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# USAID COVID-19 Inequalities and Unintended Outcomes Assessment Report

March 2024

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## CONTRACT INFORMATION

The Program Cycle Mechanism is managed by the Bureau for Planning, Learning and Resource Management and implemented by Environmental Incentives (Contract No. GS-00F-193DA/7200AA20M00002). The authors' views do not necessarily reflect the views of USAID or the United States Government.

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## ACKNOWLEDGMENTS

We are grateful for the careful guidance of Zhuzhi Moore of USAID's Bureau for Planning, Learning and Resource Management, Office of Learning, Evaluation and Research. Thanks also to USAID's assessment core team, including: Abir Aldhalimi (Bureau for Development, Democracy, and Innovation/Inclusive Development Hub), Keren Yohannes (Bureau for Humanitarian Assistance/Office of Technical and Program Quality), Vicky Santoso and Janina Mera (Bureau for Development, Democracy, and Innovation/Gender Equality and Women's Empowerment Hub), and Misrak Brhane (previously with the Bureau for Global Health/Front Office) whose feedback on drafts of this assessment identified key issues to include. We humbly thank the more than 150 stakeholders who provided valuable insights without which this report would not have been possible.

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# ACRONYMS

| | |
|---|---|
| **ADS** | Automated Directives System |
| **AOR** | Agreement Officer's Representative |
| **AMELP** | Activity Monitoring, Evaluation, and Learning Plan |
| **CBO** | Community-Based Organization |
| **CDCS** | Country Development Cooperation Strategy |
| **CEFM/U** | Child, Early, and Forced Marriage/Union |
| **CO** | Country Office |
| **COR** | Contracting Officer's Representative |
| **CSO** | Civil Society Organization |
| **GBV** | Gender-Based Violence |
| **GESI** | Gender Equality and Social Inclusion |
| **ID** | Inclusive Development |
| **IP** | Implementing Partner |
| **LGBTQI+** | Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex |
| **LOI** | Line of Inquiry |
| **MEL** | Monitoring, Evaluation, and Learning |
| **MHPSS** | Mental Health and Psychosocial Support |
| **MSMEs** | Micro, Small, and Medium Enterprises |
| **NGO** | Non-Governmental Organization |
| **OU** | Operating Unit |
| **SOW** | Statement of Work |
| **UNHCR** | United Nations High Commissioner for Human Right |
| **UNOCHA** | United Nations Office for the Coordination of Humanitarian Affairs |
| **UN Women** | United Nations Entity for Gender Equality and the Empowerment of Women |
| **UO** | Unintended Outcome |
| **USAID** | U.S. Agency for International Development |
| **WASH** | Water, Sanitation, and Hygiene |
| **WHO** | World Health Organization |

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# EXECUTIVE SUMMARY

This assessment identifies inequalities and unintended outcomes—both positive and negative—of U.S. Agency for International Development (USAID) programming that was supported by COVID-19 funds. The assessment paid particular attention to unintended outcomes for underrepresented and marginalized groups. The assessment's findings inform recommendations for how USAID might adapt its programming when responding to future crises, such as a pandemic, to advance gender equality and inclusive development.

The assessment addressed the following lines of inquiry:

- Did USAID's programming to address COVID-19 include gender and inclusive development considerations?
- Where has the Agency's response to COVID-19 yielded unintended outcomes (both positive and negative)? What was the path/link between the Agency's COVID-19 interventions and the unintended outcomes?
- With the benefit of experience and hindsight, what can/should be done moving forward to design and implement similar future programs that are intentionally and proactively inclusive?

To answer these questions, the assessment team drew on several sources of data. Using a number of selection criteria, the team included six Missions—Libya, Peru, Nepal, Nigeria, Rwanda, and Zimbabwe—as case studies in order to obtain in-depth perspectives. The team conducted key informant interviews (KIIs) with USAID Washington and Mission staff, implementing partners (IPs), and other stakeholders, as well as focus group discussions (FGDs) with participants from three activities in Nepal. These interviews enabled the assessment team to gain an insider perspective on 16 USAID activities. In addition to the interviews, the team reviewed relevant program and Mission documents. (For further details on the assessment design, see Annex A.)

Triangulation and analysis of these data provides the following topline findings:

1. **Experience with Gender Equality and Inclusive Development:** Emphasis on gender equality and inclusive development principles in activity design and early implementation was a key enabler of inclusive development during COVID-19. Missions and IPs who prioritized engagement with diverse stakeholders in decision making throughout the design and implementation of activities were better prepared to identify and address the emerging needs of women, girls, and marginalized groups during the pandemic. The assessment's findings reinforce the importance of gender equality and social inclusion (during or in absence of a crisis) throughout the Program Cycle.
2. **Local Partners and Networks:** COVID-19 shed light on the importance of investing in trusting relationships with marginalized groups to better understand their priorities. Many Missions and IPs had existing local networks and were able to quickly engage civil society organizations (CSOs), local governments, and other stakeholders to facilitate the coordination of rapid response efforts that allowed them to identify and address the emerging needs of these groups.
3. **Technology:** The ability to pivot and include technology-based approaches allowed USAID to continue implementing COVID-19 response programming, including providing critical services to vulnerable groups. Conversely, a lack of access to technology was noted as a constraint to reaching marginalized people, including in some cases women, the poor, and rural populations.

4. **Enabling Policy and Guidance:** The design and implementation of programs supported by COVID-19 funds integrated USAID's 2020 Gender Equality and Women's Empowerment Policy[1] and related guidance. On the other hand, there are minimal requirements for inclusive development, even while it is encouraged; as a result, the integration of inclusive development into programming was less formal. Many Missions' Country Development Cooperation Strategies, for example, identified increased pressures from COVID-19 on marginalized groups, but few had specific approaches to address them.
5. **Data, Evidence, and Learning:** Access to existing analyses (especially in-depth gender equality and social inclusion analyses) enabled data informed decision making around COVID-19 response. Regular monitoring also helped to inform activity implementation and adaptations to better support marginalized people.
6. **Adaptations, Contracts, and Funding:** Flexibility to adapt programming allowed for greater responsiveness to the needs of marginalized people. Additional funding during the pandemic allowed for continuation or expansion of programs supporting underrepresented and marginalized people.
7. **USAID Organizational Factors:** USAID staff experienced first- and second-order effects of COVID-19 in their personal lives, while also facing additional pressures at work. These pressures included adapting to remote work, staffing shifts related to COVID-19 evacuations, and managing new or adapted programs to meet emerging needs.

Based on these findings, this assessment offers four recommendations for USAID and IPs to consider in adapting programming for future crises:

1. **Conduct inclusive development or in-depth gender and inclusive development analyses:** In addition to USAID's required gender analysis, the assessment team recommends that Mission Program Offices conduct an inclusive development analysis (or combined in-depth gender and inclusive development analysis) during strategic planning and activity design. This should become common practice in implementing contexts where there are recurrent shocks or other identified vulnerabilities. USAID Washington Bureaus should provide technical assistance for these analyses when and where necessary. Agreement Officer's Representatives (AORs) and Contract Officer's Representatives (CORs) and IPs should integrate combined analysis findings in work plans and monitoring, evaluation, and learning (MEL) processes. ADS 205 requires and describes this process for using gender analysis findings; the same or similar process could be applied to inclusive development analysis findings.

[1] USAID's 2023 Gender Equality and Women's Empowerment Policy was released in March 2023, when most activities referenced in the assessment were nearing the end of implementation.

2. **Capacity Strengthening:** The assessment team recommends that USAID and partners prioritize capacity strengthening around gender and inclusive development principles for stakeholders, including USAID staff, IPs, CSOs, and host governments. Mission Program Offices should identify a Gender and Inclusive Development Point of Contact(s) or Advisor(s) to encourage gender and inclusive development champions across the Mission and provide up-to-date guidance. USAID should orient all Mission staff on relevant USAID policies, including but not limited to: Gender Equality and Women's Empowerment, Indigenous Peoples, Disability, Children in Adversity, Youth in Development, and LGBTQI+ policies. Program Office MEL specialists should work with MEL platforms to strengthen their capacity to conduct inclusive analyses and apply Do No Harm principles in MEL support to IPs. IPs should utilize USAID training, tools, and policies to better support marginalized groups before and during a crisis.
3. **Local Networks and Partners**: The assessment team recommends that Missions continue to invest in relationships with local partners that support marginalized and underrepresented people. Mission Program Offices should create and maintain a database of organizations working with or led by marginalized people and develop platforms to support IP coordination. In technical sectors where there is a recognized vulnerability (in this case, the health sector) and where the Mission does not have active programming, the Program Office should develop and maintain relationships with host governments, IP networks, or other donors to improve crisis readiness. Mission Technical Offices should apply the "Nothing About Us Without Us" approach and include diverse perspectives by engaging members of marginalized groups, vulnerable populations, persons with disabilities, and women and girls in the design and implementation of activities.
4. **Adaptive Management and Mechanisms:** The assessment team recommends that USAID Washington and Missions (Contracting and Agreement Officers, Activity Design Specialists, and A/CORs) embrace flexibility in contracts and implementation. For example, USAID can design activities with a focus on objectives and results while allowing flexibility to adapt programs with fewer formal modifications. In implementing contexts with recurrent shocks or other vulnerabilities, design and contracting staff should consider the addition of a crisis modifier. IPs should work with their A/CORs to identify contextual shifts and emerging needs and adapt work plans to address them. Adaptive management is critical in meeting the emerging needs of the most vulnerable in times of crisis.

# INTRODUCTION

## BACKGROUND

The COVID-19 pandemic increased women's vulnerability to food insecurity and malnutrition, widened gender poverty gaps, increased incidents of intra-household and gender-based violence (GBV), exacerbated burdens of unpaid work, increased the risk of COVID-19 for frontline workers who often are disproportionately women, hindered access to sexual and reproductive health services, and intensified gendered forms of violence and discrimination, including those directed towards people who are gender non-conforming LGBTQI+ (UNCTAD 2021; United Nations 2020; Madgavkar et al. 2020). The pandemic also laid bare the underlying gender digital divide and exacerbated its effects. Many of these intensified disadvantages have been reported for other marginalized groups, such as people who inject illicit drugs, sex workers, and incarcerated people. According to intersectionality theory, overlapping and interdependent dimensions of identity can act as social stratifiers that reflect broader systems of power; dimensions of identity might include, but are not limited to, gender, race, ethnicity, sexual orientation, social class, ability/disability, and geographic locale (Sen, Iyer, and Mukherjee 2009; Hankivsky 2012).

The U.S. Agency for International Development (USAID) has worked in more than 120 countries to mitigate the pandemic's first-order effects (prevention, treatment, and vaccination) while also addressing second-order (indirect) effects of COVID-19 by bolstering weakened health systems, addressing the social and economic effects of the pandemic, mitigating its wide-ranging impacts, and supporting recovery. Globally, USAID works with partner governments, multilateral institutions, non-governmental organizations (NGOs), other donors, and civil society to address the primary and secondary impacts of COVID-19 across sectors. From 2020 to 2022, USAID obligated over $9.81 billion ($4.14 for regional and country programming) in development and humanitarian aid in response to the COVID-19 pandemic (KFF 2022).

USAID's Bureau for Planning, Learning and Resource Management (PLR) conducted a series of nine evidence gathering and learning activities related to COVID-19, including this assessment, to help the Agency prepare and better respond to future shocks. This assessment identifies possible inequalities and unintended outcomes—both positive and negative—of USAID programming supported by COVID-19 funds on underrepresented and marginalized groups. This assessment builds on findings from an Agency-wide COVID-19 Big Picture Reflection on USAID's response and adaptations in response to COVID-19, where inclusive development was one of the five themes explored. This assessment is designed and implemented in close partnership with a core team of advisors from USAID's Bureau for Development, Democracy, and Innovation and specifically with the Office of Gender Equality and Women's Empowerment and the Inclusive Development Hub; the COVID Response Team at the Bureau for Global Health; and the Bureau for Humanitarian Assistance.

## PURPOSE AND OBJECTIVES

This assessment identifies inequalities and unintended outcomes—both positive and negative—of USAID programming supported by COVID-19 funds on underrepresented and marginalized groups. The assessment focused on the following three objectives:

1. To determine the extent to which USAID's programming, supported by COVID-19 funds, reflects the Agency's commitment to gender equality and inclusive development;
2. To identify resulting unintended outcomes, both positive and negative, that impact inequalities and outcomes for women and girls, as well as underrepresented and marginalized groups; and,
3. To identify recommendations to increase gender and inclusion-responsiveness in current and future USAID programming.

This assessment is not an evaluation. An evaluation is a process of collecting, reviewing, and using data for the purpose of programmatic learning for improvement. An assessment, by contrast, does not focus on programmatic performance but rather examines country or sector content and recommends future strategies based on past experiences (USAID ADS 201). As such, in this assessment, learning for improvement focused on how USAID can better create opportunities to promote gender equality and inclusive development, respond to the needs of marginalized groups, and strive for equitable outcomes.

# METHODOLOGY

The assessment team worked collaboratively with the core team during the assessment inception to define parameters, conceptual framework, methodology, and tools (see Annex A for more detail on the assessment design). The mixed-method assessment approach addressed three lines of inquiry (LOI):

- LOI 1: Did USAID programming to address COVID-19 include gender and inclusive development considerations?
- LOI 2: Where has the Agency's response to COVID-19 yielded unintended outcomes (both positive and negative)? What was the path/link between the Agency's COVID-19 interventions and the unintended outcomes?
- LOI 3: With the benefit of experience and hindsight, what can/should be done moving forward to design and implement similar future programs that are intentionally and proactively inclusive?

