



Ecuador: Vouchers for Sexual Reproductive Health and Rights

LOCATION	Ecuador (Huaquillas, Manta, Quito, Lago Agrio, Tulcán, Guayaquil)
MODALITY & SRHR OUTCOME	Vouchers for Sexual Reproductive Health and Rights (SRHR) goods and services
TIMELINE	Phase 1: October 2019 – August 2020 Phase 2: September 2020 – August 2021
TARGET POPULATION	Migrants, refugees, and vulnerable Ecuadoran nationals with a focus on women, adolescents, and the Lesbian, Gay, Bisexual, Trans, Queer, Intersex (LGBTQI) community
TRANSFER AMOUNT	One-time, up to 50 USD
MONITORING	Satisfaction surveys
DELIVERY MECHANISM	Paper vouchers
REACH	5,131 men, women, and gender non-conforming people

Background

This study is part of a larger multi-country study by CARE entitled “Cash and Voucher Assistance for Sexual Reproductive Health and Rights Outcomes: Learnings from Colombia, Ecuador, Lebanon and Somalia.”

Ecuador is both a transit and destination country for refugees and migrants from Venezuela and elsewhere. As of July 2020, over 400,000 Venezuelans were living in Ecuador.¹ Venezuelan refugees and migrants have considerable health, psychosocial, and economic needs. Within these groups, women, adolescents, and LGBTQI people face heightened risks of Gender-Based Violence (GBV), human trafficking, and sexual exploitation as well as challenges to earning an income while in Ecuador. Although the public health system in Ecuador is free to all regardless of migration status, not all health – and especially SRH services – are covered in the public system. Furthermore, safe access to available services without discrimination based on nationality, sexual orientation/gender identity, or age is a barrier to access and uptake of SRH services in Ecuador.

Program Design

Since late 2019, CARE Ecuador and two national partner organizations, **Diálogo Diverso** and **Alas de Colibrí Foundation** implemented a protection program, with support from *Bureau of Population, Refugees, and Migration* (PRM), using a case management approach that included vouchers for medicine and health services, mainly sexual and reproductive health, at public and private health facilities. Diálogo Diverso’s expertise is in supporting LGBTQI community members and Alas de Colibrí’s expertise is in supporting GBV and human trafficking survivors. The collaborative program worked to reach the most underserved populations among migrants, refugees, and Ecuadorian nationals, including LGBTQI individuals, survivors of GBV, adolescents, people engaged in sex work and transactional sex, people living with Human immunodeficiency virus (HIV) and other Sexually transmitted infections (STIs), and women who are pregnant or lactating. Eighty percent of the total amount of the humanitarian

assistance was earmarked for refugees and migrants, with 20% targeted to host communities.

IDENTIFICATION OF NEEDS

The program was informed by a rapid gender analysis (RGA)² undertaken in 2019 by CARE and partners to identify humanitarian needs and gaps concerning rights, SRH, water, sanitation, and hygiene (WASH), and shelter, and to make recommendations and guide CARE’s response. Some highlights related to health include:

- 57% of migrants said they need health attention; 84% had not received any recent healthcare.
- Women and members of the LGBTQI community disproportionately reported having unmet needs and required health services.
- There was high reported knowledge of contraceptive methods across groups, but there were significantly lower levels of knowledge among adolescents.
- Despite having knowledge, over half of men and women said they had no access to contraception. LGBTQI people were much less likely to have access to contraceptives.
- Barriers for health and health-seeking behaviors included lack of information and discriminatory and xenophobic attitudes of some health providers.
- Health professionals interviewed pointed to congested and over-burdened health centers and an increase in risky pregnancies and births (e.g. STI) such as syphilis in pregnancy; adolescent pregnancy).

The program design for the SRHR vouchers was further informed by a desk review of secondary resources, consultations with target populations, an assessment of the changes in migratory routes in the region, recognition of the significant risks of GBV and the specific SRHR needs of the diverse groups, and the desire to, at minimum, implement the Minimum Initial Services Package (MISP) for Sexual Reproductive Health (SRH) crisis settings and, ideally, comprehensive SRH services as guided by the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.^{3,4}

1 World Bank. (2020). **Venezuelan Migration Could Raise GDP Growth in Ecuador by Up to 2 Percent.**

2 CARE Ecuador. (2019). CARE Rapid Gender Analysis LAC – Ecuador.

3 CARE. (2020). **An Unequal Emergency: CARE Rapid Gender Analysis of the Refugee and Migrant Crisis in Colombia, Ecuador, Peru and Venezuela.**

4 IAWG. (2018). **Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.**

TRANSFER VALUES AND MECHANISMS

The three partners formed a health commission and developed agreements with health institutions, including government-run health facilities, private health providers, the Red Cross, pharmacies, and laboratories to establish a comprehensive referral system and coordinate access to health services, including general medical care, specialty consultations, laboratory tests, and medications. The health commission identified the estimated costs of SRH services, prioritized the services to be financed, defined the scope and limits of the program, and identified how to address urgent and priority health needs. Participants could access public or private providers, depending on the location and capacity of providers.

