centres, or take the vaccine to them, as the case may be. Their efforts not only helped in reaching the unreached, but were instrumental in **supporting the government** in reaching their targets.

Image 1: CAC Partners came together to organise vaccination camps for the TGNB community (picture taken in Bangalore)

Another initiative that supported gender inclusion was **telehealth**, an initiative that allowed women, who otherwise slip through the cracks of the health system, to access information and health care support during the pandemic in a safe, convenient and anonymous manner.

Image 2: Field staff spread awareness about telehealth and it's benefits amongst vulnerable communities

Swasti's model, named Call4Swasth was hybrid, with a cadre of field staff that went door to door to spread awareness and build capacities of accessing the telehealth services, and a cadre of health professionals to reach out and to over a mobile platform. The importance of this service was that women received pandemic related services, and also found a medium to reach out for various other health conditions, including sexual and reproductive health, infertility, etc., for which they might otherwise not seek health services because of stigma or the temporary suspension of non-emergency services during COVID-19. Telehealth also included a critical element of mental health, providing a more holistic healthcare engagement for women.

3.3 Amplifying women's voices

While CSOs ensured the visibility of vulnerable women in service delivery, they also amplified the communities' voices on denial of services.

Given the economic transgressions of the pandemic and subsequent nationwide lockdown, the Government of India declared financial aid packages for all vulnerable groups, including daily wage workers, construction workers, garment workers, and migrant workers. The transgender community, which constitutes a 4.88 lakh population [6], was left out. This came as a shock, considering that in 2014, the Supreme Court of India recognised the transgender as "third gender" entitled to reservation in education and jobs and eligible for many social security programmes at the central and state levels. Many state governments had constituted Transgender Welfare Boards (TWB), but these had not yet yielded concrete actions in addressing the social protection needs of transgender people, including health care, housing, education, and employment. Moreover, TWB's work in the time of pandemic remains unknown.

For the TGNB community that were denied their entitlement, CSOs rallied the power of the

people, and CAC partners provided a framework to make a case for financial relief. They won the case, and helped the government department identify the members who met the eligibility criteria to receive an entitlement support of INR 1,500.

Such victories amplify community voices that carry to the future for the attainment of rights.

> *"We have been earning a livelihood by begging in shops. Due to the outbreak, we stayed at home for days together. It was difficult for us to live our lives. During this time, Rs. 1,500 was deposited into our account. It was quite helpful, and we are happy with the money provided. We are thankful for all of them involved in helping us get these funds" – a member of the TGNB community*

3.4 Expanding reach and capacities by tribe-building

The pandemic had a silver lining for CSOs. Usually functioning in specific domains of their expertise, geographies and/or with specific community groups, the pandemic brought to fore opportunities for CSOs to scale and diversify.

Given the multiple, multi-dimensional and frequently changing needs of the communities across the many COVID-19 waves CSOs found themselves ill equipped to support their communities on diverse fronts. CSOs working in health care delivery, for instance, saw their communities struggle to put food on the table during lockdown; those working on livelihoods were caught unaware of how to facilitate health related awareness and services. Many member-based organisations could not turn a blind eye to the struggles of their communities that were not members.

CSOs partnering with CAC were able to deepen, as well and expand their service offerings. CAC designed 'high-impact interventions (HIIs)[3]' as a comprehensive solution for building resilience to COVID-19 among marginalised communities and vulnerable women. A total of 136 CAC partner organisations participated in the implementation of these HII packages. Collecting gender disaggregated data was challenging specifically while providing technical assistance to government departments. Of the nearly 40% CSOs that provided gender breakup, of the 9.4 million service instances rendered, 56% were received by women, 43% by men and 1% by the TGNB community.

[3] High Impact Interventions (HII) were designed for the CAC implementing partners for immediate and essential response against COVID -19 led pandemic. It included prevention, care and management of health. issues, vaccine readiness and vaccine administration, social protection, alternate livelihood and essential lifeskills for stress & emotional health management for the vulnerable and marginalised communities.

Image 3: A CAC organised vaccination camp under the VaxNow Initiative (picture taken in Bangalore).