## SAMPLING APPROACH

The assessment team worked in collaboration with the core team, Regional and Pillar Bureaus, and Missions and Country Offices to include perspectives from a diverse stakeholder group in the assessment sample.

**Case study country selection:** With regional representation in mind, the assessment team included one country each from the Middle East and North Africa, Asia, and Latin America and the Caribbean, and three from sub-Saharan Africa to be case studies. This selection mirrored each region's proportion of the total USAID COVID-19 funding. The team worked closely with the core team and Regional Bureaus to select the countries for the assessment. The team initially shortlisted countries that were recipients of COVID-19 supplemental funding, then consulted with Regional Bureau points of contact to finalize selection and suggest alternatives when shortlisted countries were unable to participate (due to lack of ongoing COVID-19 programming or Mission capacity). The team selected a total of six countries as case studies for the assessment: Libya, Nigeria, Nepal, Peru, Rwanda, and Zimbabwe.

**Activity selection:** The assessment team worked with Mission and Country Office staff from the six selected countries to identify three activities per country to be included in the assessment. The team mainly focused on non-health portfolio activities, to ensure a broad representation of sectors and to assess second-order impacts of COVID-19 on marginalized groups. The team also focused on activities that were ongoing at the time of the assessment to ensure that informants would be available for interviews. At the time, Peru was undergoing an evaluation of all of their COVID-19 funded activities; to avoid duplicating efforts, the assessment team focused on interviewing staff for one activity and Mission staff.

**Respondent selection:** The assessment team identified respondents from USAID Pillar and Regional Bureaus, Missions and Country Offices, implementing partners (IPs), and other downstream partners (community-based organizations (CBOs), civil society organizations (CSOs), members of local governments). The team also conducted focus group discussions (FGDs) with program participants where country context allowed (Nepal). FGDs were not possible in the remaining countries due to security context, restrictions on travel, and availability to access program participants during the assessment period. (Many COVID-19 funding activities had concluded implementation.) For the individual or group key informant interviews (KIIs), the team selected staff who were in leading, managing, or coordinating roles in their respective organizations and gender/inclusive development focal points (Agreement Officer's

Representatives [AORs], Contracting Officer's Representatives [CORs], chiefs of party, gender/inclusive development advisors/experts, etc.). In the end, the assessment included a total of 86 respondents from various stakeholder groups and 66 program participants (see Table 1).

**Table 1. Number of Respondents by USAID Operating Unit and Stakeholder Group**

| USAID Operating Unit | Number of Respondents | | | |
|---|---|---|---|---|
| | USAID | Implementing Partner | Other Stakeholder | Program Participant |
| Libya | 2 | 7 | 0 | 0 |
| Peru | 3 | 0 | 1 | 0 |
| Nepal | 9 | 10 | 6 | 66 |
| Nigeria | 2 | 5 | 0 | 0 |
| Rwanda | 4 | 4 | 0 | 0 |
| Zimbabwe | 4 | 10 | 0 | 0 |
| Regional Bureau | 10 | 0 | 0 | 0 |
| Pillar Bureau | 9 | 0 | 0 | 0 |
| Total | 43 | 36 | 7 | 66 |

## DATA COLLECTION

### DOCUMENT REVIEW

The assessment team conducted a review of secondary sources internal to USAID to understand how the Agency, Mission and Country Offices, and activity levels integrated USAID gender equality and inclusive development. The team worked with a Mission focal point to help with the collection of relevant documents from A/CORs and IPs. The team then reviewed the documents to prepare for the KIIs and inform the types of questions to ask respondents at the regional and country levels.

The team also conducted a literature review of USAID and global research to understand the second-order impacts of COVID-19 on gender equality and marginalization to further inform the assessment research questions. This helped the team gain an initial understanding of the experiences of marginalized groups during COVID-19 in specific contexts in each country using an intersectional lens. (See Annex B for the literature review and Annex C for a list of key documents consulted.)

### KIIS AND FGDS

The assessment team developed guides for semi-structured KIIs and FGDs that were specific to the type of respondent and addressed the three LOIs at the country and activity levels. This included open-ended and probing questions to allow for qualitative analysis, which were refined as needed (see Annex D for assessment interview guides). The team conducted interviews from July through November 2023.

The KIIs and FGDs engaged a total of 152 respondents (Table 1). The team conducted remote interviews with respondents from USAID Bureaus, Missions and Country Offices, and IPs, with the exception of a few program participant FGDs which the team was able to conduct in-person. The team conducted remote interviews on Google Meet, recorded the interviews with respondent consent, and reviewed the Google Meet auto-generated transcripts for accuracy.

An assessment team member traveled to Nepal to facilitate KIIs and FGDs with support from the Nepal Mission through their MEL platform. The assessment team member trained and collaborated with a staff member from the MEL platform to provide translation and logistical support to KIIs and FGDs with program participants, IP staff, and host government officials.

### RAPID ONLINE SURVEY

Data collection also included a rapid quantitative survey that was administered online to A/CORs managing COVID-19 funded activities. The survey questions were designed to better understand the extent to which gender and inclusive development was considered in programming under COVID-19. Out of the 281 respondents that were selected to participate in the survey, only 14 completed the voluntary questionnaire. The assessment team also followed up with identified respondents and extended the deadline to complete the survey. (See Annex E for the survey questions.)

## DATA ANALYSIS

The assessment team developed a codebook using an inductive approach by letting the data guide themes and codes. First, the team conducted a pilot phase to refine and validate codes and secure inter-coder reliability. This phase led to the first iteration of the codebook, which was shared with the core team for feedback and approval before moving forward with coding.

The assessment team coded the interview transcripts from the KIIs and FGDs in Atlas.ti. Through a collaborative and iterative process, the team identified and discussed coded data throughout data collection and analysis, which included reconciling differences, agreeing, and merging or splitting codes as needed. This helped to refine and establish agreement of codes grounded in the data. Following this, the team created a coding hierarchy by grouping similar codes under broader categories. The team used the codebook as a guide to ensure they used codes consistently, and modified the codebook as needed.

Upon reviewing and discussing codes for the 56 transcripts and FGD notes, the assessment team identified emerging patterns, such as co-occurence of codes, that they used to develop themes for each LOI. This also included identifying deviations, variations, and contextual nuances across countries, activities, sectors, and respondents. The team interpreted the data through code co-occurrence analysis on Atlas.ti to further identify associations and frequency of codes. During this process, the team also cross-referenced data from the primary analysis with the desk review, and used the limited data gathered through the survey to validate and triangulate findings from the KIIs and FGDs. The team presented the preliminary findings from the data analysis to the core team and followed up with a sensemaking session to co-create recommendations with the core team members.

## ASSESSMENT LIMITATIONS

### SAMPLE

The timing of the assessment presented a constraint, as many COVID-19 funded activities had ended before or during the time of the assessment. Delays in moving forward with the KIIs and FGDs outside of the assessment team's control further contributed to this. As a result, the findings were based on a limited sample of activities.

## STAKEHOLDER PARTICIPATION

Participation in the assessment was voluntary. The assessment team reached out to a number of stakeholders who did not agree or respond to requests to participate in the KIIs or FGDs. As a result, the team was not able to capture some perspectives in interviews or discussions. Table 2 below shows the number of respondents contacted and number of respondents who participated in the assessment across stakeholder types. The assessment team similarly saw limited participation in the rapid online survey that was sent to a broader group of 228 A/CORs, with only 14 respondents participating.

**Table 2. Number of Participants Who Were Contacted and Number Who Participated in Assessment KIIs and FGDs**

| | Number Contacted | Number Who Participated |
|---|---|---|
| Bureau | 48 | 19 |
| Mission | 37 | 24 |
| IP | 45 | 37 |
| Project Participant | 66 | 66 (Nepal only) |
| Host Government | 11 | 6 (Nepal only) |

## LIMITED DATA COLLECTION WITH PROGRAM PARTICIPANTS

Due to travel restrictions, the assessment team was only able to travel and conduct in-person data collection in one country, Nepal. As such, the team had limited access to program participant-level data collection and thus limited ability to include some perspectives, especially on whether the activity produced (or is producing) equitable outcomes. Where available and feasible, the team conducted a secondary review of Missions' and activities' data to plug this gap. The team collected most of the data on unintended outcomes at the level of programmatic stakeholders, with limited outreach to collect data at the field level directly with program participants. Where available, review of program documents included review of strategy-level gender analyses and any document or data that may have already captured programmatic effects including unintended effects.

## RESPONSE BIAS

In assessments, there is a risk that key informants are motivated to provide desirable or positive responses (i.e., response bias). Informants in implementing organizations may do so anticipating that their responses may influence future decisions such as continued funding. Some may simply prefer to avoid critical responses or assertions perceived as negative. The assessment team asked participants to share both positive and negative unintended outcomes to garner honest (including critical) feedback on gender equality and inclusive development. The assessment team mitigated the risk of response bias by reminding informants that the assessment was not a performance evaluation; ensuring respectful recruitment processes; investing sufficient interview time in ice-breaking questions; and minimizing, to the extent possible, any direct connection between the activity and any future opportunities for support. The team reinforced to respondents that they would remain anonymous in the data collection and reporting.

# FINDINGS

Through the assessment data review and analysis, the following themes emerged:

- Experience with gender equality and inclusive development
- Enabling policy and guidance
- Data, evidence, and learning
- Contract flexibility, adaptable mechanisms, and funding
- USAID organizational factors

The sections below share findings by theme, including enablers and constraints, unintended outcomes (both positive and negative), and lessons learned that respondents identified.

A Note on Unintended Outcomes:

The assessment team inquired about unintended outcomes, both positive and negative, of USAID programs in response to COVID-19. Despite a variety of prompts, many respondents struggled to identify unintended outcomes of programming. The majority of survey respondents also responded as "not sure" or "do not know" in identifying unintended outcomes within the COVID-19 funded activities that they managed. However, a few respondents in the survey did identify unintended outcomes across the prompted domains: laws, policies, regulations, and time use; cultural norms and beliefs; and access to and control over assets and resources. Many interview respondents shared details about the unexpected effects of the pandemic broadly. This validated the team's literature review findings, which identified some of the ways that the pandemic further marginalized vulnerable people. The first- and second-order effects shared by respondents included:

- Unequal access to COVID-19 prevention and treatment
- COVID-19 misinformation eroding public trust
- Lockdowns resulting in limited travel
- Disrupted markets resulting in reduced labor participation and livelihoods
- Food insecurity (exacerbated by supply-chain disruptions related to the war in Ukraine)
- School closures resulting in education loss
- Healthcare disruptions and weakening of the health systems
- Increased instances of GBV and Child, Early, and Forced Marriage/Union (CEFM/U)
- Reduced access to social services
- Increased strain on mental health

The limited data on unintended outcomes may be linked to case selection (activities that have not participated in evaluations to avoid excessive burden) as well as data limitations (explored as an assessment finding theme). The findings below include the limited unintended outcomes that respondents shared.

## EXPERIENCE WITH GENDER EQUALITY AND INCLUSIVE DEVELOPMENT

Respondents identified a strong emphasis on gender equality and inclusive development principles in activity design and early implementation as a key enabler of inclusive development during COVID-19 and in programming COVID-19 supplemental funds. In several examples, a focus on gender equality and inclusive development was identified before the pandemic, creating a foundation which was then adapted to include COVID-19 response. This was noted by program participants, Mission staff, and IPs alike. One IP respondent shared:

> *"I think it's laying the groundwork in inclusivity, and having that as the basis for the way you work, you build on it. But you can't suddenly become inclusive when there's a crisis. So I really do feel that's a prerequisite. And that's why I think our approach worked because I mean you can layer it on [a crisis] … if you have another COVID outbreak or let's just say, you had a major cyclone. Having those connections and those networks already in place, you can immediately respond and you can layer other responses in an inclusive way."*

Many activities prioritized inclusion of diverse stakeholders and members of marginalized groups in their networks. Activities that included staff from the targeted groups allowed for better access and adaptation to the needs of the groups. One IP respondent noted:

> *"Over time, build up a network of what we call community facilitators … that have been through the process and want to continue working with us, and they are our eyes and ears in the community. [They] understand the dynamics in their own community and make sure everything we do is interested in terms of age, in terms of gender, in terms of disability where possible, and in terms of power."*

A Mission respondent shared another example about stakeholder engagement during activity design:

> *"That process … was so deliberate about engaging a wide group of stakeholders to understand: who we were able to get insights into, who were most vulnerable, how to reach them, what sort of interventions made sense, where to look, what the barriers were, structural barriers or economic barriers, or norms? All of that. So it was a really intensive approach. Beyond getting those insights and then working with the group to figure out what the answers looked like in terms of what interventions to implement."*

Even activities that were designed to focus on gender equality and inclusive development principles struggled with the scope, scale, and duration of the pandemic, making it difficult to meet the emerging needs of women and marginalized groups. Several respondents noted that they did not anticipate some aspects of the pandemic, especially second-order effects:

- Return of migrant workers
- Strain of the pandemic on mental health (on the general population, and especially on healthcare workers)
- Increased demand for programmatic services from men who were no longer going to work
- Additional burdens on women as caregivers to children or elderly family members

Respondents identified some related unintended outcomes of USAID programming. One positive unintended outcome was the opportunity to reach beyond the initially intended program participants. In one example, an activity focused on trauma healing was able to engage male victims of trauma who were not previously interested or available to participate in programming. The closure of markets due to lockdown measures resulted in men having more available time, and the activity pivoted to provide safe spaces for men to address their trauma.