CARE designed Standard Operating Procedures (SOPs) to work through the process from identification to monitoring. These SOPs took into consideration the privacy of individuals, especially since these were highly vulnerable populations. The SOPs also defined what the voucher covered and who the target groups were.



The teams created five different vouchers for:

- Medical treatment or supplies
- Human Immunodeficiency Virus (HIV) testing/STI screening
- Pregnancy tests/SRH screening
- Special tests and medical treatment (specifically for GBV survivors)
- Contraceptives

An in-kind SRH assistance of condoms and lubricants complemented the vouchers for some participants.

Each voucher had a maximum value based on the costs of goods and services determined in a local market assessment and taking into consideration cost-efficiency and the suggested pharmaceuticals, products, or services as suggested by the Ministry of Health (MOH).

TARGETING PARTICIPANTS

CARE and the partners disseminated information about health assistance through their social networks, though many participants learned of the program through word-of-mouth. Project participants were identified through different means including:

- Direct identification by CARE or partner staff through (e.g. through case management);
- Referrals from other organizations, including health centers; and
- Self-identification (e.g. potential participants came to CARE/partners' offices seeking assistance).

FIGURE 1: VOUCHER FOR LAB EXAMS

When the potential participant arrived at the offices of CARE or the partners, the initial assessment was carried out by social workers with a diagnostic conducted to determine if the individual qualified for assistance. Persons or families were eligible for humanitarian assistance if they met at least one of the following criteria⁵:

- Families in vulnerable conditions who have not received any assistance;
- Female-headed households with children and adolescents;
- Single women (e.g. women traveling alone);
- Families with a single parent (i.e. children who live with only the mother or father);
- Families with disabled persons or catastrophic severe illnesses;
- Women who were pregnant or breast-feeding;
- Unaccompanied minors;
- LGBTQI individuals or couples;
- Women survivors of GBV; or
- The elderly.

TABLE 1: VOUCHER TYPE, TARGET GROUPS, AND MAXIMUM VALUES

VOUCHER TYPE	TARGET GROUPS	VALUE
<p>Medical treatment or supplies</p> <ul style="list-style-type: none"> ■ Consultations, procedures, and supplies not covered by public health or in previously prioritized cases from private providers ■ For medicine, redeemable at pharmacies 	Venezuelans in transit and highly vulnerable Ecuadorians; prioritization for LGBTQI people, women survivors of sexual violence, women who were pregnant and/or breast-feeding, children and adolescents, and the elderly	Up to 50 USD
<p>HIV Testing/STI Screenings</p> <ul style="list-style-type: none"> ■ Testing: rapid HIV, Hepatitis (B, C, E), STIs ■ Examinations ■ Consultations 	Venezuelans and Ecuadorians, especially LGBTQI people, women survivors of sexual violence, and people at risk of exposure to HIV or STIs	Up to 20 USD
<p>Pregnancy Tests/SRH Screening</p> <ul style="list-style-type: none"> ■ Laboratory and/or complementary tests, including pregnancy tests and pregnancy screening, or other pathologies related to SRH 	Venezuelans and Ecuadorians, especially women and LGBTQI populations; focus on women survivors of sexual violence and people at risk of exposure to HIV or STIs	Up to 50 USD
<p>Special tests and medical treatment</p> <ul style="list-style-type: none"> ■ Examinations, care, consultations, or other procedures, including clinical management of rape (CMR) ■ Medication or medical treatment redeemable at pharmacies 	Venezuelans and highly vulnerable Ecuadorians with special needs, especially LGBTQI people and women survivors of GBV, especially sexual violence, including family members affected by the situation	Up to 150 USD
<p>Contraceptives</p> <ul style="list-style-type: none"> ■ Contraceptives, including emergency contraception; mainly short acting methods (e.g. pills) ■ For medicine, redeemable at pharmacies 	Highly vulnerable Venezuelans or Ecuadorians (LGBTQI people, women survivors of sexual violence, people at risk of exposure to HIV/STIs, etc.)	Two types: <ol style="list-style-type: none"> 1. Up to 6 USD 2. Up to 14 USD