Swathi Mahila Sangha (SMS), a community organisation of women in sex work working and women living with HIV for their empowerment is a case story of how the compulsions of the pandemic context, and support from a collaborative can drive CSOs to expand and diversify. SMS ran several initiatives in Bangalore urban district for the **health, safety, security and financial inclusion** of women in sex work, such as distribution of food and medical supplies. The SMS team's capacities were built on conducting vaccination and non-communicable disease (NCD) screening camps. Through these services they reached out to not only their members, but to other sex workers who were not members. SMS further conducted camps in factories in and around Bangalore, extending services to poor and vulnerable urban women who were not their core constituents.

A similar case is of Sri Lakshmi Pengal Munnetra Sangam (SLPMS), a CBO from Tamil Nadu working with sex workers, people living with HIV (PLHIV), Transgenders (TGs), and Gay Men (MSM). SLPMS expanded their portfolio to support community members with diversified livelihoods options. A majority of their members depended on sex work for their daily income. The pandemic drastically affected them, leaving many without food or shelter. The SLPMS team knew that some community members learned how to tailor and had fair experience in sewing and saw this as an opportunity to create jobs for community members. Noticing an increase in the demand for masks, SLPMS set up a tailoring unit in Madurai for the trans community. Being a partner in CAC, SPLMS was able to reach out to potential donors to support the unit's operations and to buyers to purchase the masks.

Social protection was an area where CSOs like Head Held High, working with vulnerable youth, stepped up to build capacities and infrastructure to enable these groups to access their entitlements.

Image 4: CAC extended material support, including food and medical supplies, to several vulnerable communities including people with disabilities.

"Through the collaboration with CAC we were able to reach out to 20% more needy, deserving and disabled persons". - Association of People with Disability

Through such scale and diversity initiatives, CSOs benefitted by gaining the trust of their communities. It increased their confidence to expand their boundaries for the benefit of their communities. In fact, some CAC partners articulate their aspiration to further their impact footprint. If the partners continued these expanded services this would lead to better access to health and associated services to the communities and help the partners raise further funding, increasing resilience and building comprehensiveness of the program.

3.5 Earmarking funds for gender initiatives

Humanitarian crises open pockets, irrespective of how deep, with philanthropists and donors keen on supporting relief and recovery. In the pandemic too many donors allocated, or even diverted their funding portfolios towards pandemic response. While some donors had chosen to contribute to the Prime Minister's relief fund, many preferred a direct route to impacted communities, through CSOs. CAC gave funders options of the initiatives, geographies and partners to fund. CSOs benefitted as their initiatives gained visibility with funds through CAC.

CAC in its funding efforts was attentive to gender needs. This drew donors that precluded a focus on women for initiatives they were willing to fund. For instance, the British Asia Trust extended INR 3.26 Cr for the HII where there was special emphasis on women. Of this grant, INR 26.40 lakhs went to provide support for Covid care kits for women artisans across the country. Similarly, Arghyam granted approximately INR 47 lakhs to support the trans-kitchen livelihoods project by trans women in Madurai, Tamil Nadu. The Taras coalition, a coalition of over 70 community based organisations of women in sex work received funding of INR 862 lakhs from various donors for their initiatives on vaccination, institutional resilience, HII and

materials and equipment distribution. It further received INR 109 lakh in kind to support its women. Such funding was instrumental in enhancing gender inclusion during the pandemic.

4 Conclusion

Humanitarian crises exacerbate gender exclusion from essential services, at a time when women and TGNB are at their most vulnerable to the detrimental effects of the crises, and need the services the most. In the pandemic this vulnerability worsened multifold.

The learnings from CAC make a strong case for governments and donors to actively engage CSOs to reach the most vulnerable and excluded women in humanitarian crises. CSOs - community and not-for-profit organisations - present as they are in close proximity with the communities are the best placed to bring the special circumstances of these groups to the notice of donors, planners and service providers, and to support these groups access services.

The CAC experience demonstrates that the results are amplified when these organisations discover a platform that unites them. Given the speed and scale required to respond to the pandemic effects, CSOs are willing to extend their outreach to larger numbers and even community groups that they have not been previously working with. With training, they are also open to step out of their comfort zones and pick up new service areas to work on. The collaborative provides a ready space for CSOs to access knowledge and learning, increasing their legitimacy, credibility and confidence. It also provides donors and governments a collective of CSOs to choose from for earmarked funding or on ground initiatives, improving the efficiency of their own response.

Yet, governments and donors must not consider CSOs as mere conduits of materials, funds and services, but as true partners from whom they can learn how to design gender inclusive and impactful interventions during and beyond humanitarian crises.

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