The high demand for programming also resulted in unintended negative outcomes for some women and marginalized people. For example, much of USAID's health programming relied on female healthcare workers who experienced significant strains in their pandemic response efforts, in addition to increased burdens as caregivers at home. Healthcare workers also faced stigma related to potential exposure to the virus. In at least one example, restrictions on funding or programming made it difficult to address this need for mental health support. One additional example included reports of instances of GBV against participants in a cash transfer program which targeted women. The activity addressed the GBV with increased efforts at community sensitization and social protection.

**Lessons Learned For Future Crises: Experience with Gender Equality and Inclusive Development**

- Foundational integration of gender equality and inclusive development principles in activity design and planning is critical for promoting gender-equal and socially inclusive crisis readiness and response.
- Engaging diverse stakeholders in activity decision making is an enabler for gender equality and social inclusion.
- Greater understanding about the diverse challenges facing different groups would not only benefit participants in USAID programming, but also help to anticipate and adapt to support the challenges IP and Mission staff face during a crisis. For example, mental and physical health strain, isolation, and increased responsibilities at home impacted groups differently.

## LOCAL PARTNERS AND NETWORKS

COVID-19 shed light on the importance of investing in and sustaining relationships and local networks. Many Missions and IPs had existing trusting partnerships. They were able to quickly engage CSOs, local governments, and other partners to facilitate the coordination of rapid response efforts that addressed the needs of marginalized groups. Respondents shared examples of how working with local partners allowed them to better engage with target groups that may otherwise have been difficult to reach, such as: men who have sex with men, transgender persons, and female sex workers, among others. Therefore, investing in trusting partnerships was fundamental to expanding outreach support to vulnerable groups. As one IP respondent noted:

> *"Investing in community networks and creating the foundation [and] mobilizing local actors have all added value for us. Also, we focused on local governments which was very helpful. There was two-way communication with staff on the ground."*

One positive unintended outcome of this programming was the expanded networks that local partners developed. The high demand for services and related need for coordination provided opportunities for partners to engage with each other to address first- and second-order effects of the pandemic.

> *"The other thing, which we realized is because of the lack of economic opportunities and resultant hardships that were generated by COVID-19 and because [our activity] is not a livelihood intervention, we went out to check and see if we can link some of our structures especially women's groups, youth groups to other interventions.… We were able to identify one of the USAID-funded projects … that was distributing money [from the] COVID-19 rapid response fund, and we were able to link over 600 participants from [our activity] to this economic intervention [activity]."—IP respondent*

The literature review identified the importance of trusting relationships in an environment where misinformation is a key barrier in providing support for marginalized groups. In many countries, COVID-19 resulted in increased distrust in government, in public health systems, and in their representatives, as a result of conflicting messages around the causes and responses to the pandemic (Kunyenje 2023). The lack of trust between communities and government also hindered the reach of COVID-19 interventions:

> *"We realized that there is a big governance issue that needs to be addressed. What COVID demonstrated, especially in our world here is that there is [a] big lack of trust between the communities and the government.… People are resistant to get vaccines, not out of fear of public health repercussions, but out of lack of trust."—IP respondent*

Respondents noted the importance of trust in combating misinformation around vaccination. In several countries, for example, partners had to address young women's reluctance to receive the vaccine, as misinformation suggested vaccination would result in infertility. Local partners were able to build trust in the safety of the vaccine.

Local partners also advocated for marginalized groups who may have been excluded from local COVID-19 response programming or access to social services during this period. Marginalized groups included persons with disabilities, LGBTQI+ people, and members of remote communities. Even with previous experience or emphasis on gender equality and inclusive development in design, some IPs struggled with the sheer scope and scale of the pandemic and were not initially prepared to address the needs of some groups. In some cases, certain groups, such as LGBTQI+ people, sex workers, residents of remote areas, or people with disabilities were difficult to reach, especially where the IP did not have previous trusting relationships.

Many respondents recognized the value of gender equality and inclusive development knowledge and capacity in increasing access to services for marginalized groups. Developing and delivering orientations on gender equality and inclusive development for IPs, local leaders, and service providers, such as health workers and local government stakeholders, contributed to a targeted approach in addressing the needs of marginalized groups:

> *"We already had an existing [gender equality and social inclusion, GESI] GESI approach before COVID-19 as this was a cross-cutting area for [the activity]. This included developing and delivering orientations for municipalities and health and equity specialists. The activity also had GESI consultants throughout the life of the project. This was part of the underlying foundation that the COVID-19 activities were built on."—IP respondent*

*"Enablers were basically: capacity building and making the local level leaders responsive. And then the service providers oriented about the principles of GESI, and why it is important, so that type of training that [the activity] provided to different cadres of health workers helped. As local level leaders, that really helped to make them understand the need which was translated as policy development as well as targeting activities. So this was a positive thing that happened."—Mission staff respondent*

There was also a recognized need for capacity building efforts to navigate and adapt to the changing context of COVID-19 and address emerging challenges for program participants, such as the need for mental health support. This included leveraging the increased use of technology to improve capacity building of staff and to expand service delivery for communities in remote areas.

Training and technical support was a key enabler to support IPs, local partners, and community workers in program implementation. USAID heavily relied on IPs and their local partners in particular to directly reach marginalized groups; however, they did not have the capacity to meet all needs of the most vulnerable without operational or technical support. Many IPs did not have prior experience in a crisis or emergency response setting. As a result, capacity building efforts were a key enabler when strategic planning and operationalization of activities integrated it. Technology also helped to continue facilitating capacity building opportunities. Some respondents shared examples of the importance of capacity building, including:

*"I think [the] key to all these processes is the training in capacity building that we do with the communities to enable them to actually facilitate the processes in their communities…. And, of course, yes, we capacitated them to be able to respond to what was coming due to COVID-19, and also build resilience within individuals, as well as communities. And there was quite a lot of self care and strengthening of coping skills within this intervention."—IP respondent*

Experience in previous emergency response efforts, such as natural disasters, also prepared the Nepal Mission to operate under these circumstances with local partners to support gender and inclusive development integration. Collaboration across technical offices and activities further ensured synergy of programming in Nepal. Capturing lessons learned and best practices in response efforts may help Missions and IPs mitigate risk for the most vulnerable in future crises.

**Lessons Learned For Future Crises: Local Partnership Networks**

- Virtual training, guidance, and technical expertise is valuable for USAID and IP coordination and crisis-response capacity building of local organizations and CSOs.
- Development of local relationships and community networks is important in crisis response, but it is important to avoid over-reliance on local IPs as a "one stop shop."

## TECHNOLOGY

Lockdowns, while important in the effort to curb the spread of COVID-19, were disruptive to social services and livelihoods as well as to program implementation. Many activities pivoted to providing virtual support, which allowed for continuation of implementation. At the same time, lack of access to technology was noted as a constraint to reaching marginalized people in some cases, including women, the poor, and rural populations.

> *"I think one of the major barriers especially when COVID came through was … because of the technological divide most people did not have access to gadgets that enable them to join meetings and trainings virtually. And you will notice that especially in rural areas and other areas they will have one phone at household level and normally the father is the owner of that cell phone. And so because of that it was difficult. Say the father is gone to work or has gone somewhere to look for some funds and there's no phone at home but people are not allowed to gather so it meant that most people actually were lagging behind in terms of some of the trainings that needed to be done." —Mission staff respondent*

Several activities addressed this lack of technology access by providing internet access or airtime for target participants, including youth and persons with disabilities. In several cases, youth showed a greater comfort in learning to use new technologies to connect with others. This gave young people an opportunity to be change agents in their communities.

One example where technology was particularly useful was in providing psychosocial support and training. The assessment team's literature review included reports that cited special concerns for the mental health of children (impacted significantly by school closures, stay-at-home orders, and mask mandates, in addition to losses of loved ones) as well as healthcare workers facing increased stress (UNICEF 2021a). Several respondents noted the importance of technology as an enabler for provision of psychosocial support and other routine medical care:

> *"In fact, we were able to also start off telemedicine and we were able to train a huge number of psychosocial professionals because we saw an increase of people having depression and mental health problems among the key populations, especially with LGBTI. We were quickly able to train them and started providing this online. We cannot say that we stopped all the suicides but definitely we did make a difference. At least we avoided some of it through this daily medicine because we were able to connect the community with the bigger health systems."—Mission staff respondent*

The increased use of digital technologies was linked to a number of positive unintended outcomes by respondents. As reported by several health activities, adoption of digitization in the health sector increased efficiencies and allowed for better planning, reporting, and evidence-based decision making for governments and better coordination between local and national levels. Adaptations to provide telemedicine during pandemic lockdowns created the infrastructure to continue to provide remote care post COVID. This will be especially valuable for remote communities without local health facilities.

Examples of how programming applied technology to respond to COVID-19 included:

- Increased digital communication and coordination between USAID and IPs
- Online or phone psychosocial support training and counseling
- Telemedicine
- Communication and training with potential grants recipients
- Use of social media, online groups, and radio to engage women, people with disabilities, and youth in peacebuilding activities
- Use of Youtube to combat COVID-19 misinformation
- Digital facilitation of cash transfers
- Risk communication (i.e., radio programming, communication campaigns)

**Lessons Learned For Future Crises: Technology**

- Where possible, shifting to provision of remote services allowed for a continuity of implementation. Training IPs and program participants on digital literacy and provision of digital equipment was necessary in some cases to meet the increased demand and use of innovative technology during COVID-19. This included training health workers on using new equipment to treat patients and offering telemedicine services for the most vulnerable groups.
- IPs were able to improve access to virtual/remote programming by furnishing marginalized people with mobile phones or paying for airtime.

## ENABLING POLICY AND GUIDANCE

Respondents generally agreed that programming during the pandemic included gender and inclusive development considerations. Existing USAID policy, found in Integrating Gender Equality and Women's Empowerment in USAID's Program Cycle Consistent (ADS 205) also provides direction on gender analysis at the Mission level. The considerations focus on "the most important challenges and opportunities facing the partner country, identify those areas that the Mission plans to address" (ADS 205.3.3.). Four Missions included in the assessment developed a new country strategy during the pandemic, while the remaining two added COVID-19 amendments. Each included contextual information about COVID-19 impacts, as well as specific notes around increased vulnerabilities for women, girls, or country-specific marginalized groups. Many included references to other existing crises and the vulnerabilities of marginalized groups. Table 3 shows some of the inclusive development considerations included in these strategies for each of the case study countries.

**Table 3. Inclusive Development Considerations Included in Country Strategies, by Mission**

| Mission | Marginalized Groups Identified | COVID-19 First- and Second-Order Effects | Existing or Emergent Contextual Challenges |
|---|---|---|---|
| Libya | • Women<br>• Youth<br>• Indigenous communities<br>• Persons with disabilities<br>• Other marginalized groups | • Impacted sectors: health, service sectors, construction, light manufacturing | • Instability<br>• Terrorism<br>• Civil unrest |
| Nepal | • Religious minorities<br>• Caste groups<br>• Ethnic minorities<br>• Women<br>• Youth<br>• Other marginalized groups | • Increased unemployment<br>• Influx of returning migrant workers<br>• School closures<br>• Food insecurity<br>• Strained healthcare system and challenges to social service provision<br>• Increased GBV and CEFM/U | • Earthquakes<br>• Landslides<br>• Flooding |
| Nigeria | • Women<br>• Children<br>• Religious minoritie<br>• Persons with disabilities<br>• Internally displaced people | • Increased GBV and CEFM/U | • Climate change; persistent insecurity and conflict Illness and disease<br>• Political instability |
| Peru* | • Women<br>• Girls<br>• Indigenous communities<br>• Rural populations<br>• Venezuelan migrants/ refugees | • Socio-economic deterioration<br>• Increased illicit activities, including coca cultivation | • Climate change<br>• Neighboring humanitarian crisis |
| Rwanda* | • Young children<br>• Persons with disabilities<br>• Victims of GBV (female and male)<br>• Adolescent girls and young women (especially mothers)<br>• LGBTI+ individuals | • Strain on health system<br>• Risk of negative impacts on economic growth and regional integration | • Risks of ebola and other illnesses<br>• Regional conflict and related refugees |
| Zimbabwe | • Youth<br>• Women<br>• Persons with disabilities<br>• Persons living with HIV and AIDS<br>• Other marginalized groups | • Strain on health systems, demand for skilled health workers<br>• Unlawful arrest and detention of innocent civilians Increased corruption | • Barriers to civic participation of marginalized communities<br>• High rates of GBV and CEFM/U related to cultural, religious, and ideological biases |

*Peru and Rwanda Missions developed their country strategies before COVID-19 was declared a pandemic, thus their strategies contained more limited COVID-19 edits or amendments.

Many respondents referenced the use of gender or gender equality and inclusive development analysis in activity design or implementation, as well as the use of sex disaggregated data in accordance with ADS requirements. Respondents also stated how access to relevant and timely data and technical expertise was important for building Mission staff capacity to integrate gender equality and inclusive development across all activities and programming. Missions found it helpful to have the technical support to understand the principles of gender and inclusive development and how to include inclusive development and gender considerations in activities.