5 Criteria were adjusted at the onset of the COVID-19 pandemic.

If an individual met any of the above criteria, they then needed to provide documentation in the form of a medical exam, prescription, or analysis signed by a certified medical professional; CARE and partners did not have medical personnel on site to evaluate needs. If an individual did not have such documentation (but met eligibility criteria), they were referred to the nearest health center with which CARE and partners had an agreement where the participant was able to obtain required documentation and return. Once documentation was provided, a social worker assessed the individual's needs and generated a voucher for the participant to obtain the goods or services required along with a referral to either a public or private provider.

The use of public or private service providers depended on the capacity of the service providers in the area. Sometimes the public service providers did not have the capacity for certain services; in these cases, participants were referred to private providers. Alternatively, if a participant sought services at a private SRH provider in the referral network, the participant delivered the voucher to the provider. The vouchers were paired with complementary services and distributions these included workshops with participants on sexual reproductive health, GBV prevention, sexual diversity, and human trafficking. Both public and private service providers received similar workshops to ensure inclusive services participants. The workshops were led from a gender and human rights perspective, emphasizing inclusivity in treatment. They included a discussion of concepts and approaches such as inclusive SRHR with a special focus on care for LGBTQI populations.

REDEEMING VOUCHERS

Vouchers for medical exams, consultations, screenings, and treatment could each cover up to three services. Each voucher was issued on an individual basis; if more than one family member qualified for a voucher, they would be issued additional vouchers. If the voucher recipient needed to have follow-up exams, they would be issued a new voucher. Social workers indicated the value of the voucher based on the costs of the needed service. The transfer value was determined in consultation with the organization's social worker and service provider staff through email, a phone call, or an in-person visit. Once vouchers were filled out, they were signed and sealed by the organization staff. Vouchers were accompanied by a medical prescription for services. Both the original and copies of the vouchers were signed by the staff from the issuing organization and the service

provider. Extremely vulnerable participants, as determined by social workers, were accompanied to the service provider by the organization's staff.

For referrals to **Cruz Vital** (part of the Ecuadorian Red Cross) the SOPs were slightly different. Cruz Vital attendance was based on prior appointments. Cruz Vital accepted five means of communication: a toll-free call center, direct calls to the specific location (cell or landline), and messages or calls through either WhatsApp or Facebook Messenger (these final two options offered 24-hour services).

For laboratory tests, no appointments were necessary, but participants needed to call prior to arrival to understand the requirements for the test. For medical exams, organization staff needed to communicate some basic information including: the name of the organization; the Cruz Vital site where services were sought; whether the appointment was for general or specialized services; and the name and identification number of the participant. Once confirmed, the participant was told the time and place of the appointment at least 15 minutes prior to the appointment.

Test and screening results for participants were issued via email to the organizations' medical personnel or social worker who relayed results to the participant or guardian. HIV test results were given to the organizations' medical staff or social worker in a sealed envelope and only opened in the presence of the participant.

Vouchers for medicine were issued on an individual basis. Each of the three organizations signed an agreement with a parent company of the vendor pharmacy, SanaSana, which covered the various implementation areas. Specific locations of the pharmacy chain were identified where participants could redeem the vouchers.

The social worker supporting a participant's case was required to contact the pharmacy using its preferred mode of communication. In the most critical cases organizational staff accompanied participants to the pharmacy; social workers determined whether or not participants needed accompaniment. Each voucher needed to be accompanied by the prescription, signed by the pharmacy staff, with a copy retained by the issuing organization.

MONITORING

Each voucher was registered in CARE Ecuador's program registration system, a proprietary and personalized software with a biometric fingerprint component. The biometrics were

not mandatory and were discontinued as part the project adjusted to the COVID-19 pandemic by shifting registration to remote. CARE’s registration system allowed data to be entered and extracted according to demographic variables (e.g. sex, gender, age, nationality, sexual orientation, etc.), migration status, and vulnerability criteria. These data points could be cross-referenced with the type(s) of assistance received, including the type of voucher, the location of service, and the date of care. Monitoring included the number of participants seen, number of vouchers, and services sought.

Participants also received a satisfaction survey about the services or goods accessed, the changes they experienced in their lives, their treatment by CARE and partners, and the relevance of workshops. Surveys asked whether the voucher was useful for recipients and about the quality of the services received (e.g. respect and non-discrimination, kindness, transparency, and efficiency). Most participants reported satisfaction with the services received. Participants were also made aware of a feedback mechanism for any concerns, questions, or complaints.