Existing policies and guidance promote practices that are encouraged but not mandatory, especially around inclusive development. For example, while a gender analysis is mandatory as part of Country Development Cooperation Strategies and activity design, inclusive development analyses are encouraged but not required (ADS 201, "Suggested Approaches for Integrating Inclusive Development Across the Program Cycle"; also in Mission Operations Additional Help for ADS 201). Missions may decide to include additional requirements. For example, a respondent from the Nepal Mission shared:

> *"Implementing partners were also required to produce GESI analysis and action plans in their response programming. This helped to focus and pivot Nepal's programming to reach marginalized groups. They were able to use existing processes and practices in the context of the pandemic to mitigate risk and focus funding on marginalized groups and sectors that were most vulnerable as well. This was general practice by the Mission, Government of Nepal, multilaterals, and other development actors."*

USAID provided Missions and IPs with additional guidance and information throughout the pandemic. For example, USAID's Office of Gender Equality and Women's Empowerment developed a job aid tool, Carrying Out a COVID-Specific Gender Analysis**,** and USAID education-in-crisis and conflict specialists developed a toolkit, Returning to Learning during Crises. Several respondents noted that there was a high volume of guidance and tools, which were hard to prioritize during the peaks of the pandemic.

**Lessons Learned For Future Crises: Enabling Policy and Guidance**

- In times of crisis, Missions and IPs would benefit from greater clarity on operationalizing policies and applying guidance from Washington. Specifically, guidance provided should be brief and actionable, and disseminated in a coordinated fashion via the Regional Bureaus or to a designated point of contact in the Mission.

## DATA, EVIDENCE, AND LEARNING

Both Missions and IPs shared that access to existing data or assessments about gender or inclusive development was an enabler for integrating these principles into programming. Barrier analysis, context analysis, and social mapping, while not required, all provided useful information to inform design. One Mission staff respondent noted the success of using social mapping as a helpful tool to identify and target marginalized populations:

> *"Social mapping as a tool really helped serve from a provider perspective, like how they are going to be inclusive in service provision, how they need to be inclusive in making access to services to the most marginalized community. And then the other part that [the activity] contributed to at the municipality level, and at the provincial levels, is to use data for planning and budgeting. So capacity building around that, and the service for the use of that data to allocate the resources. So I think these types of activities will sustainably build capacity at the municipality level to plan and break those barriers from the service provider perspective."*

Additionally, regular communication and engagement with communities helped to inform and adapt approaches to implementation. Lack of information or disaggregated data about certain populations, particularly LGBTQI+ people and migrants, made it difficult to track access to programming. Access to timely data and evidence was especially important in the health sector, where virus response shifted greatly as more was understood about COVID-19. One IP respondent shared more about this challenge:

> *"What we often found was needed was very clear, specific, replicable, and dependable guidance on what to do [when] confronted with the various situations that would find yourself [in] during COVID programming. So a lot of guidance sometimes was not very clear and was not grounded in very good science if you want to be evidence based in your programming.… [There] could have been a more consistent and dependable platform or channel that should have probably been pushing a lot of the new knowledge that was coming out fairly fast at that time into the hands of implementers like us to quickly adapt our mechanism. So you find there would be a period between what is the best practice or what is evidence informed now versus what we were doing."*

Due to travel restrictions, the use of technology was leveraged to strengthen communication channels between Missions, IPs, and program participants. Some IPs used digital platforms and mobile phones to develop feedback loops that supported timely coordination efforts and allowed access to timely information, allowing them to identify the needs of marginalized communities and opportunities to expand access to services. Real time data, collected via phone surveys, was used by one health activity to continuously adapt messaging about COVID-19:

> *"What sort of voices do we need to have more of because we also tested or asked questions around trusted voices, questions around preferred source of information in terms of platforms, what media platforms were trusted, So we constantly made those kinds of tweaks and then looked at those responses over time to gauge to what degree we were moving the needle. If a certain sex or age group was falling behind, how did we tweak what we're doing to specifically address issues within that age group? So, yeah, those kinds of results were constantly used to reevaluate, rethink strategies, make shifts as needed."— Mission staff respondent*

**Lessons Learned For Future Crises: Data, Evidence, and Learning**

- Using analysis tools (e.g., social mapping analysis, rapid assessment, Do No Harm analysis, and barrier analysis) during country strategy development and activity design is useful for understanding complex contexts and implications for vulnerable or marginalized peoples. These analyses provide important foundational information that can be revisited and adapted in times of crisis as contexts shift.
- Performance and context monitoring contribute to data informed decision making, which is important for adapting to shifting vulnerabilities of marginalized groups during a crisis. Integrating pause and reflect opportunities could be one way in which to incorporate data and learning strategically.
- Feedback mechanisms between IPs and program participants are another way to meet emerging needs of marginalized groups. This can also be an opportunity to capture unintended outcomes, both positive and negative, of programming and follow Do No Harm principles.
- Capturing learning during a crisis and using it to inform programming is an opportunity for stakeholders to improve readiness and response to future crises. A Nepal Mission respondent provided an example of this:

*"They were able to draw from lessons learned in previous crisis/pandemics (i.e., earthquake) on reaching out to marginalized women and people in vulnerable situations. It was not difficult to raise issues of discrimination during the pandemic. The media was bringing out coverage on issues faced by women, pregnant women, migrant women, and younger women. The government was also engaged in this with a network of women in disasters so there was much more of an open approach towards inclusion during a crisis."*

## CONTRACT FLEXIBILITY, ADAPTABLE MECHANISMS, AND FUNDING

Missions and IPs faced an overwhelming demand to develop new programming or adapt existing activities to quickly respond to the emerging health demands and second-order effects of the pandemic. Many respondents noted that COVID-19 response funds were restricted to addressing first-order impacts (i.e., prevention, treatment, and vaccinations). Respondents referenced several health activities shifting from a focus on providing mainly HIV or tuberculosis testing and treatments to provide COVID-19 prevention, treatment, and vaccination support.

Access to additional COVID-19 response funds in some Missions provided opportunities for activities to expand or adapt to address emerging needs. In one example, an activity providing rehabilitation support to persons with disabilities was given additional funds which allowed for continuation of services even during lockdowns. Added COVID-19 funds allowed Missions and IPs to continue to implement in an inclusive manner. At the same time, much of the COVID-19 funding was provided incrementally, making it difficult for Missions and IPs to plan.

The most common constraint that respondents shared was the inability of activities to respond to some of the second-order effects of COVID-19. Earmark or other fund restrictions, as well as long procurement processes, made it difficult to respond to some emerging needs. During the pandemic, many marginalized

people experienced GBV, food insecurity, CEFM/U, and mental health issues. Many Mission respondents noted that they were aware of these second-order effects of the pandemic through media reporting and feedback from IPs or program participants, but did not feel that existing programs could address these effects. In some cases this was linked to the siloing of programs by technical sectors; in other cases, it was related to funding restrictions. These challenges were often linked to decreased livelihoods:

> *"[Our] economy is highly informalized. So also the issue that because of the informal work, most of their work is dependent on them, being on the ground, interfacing with other people so that they can sell their wares…. So because that was limited during COVID, it meant that the source of livelihood for most people was restricted and most young girls resulted to looking for other means of survival and the easy way out was to find someone who's willing to finance them and in most cases that would end up in child marriages."—Mission staff respondent*

Centrally managed mechanisms were one opportunity to fill funding gaps and develop programs for marginalized groups. The Multi-Donor LGBTI Global Human Rights Initiative, for example, provided emergency grants during this period to help partners adapt to meet the emergent needs of LGBTQI+ people.

**Lessons Learned For Future Crises: Contract Flexibility, Adaptable Mechanisms, and Funding**

- Flexibility is needed in crisis response efforts. Many of USAID's existing structures, funding, and narrow scope for awards make adapting to emerging needs difficult.
- One opportunity to increase integration of gender equality and inclusive development in programming is the addition of language to requests for applications and proposals that emphasize the importance of inclusive principles or requirement of key personnel with gender equality and inclusive development expertise.

## USAID ORGANIZATIONAL FACTORS

Interviews identified several contextual and organizational constraints and enablers affecting USAID's ability to address emerging needs of marginalized groups during the pandemic. USAID staff experienced several first- and second-order effects of the COVID-19 pandemic. Staff faced increased pressures at work, including adapting to remote work, staffing shifts related to COVID-19 evacuations, and managing new or adapted programs. Staff also faced increased stress at home, such as worsening mental and physical health, and increased caregiving responsibilities—especially for women—related to pandemic lockdowns and school and childcare closures.

As noted in the previous section, many activities experienced challenges in addressing emerging needs outside their scope or technical area. One opportunity to address this issue is to have greater cross-office coordination within Missions to address the cross-sectoral emerging needs of marginalized groups during crises.

Rapid response in the initial phases of the pandemic proved to be particularly challenging for Missions that did not have Health Offices or active health programming (for example, Libya, Costa Rica, Peru, and Uruguay Missions). In those cases, Missions needed to develop new relationships with government ministries and health focused CSOs in a short period to support COVID-19 prevention. Mission staff then needed to manage this support.

Respondents identified Agency expertise and championing of gender equality and inclusive development as enabling inclusive development. While USAID policy encourages practices to integrate inclusion in programming, gender equality and inclusive development champions can support integration through the Program Cycle. Respondents also noted that the presence of gender equality and inclusive development champions on the Agency crisis task force enabled the development of guidance with gender equality and inclusive development considerations.

**Lessons Learned For Future Crises: USAID Organizational Factors**

- Developing a layered and cross-sectoral approach can help address immediate and long-term impacts of crises on marginalized groups such as mental health issues, economic recovery, and social or cultural norms. Examples of interventions include: mental health and psychosocial counseling, income generation (i.e., cash assistance), risk communication (i.e., radio programming and communication campaigns).
- Addressing COVID-19 was difficult for Missions that did not have existing health sector programming, as staff needed to quickly build relationships with partners and host governments to support COVID-19 response.

# RECOMMENDATIONS

The assessment team co-created the following recommendations with USAID Mission and Washington stakeholders based on the assessment findings. In applying these recommendations or taking other actions based on the assessment findings, it is critical that stakeholders apply Do No Harm principles to safeguard against negative unintended outcomes.

> *Do No Harm: "Take measures to ensure that efforts do not put any marginalized and/or underrepresented individual at increased risk of harm nor contribute to inequities, exclusion, discrimination, vulnerability, stigmatization, or violence towards any group in USAID programming design, implementation, monitoring, or funding decisions. 'Do No Harm' does not mean 'do nothing.'"—Inclusive Development, Additional Help For ADS 201*

1. **Conduct inclusive development or in-depth gender and inclusive development analyses:** The assessment team recommends that Missions conduct an inclusive development analysis, in addition to the required gender analysis (or combined in-depth gender and inclusive development analysis). This could become common practice in implementing contexts where there are recurrent shocks or other identified vulnerabilities.

Gender and Inclusive Development Analysis:

The assessment team defines a gender and inclusive development analysis as an effort that combines guidance on conducting a gender analysis in ADS Chapter 205 (205.3.2)—"Integrating Gender Equality" and "Women's Empowerment in USAID's Program Cycle"—and *USAID's Guide to Inclusive Development Analysis*. This would result in an analysis that applies a robust intersectional lens to: identify the marginalized groups and understand the factors that lead to marginalization; capture the differential impacts of policies and programs on women, girls, and marginalized groups; and generate specific programmatic recommendations to increase inclusion in programming and policy. This applied analysis would enhance program effectiveness in understanding and meeting the needs of women, girls, and marginalized communities. USAID's Gender Equity and Women's Empowerment Policy notes:

> *Incorporating an intersectional gender lens improves our programming by identifying—and strategically addressing—the ways in which gender and other inequalities can limit certain people's access to, participation in, and benefit from development interventions.*

- **Mission Program Offices** should conduct a combined gender and inclusive development analysis at the strategy level, especially in implementing contexts where there are recurrent shocks or identified vulnerabilities. Mission Program Offices should disseminate analysis findings to broader Mission staff (especially activity A/CORs). Solicitation language should integrate analysis findings in statements of work, activity deliverables, staffing (key personnel) and MEL requirements.

- **A/CORs** should share relevant findings from strategy-level gender and inclusive development analyses with IPs, and require IPs to integrate analysis findings in work plans and MEL processes.
- **USAID Washington Bureaus** should provide more technical assistance for inclusive development or gender and inclusive development analyses to Missions that lack the internal capacity to do so without support. Washington Bureaus should also encourage Missions to buy into mechanisms that would provide inclusive development capacity strengthening (see Annex G for a list of gender equality and inclusive development resources).
- **IPs** should utilize gender, inclusive development, or combined gender and inclusive development analysis in work plans and implementation. IPs should revisit the analysis during a crisis to inform inclusive programmatic adaptations.

2. **Capacity Strengthening:** The assessment team recommends that USAID and its partners prioritize capacity strengthening around gender and inclusive development principles for stakeholders, including USAID staff, IPs, CSOs, and host governments.
   - **Mission Program and Technical Offices** should invest (in the form of budget, staff, and training materials) in gender and inclusive development capacity building across Mission staff, not only gender or inclusive development advisors. The Program Office should identify an Inclusive Development Point of Contact or Advisor to encourage gender and inclusive development champions across the Mission and provide up-to-date guidance. Missions should orient all staff on relevant USAID policies, including but not limited to: Indigenous Peoples, Disability, Children in Adversity, Youth in Development, and LGBTQI+ policies. Program Office MEL specialists should work with MEL platforms to strengthen their capacity to conduct inclusive analyses and apply Do No Harm principles in MEL support to IPs (see Annex G for resources).
   - **USAID Washington Bureaus** should use designated points of contact to filter and disseminate guidance and communication with Mission teams. USAID Washington should also develop and disseminate gender and inclusive development MEL guidance, templates, and tools.
   - **IPs** should utilize USAID training, tools, and policies to better support marginalized groups before and during a crisis. They should consult and partner with a wide range of marginalized groups, utilizing USAID's Safety/Security-Sensitive and Trauma-Informed Stakeholder Consultations with Members of Marginalized Groups.

3. **Local Networks and Partners:** The assessment team recommends that Missions continue to invest in relationships with local partners that support vulnerable, marginalized, or underrepresented people.
   - **Mission Program Offices** should create and maintain a database of organizations led by marginalized people and develop platforms for IP coordination. In technical sectors where there is a recognized vulnerability (in this case, the health sector) and where the Mission does not have active programming, the Program Office should develop and maintain relationships with host governments, IP networks, or other donors to improve crisis readiness.
   - **Mission Technical Offices** should apply the "Nothing About Us Without Us" approach and include diverse perspectives by engaging members of marginalized groups, vulnerable populations, persons with disabilities, and women and girls in the design and implementation of activities.

4. **Adaptive Management and Mechanisms:** The assessment team recommends that USAID Missions and IPs embrace flexibility in contracts and implementation. Adaptive management is critical in meeting the emerging needs of the most vulnerable in times of crisis.

    - **Mission Contracting and Agreement Officers and Activity Design Specialists** should build flexibility into designs by, for example, designing activities with a focus on objectives and results and allowing flexibility to adapt programs with fewer formal modifications. In implementing contexts with recurrent shocks or other vulnerabilities, design and contracting staff should consider the addition of a crisis modifier. Contracts and agreements should include budget and time for coordination and collaboration across IPs. Mission staff should be open to investing in inclusive digital programming approaches which may improve efficiencies in implementation, increase reach to remote populations, and provide more flexibility during shocks which disrupt travel.
    - **A/CORs** should work collaboratively with IPs to identify when crisis conditions may significantly impair their ability to reach objectives and develop plans to address the situations (CFR 200.329). They should also coordinate across Technical Offices to address the cross-sectoral emerging needs of marginalized groups during crises.
    - **USAID Washington Bureaus** should proactively strengthen the capacity of Mission A/CORs to operationalize adaptive management through more flexible contracts and agreements.
    - **IPs** should monitor contextual shifts, identify disruptions in implementation, and recognize emerging needs of target populations. They should inform their A/CORs when crisis conditions may significantly impair their ability to reach objectives and develop plans (CFR 200.329).

# ANNEX A: ASSESSMENT DESIGN

## KEY DEFINITIONS AND PARAMETERS

### USAID GENDER EQUALITY AND WOMEN'S EMPOWERMENT POLICY

USAID affirms that gender equality and women's and girls' empowerment are fundamental for the realization of human rights and key to effective and sustainable development outcomes. USAID's *Gender Equality and Women's Empowerment Strategy* lays out these commitments to these issues. This assessment aligns with the strategy's commitment to evidenced-based and data-driven decision making and with the strategy's strategic objectives: reducing gender disparities; striving to eliminate gender-based violence (GBV) and mitigate its harmful effects; increasing women's and girls' agency; and advancing structural changes and equitable gender norms. Specifically, this assessment supports the policy's commitment to "consistently identify and address gender inequalities" through its targeted research.

### AUTOMATED DIRECTIVES SYSTEM (ADS) 205 AND 201 AND BUREAU FOR HUMANITARIAN ASSISTANCE EMERGENCY APPLICATION GUIDELINES

USAID's ADS 205, "Integrating Gender Equality and Female Empowerment in USAID's Program Cycle," outlines the key analytical domains for USAID to explore when analyzing gender in different country or regional contexts. USAID's "Additional Help: Suggested Approaches for Integrating Inclusive Development Across the Program Cycle and in Mission Operations," suggests that, "this same 'domain model' of gender analysis applies to any marginalized group". USAID's commitment to mitigating protection concerns for women and vulnerable groups is laid out in the Emergency Application Guidelines that the Bureau for Humanitarian Assistance issued. Requirements to consider gender, age, ethnicity, disability, and language as part of humanitarian action support an inclusive approach. This assessment aligns with the requirements to understand the extent to which programming supported by COVID-19 funds has integrated the needs of high-risk populations.

This assessment used six domains of analysis as a key component for assessing the extent to which programming supported by COVID-19 funds addressed gender equality and inclusive development. The assessment also used the domains to classify gender inequalities and unintended outcomes on underrepresented and marginalized groups. The six domains include:

- Laws, policies, regulations, and institutional practices
- Cultural norms and beliefs
- Roles, responsibilities, and time use
- Patterns of power and decision making
- Access to and control over assets and resources
- Safety and security

## MARGINALIZED GROUPS

Under the *U.S. COVID-19 Global Response and Recovery Framework* (2021), the U.S. government (USG) seeks to promote equity in its COVID-19 activities and elevate the voices, participation, and decision making of women and girls, youth, older persons, persons with disabilities, LGBTQI+ people, Indigenous Peoples, displaced people, and other vulnerable, marginalized, and underserved populations—especially those whom COVID-19 has disproportionately affected. These groups often suffer from discrimination in the application of laws and policies and access to resources, services, and social protection; they may be subject to persecution, harassment, or violence (White House 2021). These groups differ depending on the country- and region-specific context. USAID's "Suggested Approaches for Integrating Inclusive Development Across the Program Cycle and in Mission Operations, Additional Help for ADS 201" defines marginalized groups as:

> *People who are typically denied access to legal protection or social and economic participation and programs (i.e., police protection, political participation, access to healthcare, education, employment), whether in practice or in principle, for historical, cultural, political, and/or other contextual reasons. Such groups may include, but are not limited to, women and girls, persons with disabilities, LGBTI people, displaced persons, migrants, indigenous individuals and communities, youth and the elderly, religious minorities, ethnic minorities, people in lower castes, and people of diverse economic class and political opinions. These groups often suffer from discrimination in the application of laws and policy and/or access to resources, services, and social protection, and may be subject to persecution, harassment, and/or violence. They may also be described as "underrepresented," "at-risk," or "vulnerable".*

This assessment uses this definition of marginalized groups and more detailed definitions of specific groups according to the context. Recognizing that many forms of marginalization apply across contexts, the assessment team focused on the following key groups:

1. Women/girls facing multiple forms of marginalization
2. Youth (ages 10-29)
3. Elderly
4. Persons with disabilities
5. LGBTQI+ people

The assessment team included additional categories of marginalized groups depending on the country context, such as certain ethnic minorities, internally displaced persons or migrants, people involved in sex work and/or use of illicit drugs, and Indigenous Peoples.

Lastly, the team applied an intersectional lens, recognizing that sex and gender identity—as well as a range of other characteristics—shape women and girls, men and boys, and gender-diverse individuals. Individuals with overlapping, marginalized identities, for example, experience overlapping inequalities.
In contrast with the bulk of the literature on the effects of the COVID-19 pandemic in low- and middle-income countries, this assessment focuses on specific questions regarding USAID's programming that was supported by COVID-19 funds.

An extensive literature has emerged documenting the serious effects of the COVID-19 pandemic far beyond the health sector. The bulk of the literature, including the myriad evaluations of COVID-19 programs around the world, describes efforts to combat the virus through provision of personal protective

equipment (PPE) and vaccines, and seeks to understand the effects of the pandemic upon groups, occupations, and countries (Global COVID-19 Evaluation Coalition 2023). Instead of focusing on the immediate effects of COVID-19, this assessment focuses on the implementation of USAID's policies and processes regarding gender and inclusive development, with special focus on second-order effects of the pandemic, such as the impact on primary, secondary and tertiary education, mental health and psychosocial stress among care-givers, increases in GBV, threats to democratic institutions, and losses of livelihood resulting from policies and mandates that were intended to reduce the spread of the virus.

Specifically, this assessment explores how, why, and to what extent USAID Operating Units (OUs) operationalized the Agency's commitments to gender equality and social inclusion that are defined by Agency policies and mandates, as they allocated COVID-19 funds and designed and managed activities to mitigate the second-order effects of the pandemic. Factors expected to explain the alignment of OUs' decisions with USAID's gender and inclusive development policies may include: funding levels and funding constraints (such as specific conditions of the funding authorization); the OU's pre-COVID-19 strategic plan and portfolio of activities; organizational capacity; decision making and accountability mechanisms and processes at the Agency, Bureau, Mission and Country Office, and activity levels; implementing partner (IP) presence and capacity; the strength and focus of civil society organizations (CSOs); the presence and comparative advantage of other development partners; and the background gender, culture, and the socioeconomic context and infrastructure.

An initial review of the literature identified efforts to mitigate overlapping and interacting second-order effects in nine Agency sectors: water, sanitation, and hygiene (WASH); health; education; agriculture and food security; economic growth and trade; environment, energy and infrastructure; democracy, governance and human rights; humanitarian assistance; and innovation, technology and research. For example, loss of livelihood related to decreased food security, postponing or avoiding non-COVID-19 related healthcare, and withdrawal of children from school to assist with economic activity or care of family members. The USAID policies on gender and on social inclusion detail these interacting factors. This assessment focuses on the extent to which USAID OUs utilized COVID-19 funds to address or redress the added deficits and layered challenges faced by women and girls and marginalized groups in coping with these second-order effects of the pandemic. To comply with the assessment timeline and resources, the assessment team focused on activities in six sectors: agriculture and food security; economic growth and livelihood support; education; democracy, human rights and governance; health (beyond COVID-19); and WASH.

Country needs, USAID's investments of COVID-19 funding in different activities and sectors, and the causal pathways and effects involved are various and interacting, and they depend heavily on the specific background conditions in each of the 124 countries where USAID allocated COVID-19 funds (KFF 2022). Given USAID's country presence and history of engagement at country level, the assessment team assumed that each Mission and Country Office approached the principles and mandates encoded in the Agency's gender policy and social inclusion policy with their deep and up-to-date knowledge of these contextual factors. However, the assessment is not intended to trace causal pathways or to evaluate the effectiveness or outcomes of the activities that received COVID-19 funds. The assessment is not an hypothesis-testing exercise, but a rigorous search for patterns in the operationalization of USAID's gender and social inclusion policies under crisis conditions, so as to offer practical insights that may be useful to USAID in future crises. The use of a systematic, inductive approach allowed for analysis and engagement with stakeholders at multiple levels, including with Agency, Bureau, Mission and Country Office, IP, and activity participants.

The conceptual framework for the assessment design is depicted in Figure 1 below.

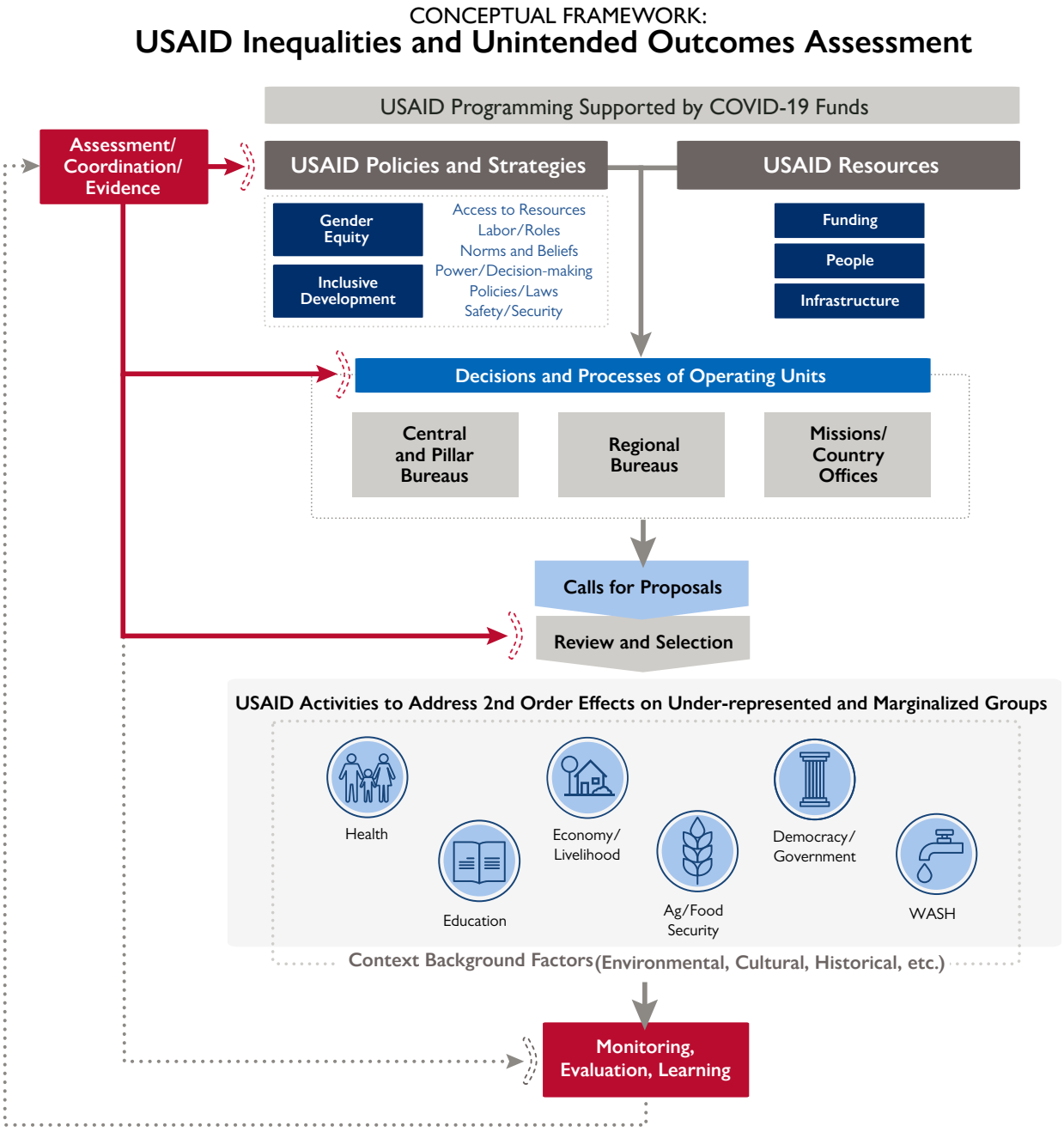


**Figure 1. Conceptual Framework**

## ASSESSMENT PRINCIPLES

The assessment team designed the assessment in close collaboration with a core team of advisors from the Bureau for Development, Democracy, and Innovation; the Bureau for Planning, Learning and Resource Management; the Bureau for Humanitarian Assistance; and USAID's COVID-19 Response Team. The core team validated the assessment scope, country selection, development of key assessment questions, tool development, and methodological considerations.