Outcomes

The SRHR component of the program, implemented from September 2019 to August 2020, reached 5,131 people with SRHR assistance. Of these participants, 57% were women, 41% were men, and 2% identified with other genders. Just over half of the participants were Venezuelan migrants (54%) and 46% were Ecuadorians. The majority were between 18 and 49 years of age with smaller numbers of participants aged 13 to 17 and 50 to 64. The majority of participants

sought pregnancy tests, SRHR and STI screenings, HIV testing and and other SRH consultations. Additionally, condoms and lubricants were distributed during workshops and information sessions on SRHR topics.

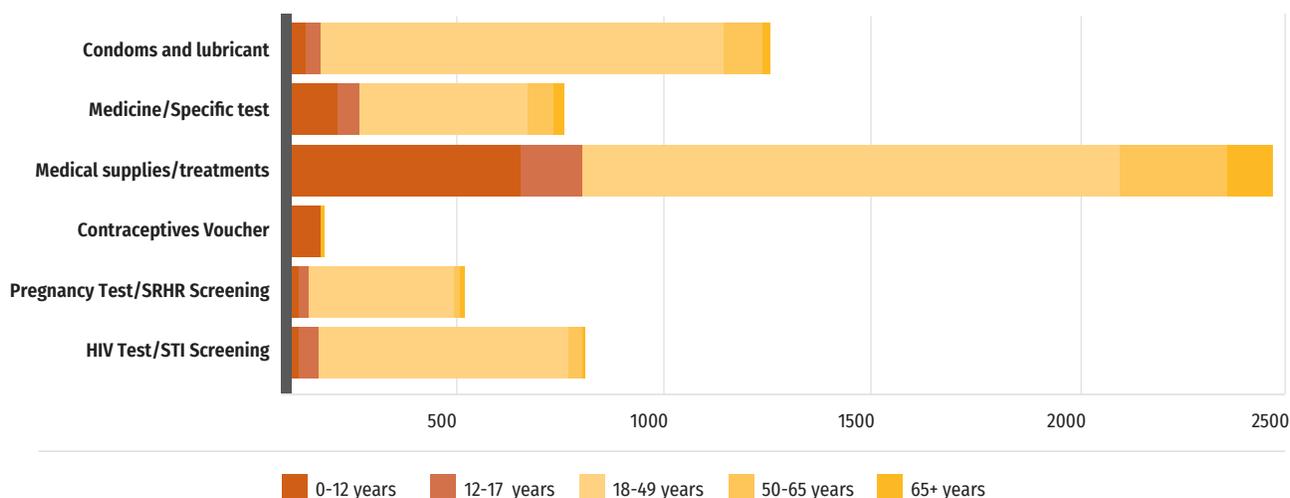
The next most common voucher types for adults were condoms and lubricant followed by HIV/STI tests and medicine/specific tests. For adolescents, the most frequently sought services were medical supplies and treatments followed by medicine/specific tests and HIV/STI tests.

Prevention and timely detection of HIV/STIs was discussed with sexually active local and migrant men and women. Because of the oversaturated health system in Venezuela, these populations had not been able to access SRH services in their country of origin. Along with HIV and STI tests, participants received pre- and post-counseling based on the MOH’s algorithms. CARE and partners’ technical staff were fully trained on these counselling methods. The most commonly identified STIs were syphilis and HIV, with less common detection of human papillomavirus (HPV), herpes, and Hepatitis B and C.

Women and LGBTIQ individuals who survived sexual violence were able to access specialty consultations, such as neurology, gynecology, psychiatry, dentistry, and more. Additionally, they accessed specialized medications, such as anti-D or Rho (D)immune globulin injections to counteract blood incompatibility between mother and fetus to reduce pregnancy risk.

Two hundred seven awareness sessions on SRHR and emotional health were delivered to 4,998 people (1,899 female; 3,042 male; 57 LGBTIQI/no binary people).

FIGURE 2: NUMBER OF SRHR VOUCHERS ACCESSED, BY AGE



Additionally, mental health needs were addressed to develop response capacities in the face of “migratory grief” and other situations like discrimination and xenophobia to support coping and facilitate integration in Ecuador.