### COLLABORATIVE APPROACH

The assessment follows a collaborative approach as a core assessment principle, building on the consultative co-design. The assessment team engaged USAID stakeholders throughout the development of data collection tools, findings validation, recommendation development, and report writing phases. This approach not only captures diverse voices and a heterogeneity of perspectives, but also helps secure Agency-wide (and external, where relevant) buy-in of findings, learnings, and recommendations.

### EQUITY AS CORE ASSESSMENT CRITERION

The assessment team consistently used gender equality and inclusive development as the key assessment lens, as opposed to standard assessment frameworks or criteria that tend to focus on 'what worked' at the level of outcomes or objectives with inconsistent analysis of cross-cutting gender and inclusive development considerations. For this assessment, a key objective is understanding the extent to which USAID COVID-19 programming integrated gender equality and inclusive development considerations at design and implementation.

### INDUCTIVE FRAMING

To unpack unintended outcomes of USAID COVID-19 programming, the assessment team encouraged respondents to reflect on key changes both at the programmatic or operational level and at the outcome level, stepping back from the logic of a results framework or its performance indicators and focusing on the most meaningful factors and processes to them. This means that the approach was inductive, guided by unintended outcome priority themes. Given that this is not a performance evaluation or performance assessment, predetermined activity or program results frameworks (and performance against result indicators) are not a priority for this assessment. The assessment team did not test or validate pre-formed hypotheses regarding the programs' or activities' intended outcomes.

## ASSESSMENT METHODS

The assessment used a mixed-method approach, with a strong emphasis on qualitative data.

### PRIMARY DATA COLLECTION

***Key informant interview (KII):*** The assessment includes interviews with key informants using semi-structured tools that investigate the lines of inquiry and associated assessment questions. KIIs also occasionally took the shape of group interviews (e.g., when a selected respondent suggested adding a well-informed colleague), and in this case views of both respondents were captured for each question. This is different from a focus group discussion, which requires moderation among interacting participants.

***Participatory group discussion (FGD):*** The assessment includes FGDs using a focus group guide with a select set of program participants. FGDs help assess gender equality and inclusive development integration in USAID programming from a bottom-up perspective. Participants reflected upon unintended outcomes that they may have experienced or seen others experiencing as a result of participation in USAID activities.

For the second line of inquiry (LOI 2) which assesses unintended outcomes, the assessment team encouraged respondents to reflect upon unintended outcomes within 'outcome domains' that relate to gender equality and inclusive development integration. The set of outcome domains reflect USAID priorities as gleaned from the unintended outcomes review in the USAID COVID-19 Big Picture Reflection—a pause and reflect exercise to support learning which involved broad stakeholder participation. Under each outcome domain, the assessment collects evidence of outcome trends and illustrative stories to unpack high-level findings on unintended outcomes, and discern Agency-wide and context-specific patterns. The outcome domains (ODs) are:

- Gender equality- or inclusive development-related positive or negative unintended outcomes at the organizational/operational/project management level
- Gender equality- or inclusive development-related positive and negative unintended outcomes at the project participant level

For each of these ODs, the assessment probes for unintended outcomes related to the following outcome areas:

- Mental health and psychosocial support
- Safety and security (including GBV)
- Intra-household power dynamics (decision making)
- Civic participation and leadership
- Access to digital technologies or virtual platforms

These ODs were identified during the USAID COVID-19 Big Picture Reflection which engaged multiple stakeholders in a participatory reflection and review of USAID programming during COVID-19.

***Rapid quantitative survey:*** The assessment includes a short, quantitative questionnaire to USAID Agreement Officer's Representatives (AORs) and Contracting Officer's Representatives (CORs) for activities that received USAID COVID-19 response funds. The survey aimed to garner high-level information on the extent to which programming supported by COVID-19 funding considered gender and inclusive development. The questions investigate organizational and resourcing facts (e.g., presence of a gender or inclusive development advisor, allocated/used Level of Effort on COVID-19 programming); portfolio and program design elements (e.g., whether gender or inclusive development analyses were undertaken, whether Activity MEL Plans considered sex disaggregated data); and operational aspects (e.g., gender-responsiveness in partnerships, IP selection). The intent of the survey is to provide a high-level descriptive snapshot of responses on Mission gender and inclusive development considerations; however, data from the other qualitative collection methods are the main source of evidence for investigating the assessment's questions.

## SECONDARY SOURCES

***USAID document review:*** The assessment includes a secondary review of programmatic documents—i.e., documents pertaining to USAID COVID-19 funding and its programs—from both Agency-wide and Regional Bureau and Country Mission levels. With help from Regional Bureaus, the assessment team identified and worked with a Mission focal point to collect relevant documents from A/CORs and IPs.

***Existing research:*** Though internal USAID documents are the primary focus of the document review, the assessment also draws on other literature. For example, the COVID-19 Global Evaluation Coalition (2023) cited 150 evaluations that partners conducted of COVID-19 investments. In order to avoid duplication of effort and to align research design with existing evidence and research, the assessment team used USAID and non-USAID literature to conduct a summative review of the second-order impacts of COVID-19 on gender equality and marginalization. This literature review informed the development of the assessment sub-questions on how USAID integrated gender and inclusive development. The team used non-USAID literature as well to triangulate findings from primary data collection and review of internal USAID documentation. (See Annex D for the summary of this literature.)

Finally, the assessment team also collected case-study (country)-specific literature in order to better understand specific contexts in each country related to gender equality, inclusive development, and the experience of different marginalized groups.

## SAMPLING METHOD

The assessment team undertook sampling and selection at three levels, as set out below. The assessment team brainstormed the selection approach with USAID through multiple iterations. The team attempted to include a range and breadth at all levels of selection.

***Case study country selection:*** The assessment covers six Missions. To arrive at the selection, the assessment team decided to use regional representation proportional to each region's share in total USAID COVID-19 funding. Using this approach, the team proposed including three countries from sub-Saharan Africa and one each from the regions of Asia, Middle East and North Africa, and Latin America and the Caribbean. The team then short-listed 18 countries across these regions which the team identified as the top recipients of COVID-19 funds. From this short-list, the team excluded eight countries represented in ongoing COVID-19 evaluations. The final selection of six Missions reflects feedback and recommendations from the Regional Bureaus and concurrence from the respective Missions and Country Offices.

***Activity selection:*** Based on a list of all COVID-19 response activities in the selected countries, the assessment team requested participation from three activities per Mission, which together represent a variety of technical sectors, themes, and activity sizes. Activities needed also to have met the timeline threshold of being up and running for at least a year. The Peru Mission was conducting an evaluation of its portfolio of COVID-19 programming, and the team had limited access to its activities; for the remaining five countries, the team agreed a final list of activities with USAID after gaining access to full details of those Missions' activities and their COVID-19 response. The assessment team sought to include at least one non-health intervention per country so as not to lose sight of the range of second-order effects of COVID-19. Following Mission inputs, the team finalized the activity selection.

***Respondent selection:*** The team selected respondents to cover a spectrum of experiences and stakeholder types. The team engaged USAID informants at the headquarter level and at the country level; key informants from IPs and their downstream partners (such as CSOs); and, where country context allowed, program participants. For the KIIs and FDGs, the team invited staff who were in leading, managing, or coordinating roles in their respective organizations and gender or inclusive development focal points (A/CORs, chiefs of party, team leads, program leads, gender or inclusive development advisors/experts, etc.) to participate.

### ESTIMATED SAMPLE SIZE

This assessment team aimed to engage between 150 and 240 individuals (see Table 4 below). The team categorized candidates for KIIs by organization type (USAID staff, IPs, and other international organizations) to represent a best-fit set of informants.

The assessment team employed dyad or triad interviews to maximize engagement with technical experts from USAID technical offices and IPs while minimizing the impact on their time. This approach increased the assessment sample size.

**Table 4. Primary Data Collection Methods, Stakeholders, and Sample Size**

| Data Collection Method | Stakeholders | Sample Size (Number of Respondents) |
|---|---|---|
| Semi-structured interviews[2] | USAID staff in OUs, Regional Bureaus, etc. | 19 |
| | Mission/Country Office USAID staff, including Office Directors, foreign service national (FSN) technical experts, Program Office staff, and gender/inclusion advisors/focal points | 24 |
| | USAID IPs (including gender advisors, focal points, sector-specific experts, and senior managers) and sub-partners (local CSOs, CBOs, etc.) | 36 |
| | Other national stakeholders (host governments), and international organizations, multi/bilaterals, and donors (gender advisors and sector technical experts) | 6 |
| Participatory group discussions | Program participants from selected USAID activities in each country where feasible[3] | 66 |
| Rapid quantitative survey | USAID A/CORs for activities that received USAID COVID-19 response funds | 14 |

[2] Mission and Country Office and IP respondents sampled to represent sectors across USAID technical offices.

[3] Semi-structured, one-on-one interviews were available for program participants if they had safety or security concerns.

## DATA ANALYSIS

The qualitative data analysis followed an inductive approach. The team mapped core meanings evident in the interview or discussion transcripts to the assessment questions. The team discussed interview notes and emerging themes in an iterative, collaborative process throughout data collection and after data collection concluded. USAID's Automated Directives System (ADS) 205 offers a set of domains to guide gender analysis, which the team also applied to inclusive development analysis. The analytical framework for the first line of inquiry (LOI 1) primarily covers the domains that cut across the assessment questions and investigates various aspects of gender equality and inclusive development in programming. In other words, for LOI 1, a predetermined framework guides analysis, while allowing for new dimensions also to emerge. For LOI 2, the team analyzed the most important themes to emerge within the overarching framework of outcome domains for unintended outcomes (see section on "Primary Data Collection").

The team digitally recorded and transcribed interviews, or captured them in interviewer notes. In instances where interviews were conducted in a language other than English, the assessment team translated transcripts into English. The team then used a qualitative software program to code and cross-classify the textual data from the transcripts. Additionally, the team took notes during each interview and expanded the notes into memos for researchers re-listening to segments of interviews.

Next, researchers reread transcripts to inductively identify emerging themes that were not overtly included in the interview guide topics. The assessment team collaboratively discussed codes and emergent or unexpected themes to improve reliability of coding. Utilizing Atlas.ti helped researchers to summarize key patterns from the qualitative data and illustrate those patterns with meaningful quotes.

Recurrent responses to each assessment question during data collection could indicate major themes; however, in a multi-country assessment, variations and contextual nuances played an equally important role in analyses. Triangulation of findings (both internal, i.e., across respondent and stakeholder types; and external, i.e., across data sources) helped ensure that the assessment recognized a range of respondent experiences, explained variability, and explored nuances. Analysis situated the findings within the context, and cross-references with the literature review played an important role. Finally, the report references all evidence-based findings throughout to document a clear through line between findings, conclusions, and recommendations for USAID audiences, while maintaining strict confidentiality of the primary data by anonymizing individual sources.

### VALIDATION OF PRELIMINARY FINDINGS AND RECOMMENDATIONS

As part of the approach to holistic participation and collaborative learning, the assessment team organized a stakeholder validation workshop to solicit stakeholder feedback on preliminary findings and to co-create recommendations.

# ANNEX B: LITERATURE REVIEW

The COVID-19 pandemic has reached almost every part of society and affected people in different ways. It has affected people's physical and mental health, but it is much more than a health crisis; it is a human, economic, and social crisis that, if not adequately addressed, could lead to an increase in inequality, exclusion, discrimination, and global unemployment (de Sousa 2022; Htay et al. 2021; Sümen and Adibelli 2021; United Nations [UN] 2020).

Many segments of the population have felt the consequences and adverse effects of the pandemic on their lives and well-being (UN Department of Economic and Social Affairs [UN DESA] 2021). The virus has hit the already vulnerable, marginalized, and poorer segments of societies particularly hard, including people living in poverty, older adults, persons with disabilities, women, youth, LGBTQI+, and internally displaced persons, migrants, and refugees (UN DESA 2021). In certain contexts, COVID-19 also more negatively impacted ethnic minorities and Indigenous groups.

## CROSS-CUTTING: GENDER AND INCLUSION SECOND-ORDER EFFECTS

### WOMEN'S TIME BURDEN AND CARETAKING ROLES

The COVID-19 global crisis has made starkly visible that the world's formal economies and the maintenance of daily lives are built on the invisible and unpaid labor of women and girls. The demands on care work due to COVID-19 intensified exponentially with children out of school; intensified care needs of older persons and ill family members; and overwhelmed health services. Furthermore, there are gross imbalances in the gender distribution of unpaid care work. Even before COVID-19 became a global pandemic, women were doing three times as much unpaid care and domestic work as men. This unseen economy has real impacts on the formal economy, and women's lives. In Latin America the value of unpaid work is estimated to represent between 15 percent and 26 percent of GDP (United Nations 2020).