Within this framework, Alas de Colibri Foundation developed the campaign “Free and Safe Sexual and Reproductive Health,” which reached 1,064 people. The campaign provided prenatal check-ups, STI screening, and FP counseling, including contraceptive methods to support SRHR of affected communities. In addition, awareness events were developed to assist migrants, refugees, and the host community in preventing GBV, forced migration, to human trafficking and to raise awareness of gender diversity, and children’s rights. Additionally, in coordination with UNFPA, CARE supported the development of information, education, and communication materials on SRHR and GBV (e.g. flipcharts, brochures on SRHR, and prevention of GBV in emergency contexts). Faced with the social isolation measures imposed due to COVID-19, collective activities were reprogrammed to be carried out virtually. CARE and its partners developed expertise in conducting virtual workshops and awareness events on GBV prevention and SRHR. Finally, CARE and the partners developed and delivered trainings on inclusive health center certification to 73 health providers.

The collaborative project contributed to strengthening the case management referral system of INGOs, national organizations, and public and private health providers. For example, coordination processes for referrals were agreed upon with the MOH, and similar coordination has occurred with other humanitarian assistance organizations. The program strengthened relationships among the members of the referral network⁶ creating a network aimed at improving access to services through vouchers. In addition, the project strengthened the national health system by increasing demand for national health system services. The program improved delivery of health services by training health providers on rights-based care, essential SRH services, and provision of quality, respectful care to a range of often hidden and underserved participants. The program supported participants in navigating the health system and in determining what health services they needed while sharing SRHR referral information during case management. CARE staff observed that the program increased services to SRH care for survivors of sexual violence and access to



FIGURE 3: INFORMATIONAL MATERIALS

hormonal treatments for trans women. They also spoke of the project contributing to a quality approach to SRHR care by focusing on specific needs of individuals and linking them directly to quality referrals.

Facilitating Factors

The implementing agencies underscored the importance of the partnership between experienced organizations to enable a truly inclusive program to respond to the specific needs of diverse target groups. The establishment of a health commission was critical to designing the scope of the project, identifying key services and providers to include, and offering tailored care to individuals. In addition, staff and colleagues emphasized the importance of including refugees, migrants, and Ecuadorians in the target groups to reduce xenophobia, and the importance of including LGBTQI people to reduce discrimination and strengthen the care provided in the national health system. Partnership with the public and private sectors has been important to the process because it guaranteed coordinated and comprehensive care

6 International Organization for Migration (IOM), UNHCR, Adventist Development Agency (ADRA), and Jesuit Refugee Service (JRS)

for the participants.

Challenges

There were several challenges that impacted the program. This included a national strike in October 2019 that interrupted and delayed all institutional agreements required for implementation. The selection of health providers and defining the voucher “life cycle” also proved challenging. The outbreak of the COVID-19 pandemic shifted strategies considerably and redirected project budgets into COVID-19 response. Systems and processes were updated in light of limited staff mobility and vouchers became electronic, with follow-up shifting to phone calls. Like many organizations, staff also began working remotely and coordination meetings went virtual. Finally, the lack of available comprehensive protocols for health providers made it difficult to ensure quality standards of care for referred services. Also important to the context was the impact of austerity measures impacting the Ecuadorian national health system a few months before the COVID-19 pandemic outbreak; this resulted in the departure of thousands of doctors and other health personnel causing enormous challenges for health care in Ecuador.⁷

Lessons Learned

A case management approach to SRHR vouchers can be beneficial. In general, organizations and health providers viewed the program as transparent and collaborative. The

program findings showed that health vouchers are more impactful if they are part of a case management program that also includes legal and psychosocial support and provides SRHR information.

Including both host and migrant/refugee populations in a project can have impacts beyond meeting SRHR needs. Vulnerability criteria for the program included both migrant and refugee populations and vulnerable Ecuadorians. This contributed to reducing discrimination and xenophobic practices and complied with the principle of action without harm. The approach allowed the organizations to reach the most vulnerable people.

Relationship building at multiple levels is critical to project success. It was clear that there needs to be the same effort at building relationships among stakeholders in all program locations; during this program, more effort was focused on building relationships at the national level between CARE, referral partners, and the MOH.

Flexibility and contextual analysis are essential for appropriate and effective CVA for SRHR programs. In the context of the pandemic, the SRHR vouchers became even more relevant and more in demand. The increased demand was linked to increased challenges in access to healthcare, especially for Venezuelan migrants, due to the reduction of livelihood opportunities, increased economic needs, and an overwhelmed healthcare system. CARE and its partners were able to quickly adapt to virtual programming to allow continued programming during this health emergency.

7 Pablo Iturralde. (2020) “The IMF’s role in the devastating impacts of Covid-19 – the case of Ecuador.”