In the context of the pandemic, the increased demand for care work has deepened gender inequalities in the division of labor. The less visible parts of the care economy are coming under increasing strain but remain unaccounted for in the economic response. School closures have put additional strain and demand on women and girls. As formal and informal supply of childcare declines, the demand for unpaid childcare provision is falling more heavily on women, not only because of the existing structure of the workforce, but also because of social norms. These demands, moreover, constrain women's ability to work, particularly when jobs cannot be carried out remotely. The lack of childcare support is particularly problematic for essential workers who have care responsibilities.

### PARTICIPATION AND LEADERSHIP OF WOMEN AND MARGINALIZED GROUPS IN COVID-19 RESPONSE

Women's and underrepresented groups' participation is necessary at every level and in every arena to respond to crises, from national committees to the local communities on the frontlines of humanitarian responses. Without women's equal leadership and participation, COVID-19 responses are less effective at meeting the needs of women and girls, and this will have short- and long-term consequences for entire communities. Research demonstrates that women leaders have been more successful than their male counterparts at reducing COVID-19 transmission in their countries (Fioramonti et al. 2020).

An analysis by Care (2020) looked at women's leadership in 30 countries' COVID-19 response and found that the majority of national-level committees established to respond to COVID-19 did not have equal female-male representation. Of the countries surveyed, 74 percent had fewer than one-third female membership, and only one committee was fully equal. On average, women made up 24 percent of the committees. In seven countries, CARE could not find evidence that the government had made funding or policy commitments for GBV, sexual and reproductive health services, or women-specific economic assistance. Fifty-four percent of countries had not taken any action on GBV, and 33 percent did not appear to have addressed sexual and reproductive health in their response, despite clear evidence of the impact of the crisis on these issues. Seventy-six percent of the countries surveyed made at least one policy commitment that supports women, but one policy cannot account for the pandemic's impact on gender equality (CARE 2020).

Countries that have more women in leadership, as measured by the Council on Foreign Relations' Women's Power Index, were more likely to deliver COVID-19 responses that considered the effects of the crisis on women and girls (CARE, 2020). On average, the higher a country's score on the index, the more likely it was to craft a gendered response. Governments with less women in leadership risk creating COVID-19 response plans that do not consider the pandemic's disproportionate impact on women and girls, and failing to implement policies that support them. In many contexts, a lack of gender-balanced leadership could worsen the effects of the crisis for women and girls and their families and communities. There is also a risk that gender equality gains could be lost due to the COVID-19 crisis. Lastly, decision making in humanitarian response is not including local women's rights and women-led organizations and leaders, and women are not receiving their fair share of funding (Care 2020).

### GENDER-BASED VIOLENCE (GBV)

GBV increased during the COVID-19 pandemic. COVID-19 and other past pandemics have led to increases in intimate partner violence that includes physical, verbal, economic, and psychological violence (John et al. 2020). Pandemics are also associated with digital harm, including online and offline sexual harassment and gender-based bullying and abuse; sexual exploitation and abuse, especially of women and girls; and trafficking for commercial exploitation, especially of girls through online means (UN Women 2020a). The COVID-19 pandemic has detrimentally affected efforts to end harmful practices, such as child, early, and forced marriage/unions (UNICEF 2021b). Moreover, COVID-19 impacted the abuse and mistreatment of persons with disabilities, and LGBTQI+ people; female genital mutilation and cutting; attacks against female health workers; and trafficking in persons (UNHCR 2020; Esho et al. 2022; Bhatti et al. 2021; UN Women 2020a). Factors that contributed to these trends included curtailed movement from home because of stay-at-home measures; or social isolation; increased use of the internet; reduced access to support networks; and financial stress. At the same time, in many countries, abuse reports and calls to domestic violence hotlines decreased as women could not leave home or access help online or by telephone (UN Women 2020b). The following points are documented factors that impact GBV prevention and response during pandemics:

***GBV risk mitigation measures*** – Evidence from previous pandemics, such as the Ebola virus, highlights how not putting GBV risk mitigation in place across sectors and activities may unintentionally heighten the risk of GBV (John et al. 2020). Not integrating support—such as measures to address economic and emotional stressors at the household level; provide girls with equal access and participation in distance learning and safe return to learning; and provide safe access to water, sanitation, and hygiene—could enhance these risks (UN Women 2020b).

***Limited access to GBV response services*** – COVID-19 stay-at-home measures and quarantines forced some GBV survivors to remain confined with abusers and perpetrators, limiting their ability to access legal, health, and other frontline GBV services and informal support networks (John et al. 2020). Violent partners may use confinement to exercise further power and control. At the same time, women and certain marginalized groups have less income, fewer opportunities for social contact, and limited access to services and community support—all of which give them fewer exit options (UN Women and UN Development Programme [UNDP] 2022). In many countries, survivors experienced increased barriers accessing support services. This was because of operational challenges due to shelter-in-place orders, backlogs in court cases, and reduced funding for law enforcement and women's rights organizations, which play an essential role in GBV service provision (UN Women and UNDP 2022). Health services for GBV survivors have diminished in some contexts due to the diversion of healthcare supplies and facilities from GBV and sexual and reproductive healthcare services to the COVID-19 response. GBV service providers face mobility challenges related to the lockdown measures in addition to resource constraints that limit their ability to meet the growing needs of GBV survivors (John et al. 2020). Lastly, government responses to the surge in violence against women have been uneven; however, analysis reveals a range of measures taken, including awareness-raising campaigns, support for shelters, and efforts to strengthen women's access to justice (UN Women 2020c).

***Mental health and psychosocial support (MHPSS) needs of GBV survivors*** – GBV takes a significant toll on survivors' mental health and psychosocial well-being. However, access to MHPSS resources has been limited during the COVID-19 pandemic. This is due to increased demand for services, reduced budgets before the pandemic, and reduction in MHPSS services as resources have been diverted to the COVID-19 response (Guidorzi 2020). Stay-at-home measures and women's lack of childcare may also limit GBV survivors' access to MHPSS services (Guidorzi 2020).

***Economic support for women and GBV survivors*** – Women may not be able to leave an abusive partner due to a lack of economic support. Women may have to miss work due to caregiving responsibilities or themselves becoming infected with COVID-19; they may also not have sick leave. Women may become unemployed due to closure of a job site. At the same time, women, including GBV survivors, who receive targeted economic support may experience increases in violence (John et al. 2020).

***Sexual exploitation and abuse of affected communities by aid workers during COVID-19*** – Sexual exploitation and abuse is a form of GBV for which all aid workers are accountable. It is likely present in every aid context. Sexual exploitation and abuse carries serious emotional and physical health implications for those affected, particularly if it occurs alongside other traumatic events, such as losing a loved one or experiencing food or economic insecurity. The impact of sexual exploitation and abuse goes beyond individuals, causing collective harm and trauma to communities and requiring large amounts of community resources to care for the survivors.

***Pandemics intensify other forms of violence and discrimination*** – Evidence across countries shows that women with disabilities are two times more likely to experience violence from partners and family members than women without disabilities, and they are up to 10 times more likely to suffer from sexual violence (UNFPA 2020; UNFPA 2018). In the context of lockdowns, institutionalized women with disabilities may also be at further risk of violence when visitors and monitors are not allowed due to restrictions (UN Women 2020c).

Evidence from previous pandemics reveals increased violence against female health workers, online violence, femicide, harmful practices, and racial and ethnic discrimination and violence (Devi 2020; Dey et al. 2022; UN Women 2020a; UNOCHA 2020). For example, in China, Italy, Singapore, and other countries, there have been reports of physical and verbal attacks on healthcare workers linked to COVID-19 (UN Women 2020c). Similarly, people of Asian descent have been the target of verbal abuse, harassment, and violence in public spaces across the globe as scapegoats for the pandemic (UN Women 2020c).

## MARGINALIZED GROUPS

### LGBTQI+ PEOPLE

In many countries where USAID works, governments do not recognize the LGBTQI+ community. In other cases, governments criminalize those who identify as LGBTQI+. As a result, government policies and COVID-19 support programs often leave out this community. Relatedly, the LGBTQI+ community faces challenges in accessing healthcare systems due to stigma and discrimination, and in contexts where they are criminalized, face threats to their security and lives (UN Women 2021). Additionally, delays in care and lack of access to care was a widespread concern, especially lack of gender affirming care, which was deemed non-essential during the height of the pandemic (The Global Health Council 2021). Many key funders of LGBTQI+ organizations withdrew funding during the pandemic due to a perceived inability to continue their work due to COVID-19 restrictions.

### PERSONS WITH DISABILITIES

Persons with disabilities face challenges in accessing health-care services, due to lack of availability, accessibility, and affordability, as well as stigma and discrimination. Other issues compound the risks of infection from COVID-19 for persons with disabilities, which warrant specific action: disruption of services and support; pre-existing health conditions, which in some cases increase their risk of developing serious illness or dying; exclusion from health information and mainstream health provision; often limited accessibility to goods and services; and being disproportionately more likely to live in institutional settings.

General individual self-care and other preventive measures against the COVID-19 outbreak can entail challenges for persons with disabilities. Cleaning homes and washing hands frequently can be challenging due to physical impairments, environmental barriers, or interrupted services. Others may not be able to practice social distancing or cannot isolate themselves because they rely on regular help and support from other people for everyday tasks. Those with neurodiverse conditions may experience higher levels of depression and anxiety as a result of pandemic-related disruptions (Samji et al. 2021).

To support persons with disabilities' access to COVID-19 information, it must be made available in accessible formats. Healthcare buildings must also be physically accessible to persons with mobility, sensory, and cognitive impairments. Moreover, financial barriers must not prevent persons with disabilities from accessing the health services they need in times of emergency.

### YOUTH

In terms of employment, youth are disproportionately unemployed. Those who are employed often work in the informal or gig economy or in the service sectors, which COVID-19 severely affected. More than one billion youth are now no longer physically in school after the closure of schools and universities across many countries. The disruption in education and learning could have medium- and long-term consequences on the quality of education, though the efforts made by teachers, school administrations, and local and national governments to cope with the unprecedented circumstances to the best of their ability should be recognized.

### ELDERLY

Older persons are particularly susceptible to the risk of infection from COVID-19, especially those with chronic health conditions such as hypertension, cardiovascular disease, and diabetes. Older persons are also likely to be less capable of supporting themselves in isolation. The discourse around COVID-19 as being a disease of the elderly exacerbated negative stereotypes of older persons who may be viewed as weak, unimportant, and a burden on society. Such age-based discrimination may manifest in the provision of services because the treatment of older persons may be perceived to have less value than the treatment of younger generations.

### INDIGENOUS PEOPLES

As the number of COVID-19 infections rose worldwide, as well as the high mortality rates among certain vulnerable groups with underlying health conditions, data on the rate of infection of Indigenous Peoples are either not yet available (even where reporting and testing are available), or not recorded. Relevant information about infectious diseases and preventive measures is also not available in Indigenous languages.

Indigenous Peoples experience a high degree of socio-economic marginalization and are at disproportionate risk in public health emergencies. Due to lack of access to effective monitoring and early-warning systems and adequate health and social services, Indigenous Peoples became even more vulnerable during the COVID-19 pandemic (United Nations n.d.).

As lockdowns continue in some countries, Indigenous Peoples who already face food insecurity as a result of the loss of their traditional lands and territories confront even greater challenges accessing food. Many Indigenous Peoples who work in traditional occupations and subsistence economies or in the informal sector have been adversely affected by the pandemic. The situation of Indigenous women, who are often the main providers of food and nutrition in their families, is even graver.

### REFUGEES, MIGRANTS, AND INTERNALLY DISPLACED PERSONS

Refugees and internally displaced persons face legal status, discrimination, and language barriers that may limit access to otherwise publicly available preventative healthcare and social services. Health service information and government announcements may not reach them during COVID-19. Similarly, a lack of documentation and financial resources may hinder access to life-saving health services. Refugees and migrants may not be included in national strategies, plans, or interventions. During the COVID-19 pandemic, refugees' and migrants' mobility and cross-border movement made them difficult to reach.

## SECTOR-SPECIFIC GENDER AND INCLUSION SECOND-ORDER EFFECTS

### GLOBAL HEALTH

***Overview:***

Reviews of the short- and longer-term impact of the COVID-19 pandemic have identified a wide range of second-order effects in the health sector. These can be grouped at the level of health systems, population groups, and individual health behavior. At each of these levels, some—but not all—effects appear to be intensified for women and girls and marginalized groups, mirroring effects in other contexts. However, the literature review findings noted here should be considered provisional given the dearth of sex-disaggregated data; the even more limited data available on the pandemic's effects on LGBTQI+ people and other marginalized groups; and the shortage of quantitative measures of effects, including the observations of trends and changes in effects over time. This is also the case because an emphasis on gender and social inclusion in policy documents and plans does not always translate into that emphasis on the ground. The Lancet Commission on Gender and Global Health observed: "Gender is everywhere in global health discourse and promises, but nowhere in action or accountability plans" (Taukobong et al. 2016). The section concludes with a brief overview of health sector responses to these challenges, and a few unexpected and emerging opportunities for strengthening health sector responses.

***Health resources shifted to COVID-19 responses, constraining other health programs*** – Numerous studies affirm that, worldwide, the urgent requirement to respond to COVID-19 led governments, multi-laterals, and development partners to utilize readily available health sector staff and funding to mount COVID-19 responses (Independent Evaluation Group 2022). Although additive COVID-19 resources became available in many sites, numerous reports highlight negative effects in other health services. The World Health Organization (2021) noted that 94 percent of 135 countries surveyed in 2021 reported disruptions of basic health services. There are numerous reports of delayed or reduced investment in vertical health programs, including childhood immunization programs, tuberculosis control and treatment programs, malaria prevention programs, sexual and reproductive health programs, and maternal and child health programs (UNICEF 2021a; Global Fund 2021; Mukherjee et al. 2021; Roberton et al. 2020). For example, in a modeling study of 116 low- and middle-income countries, Roberton et al. (2020) estimated that reduced access to antibiotics for perinatal sepsis and pneumonia, and to oral rehydration solution for diarrhea would account for 41 percent of excess deaths in children. COVID-responses in many countries entailed re-deploying health workers and systems that funding from the President's Emergency Plan for AIDS Relief (PEPFAR) had strengthened. These countries also adapted protocols for HIV prevention and treatment to maintain services under pandemic conditions (e.g., shifting to multi-month prescriptions for antiretroviral medications to reduce clients' needs to contact the health system) (Fischer et al. 2022; Bachanas et al. 2022). The long-term effects of diversion of health resources to address the COVID-19 pandemic are yet to be calculated.

***The pandemic strained fragile healthcare systems*** – The pandemic intensified strain on public and private healthcare delivery systems in multiple ways (Hopman et al. 2020; USAID 2022). It drastically increased patient volume, especially the number of patients needing intensive care. Reports note that healthcare staff who treated COVID-19 patients, often without adequate personal protective equipment (PPE), fell ill and could not work, adding to staff shortages and increasing the work-load for remaining care providers. Local and global supply chain disruptions caused shortages of essential pharmaceuticals and medical supplies. Providers struggled with insufficient oxygen equipment and supplies, lack of facilities for infection control such as airborne infection isolation rooms and supplies of PPE, and insufficient COVID testing supplies.

Some reports cited abuse and ostracism of healthcare workers by community members frightened of COVID-19, thus increasing anxieties for healthcare workers and the incentives for them to consider leaving the profession. These challenges reached crisis levels in wealthy, industrialized countries, especially in the first year of the pandemic, but they were even more traumatic in low- and middle-income countries which had to confront these unprecedented and extended strains with limited resources and pre-existing weaknesses in their health systems (Burau et al. 2021; Mercier et al. 2020). While specialized agencies highlighted the impact of these constraints on migrants and refugees, rarely did reports mention other marginalized groups such as sex workers, LGBTQI+ people, and people who use drugs, and the special attention and resources required to reach them with COVID-19 information and services (Betts 2022; International Organization for Migration 2021).

**The pandemic highlighted deficits in support for mental health and psychosocial stress (MHPSS)** – Many reports cite increased anxiety, stress, and other mental health concerns among healthcare workers (Dawood et al. 2022). They faced dramatically increased patient loads; risks of nosocomial infection and the threat of transmitting the virus to family members at home; increased needs for palliative care and the emotional strain of intervening with family members who were barred from visiting their sick or dying loved ones; and lack of clear and consistent information about the spread and treatment of the SARS-CoV 2 virus (Dawood et al. 2022). Uncertainties around how to prevent and treat COVID-19, reports of overflowing hospitals, and personal experiences of loss affected community members as well. Reports cite special concern for the mental health of children, who struggled to cope with school closures, stay-at-home orders, and mask mandates, in addition to losses of loved ones (UNICEF 2021a). The need for greater investment in professional training and staffing for MHPSS services has been noted across high-, middle-, and low-income countries, but the COVID-19 pandemic has shifted the longstanding need for investment in MHPSS onto the global development policy agenda (Sachs and Sachs 2007; Kola et al. 2021). Barriers to information and care for marginalized groups may have amplified anxieties around COVID-19, although resources reviewed did not cite this.

**The pandemic had direct and indirect effects on health behavior** – Many sources cite deferred or delayed healthcare seeking as a result of people's fears of COVID-19 infection in healthcare settings (UNHCR 2022; Kunyenje 2023). In addition to fears of infection, some government mandates also impeded contact with the health system through measures such as stay-at-home orders, or recommendations to maintain distance and limit contact with people whose COVID-19 infection status was unknown. Consequent effects on livelihoods affected some people's ability to afford time off from productive work and the costs of transport to healthcare facilities, effects that were more pronounced for the poor. UNICEF referred to the pandemic as a "de-equalizing crisis" (2022a). Increased demands for care at home, including care of sick family members, reduced time available for help seeking. Many reports cite these limitations as being more intense for women and girls. In addition, some reports cite pre-existing mistrust of government, and mistrust of the healthcare system as barriers to care seeking and adherence to government recommendations for COVID-19 prevention and care (e.g., mask wearing, social distancing, testing, vaccination). Experience with HIV and Ebola suggests that fear and mistrust of government interventions are likely to be heightened among marginalized groups, but this challenge was not widely reported in the COVID-19 health sector literature (Richards et al. 2019; Brennan et al. 2012).

**Information and communication about COVID-19 was insufficient and inconsistent** – Communication—among scientists, clinicians, policy-makers, and the public—is a critical component of any public health response. Public health communication about COVID-19 faced a number of distinctive

challenges (Cowper 2020). First, the knowledge base was dynamic and evolving at an unprecedented rate, due partly to international collaboration and information sharing among concerned experts (scientists, healthcare providers, development assistance programs, and community advocates) (Dong et al. 2020; Finset et al. 2020). Use of the internet and social media channels, which can bypass traditional curating and vetting mechanisms in the health arena (peer review, etc.) facilitated the speed and breadth of collaboration. Second, the COVID-19 virus was novel and evolving. As new strains showed differences in infectiousness and severity, guidelines and mandates designed to contain virus spread shifted, as did the communications to convey these changes. Third, the intensity of the crisis and the need for national or subnational mandates placed politicians and mass media center stage in COVID-19 communications. However, neither they nor the public were well prepared to interpret and communicate the changing recommendations (Finset et al. 2020). Instead, in the United States and elsewhere, people interpreted the fact that public health recommendations were changing as evidence that the recommendations, and those making them, were incompetent or confusing, and in some cases recommendations became intensely politicized (Cowper 2020). Fourth, the channels that supported rapid information sharing among responsible stakeholders were also used to purvey speculation, misinformation, conspiracy theories, and disinformation about the virus and the government-endorsed responses to it. Many reports of the COVID-19 response cite increased distrust in government, public health systems, and in their representatives, as a result of conflicting messages around the causes and responses to the pandemic (Kunyenje 2023). These reports observe that rebuilding this trust will take years, and call for greater attention to public-health communications training within the health sector and the general public, since it is widely acknowledged that COVID-19 will not be the last pandemic.

### NUTRITION

Gender inequality is a cause and effect of malnutrition. Pre-pandemic, gender power relations created upstream inequities, so that of the 881 million undernourished people worldwide, 60 percent were women and girls (Kalbarczyk et al. 2022). Researchers have found a positive relationship between nutrition outcomes and women's decision-making power, education, and mobility (Taukobong et al. 2016). The COVID-19 crisis has only exacerbated gender inequality and its effect on malnutrition. Estimates suggest, for example, that the COVID-19 crisis has added 141 million people to the 3 billion already unable to afford a healthy diet worldwide (Laborde et al. 2021). Further estimates indicate that the pandemic may have added 13.6 million more children to those suffering from wasting and 4.8 million more women experiencing maternal anemia (Osendarp 2021a). As much as 50 percent of the global population may not be able to afford even half the cost of a nutritious diet (Osendarp 2021b).

When a household experiences shocks or disruptions, such as those caused by COVID-19, a cascade of responses is typically observed, including reduced expenditure on higher-quality diets, intra-household coping strategies such as food rationing and food stretching, children dropping out of school, and increased child labor. Surveillance evidence suggests that women deal with food shocks by reducing their own nutrient intakes of macro- and micronutrients before that of their children, causing deleterious effects on their nutritional status (Kalbarczyk et al. 2022).

### WASH

The World Health Organization (2021) estimates that 2.2 billion people do not have access to safely managed drinking water services. This means as millions of people cope with the COVID-19 pandemic, they continue to lack access to clean water that is available from sources located on-premises, free from contamination, and available when needed (Fisher Ingraham and Joe 2021). The COVID-19 pandemic has exacerbated and exposed water-related inequities. Water scarcity increasingly threatens people in

displacement camps, informal settlements, and lesser-resourced communities (Fisher Ingraham and Joe 2021). Access to clean water supplies within these settings for hand hygiene, on-site sanitation, bathing, and laundry is a critical yet increasingly vulnerable component of the global pandemic response (Fisher Ingraham and Joe 2021).

Gaps in the provision of water services, such as disruptions to safe water supply or increased costs driven by scarcity of supply, are notable consequences of the COVID-19 pandemic (UNICEF 2020). A 2020 WaterAid study surveyed practitioners across 14 countries in Africa and South Asia; 65 percent of respondents acknowledged that individuals lacked sufficient access to water to meet all of their daily needs during the pandemic (WaterAid 2021). This same survey found that 61 percent of respondents reported an increase in the cost of water and soap, potentially jeopardizing a key WASH strategy for mitigating the impacts of COVID-19. These rising costs can disproportionately affect women and girls by increasing their domestic workloads as they struggle to find different or cheaper water sources, which in turn further limits their access to education, income generation, or leisure time (WaterAid 2021).

Relatedly, persons facing multiple forms of marginalization have less access to public health information related to WASH. Persons with disabilities, in particular women and girls, face greater risks of contracting COVID-19 because of a lack of access to public health information in accessible formats; lack of access to WASH facilities; and challenges with following social distancing and self-isolation measures due to their reliance on caregivers (Meaney-Davis 2020).

Secondary impacts of the pandemic stem from tools designed to both control and manage the spread of COVID-19. While the intensity of the pandemic and local response varies, both communities and households experience frequent disruptions of WASH access and services (UNICEF 2020). The failure to maintain WASH systems compromises water safety and the distribution of safe water; breakdowns in sanitation infrastructure contribute to the contamination of groundwater. These failures have dramatically compounded effects on women and girls and can lead to numerous challenges because:

- Women and girls are often last in a household to have access to water supplies and WASH resources, which are in more limited supply (WaterAid 2021).
- Restricted water availability or increased water costs can lead to an inability to safely and effectively manage menstruation (Sharma et al. 2021).
- Social distancing requirements increase vulnerability to GBV when collecting water or cleaning toilets (WaterAid2021).
- Unsafe water can increase the risk of infection for menstruators and pregnant women, as well as increase the potential for disease outbreaks (WaterAid 2021).

### EDUCATION

As of mid-April 2020, 1.5 billion children and young people in 195 countries have been affected by school closures (Wu et al. 2022). The disruption of education as a result of the pandemic has put women and girls at greater risk of dropping out of school. This has further exacerbated existing educational disparities by reducing educational opportunities for women and girls, including those with disabilities or from low-income households or conflict-affected countries. Due to school closures, women and girls experience greater learning losses, including a decrease in learning scores in basic skills, which can have long-term implications on educational outcomes (Wu et al. 2022). The closure of schools has also increased unpaid care work for women and girls who are the main provider for homeschooling, in addition to childcare and household

responsibilities. This also includes learning new technologies required for remote learning (UNESCO 2020). Due to higher drop-out rates, girls also face increased risk of child marriage, early pregnancy, domestic violence and GBV, and child labor exploitation (WEF 2021). According to UNESCO, 11 million girls may never return to school after the pandemic. Women in higher education also face more challenges than their male peers to establish a balance between academic, household, and childcare responsibilities that negatively impacted their academic productivity during the pandemic (Hamadeh et al. 2022). Therefore, they are likely to experience high levels of stress and anxiety.

The transition of education to online learning has also disproportionately affected women and girls who do not have access to technology and infrastructure, particularly those who live in rural settings (Wu et al. 2022). Women and girls are also less likely to have the necessary digital skills for remote learning. Women who play an essential role as teachers in the education sector were unprepared to support online learning as they lacked the basic digital skills, particularly in developing countries. They account for nearly 94 percent of teachers in pre-primary education (UNESCO 2020). This further exposes the digital gender divide as a continued barrier to education in low- and middle-income countries (Flor et al. 2022).

### SOCIAL PROTECTION

According to the UNDP COVID-19 Global Gender Response Tracker, only 17 percent of the social protection policy measures are gender-sensitive (O'Donnell et al. 2021). The gendered impacts of COVID-19 exposed the inadequacy of social protection measures in response to the crisis, which did not address the pandemic's disproportionate effect on the income, employment, and livelihoods of women; this has led to increases in poverty, food insecurity, and GBV. Social protection measures often did not provide for access to paid leave, unemployment protection, health insurance, and social assistance, putting women and girls at greater risk (Gavrilovic et al. 2022). Social protection efforts also excluded women workers—including informal and care workers—in low-income households, and often failed to respond to the basic infrastructure and public care services in rural and informal settings to address precarious working conditions and reduce unpaid care work (International Labour Organization 2020). Women migrant workers are least likely to have access to social protection care, particularly those in informal roles due to their migration status. Women without access to digital platforms and technology, including mobile phones and bank accounts, are also disproportionately affected, further hindering them from accessing social assistance and insurance (O'Donnell et al. 2021). The lack of social protection coverage further demonstrates that the needs and priorities of women and marginalized groups are not being reached.

Evidence shows there is a lack of information and data on key gender components and highlights the inadequacy of gender-informed social policy protection measures, even for countries with high social protection coverage (Gavrilovic et al. 2022). These measures fail to capture sex-disaggregated data and intersectional data, particularly in low-and middle-income countries, that is necessary to inform the design and implementation of social protection responses and programmatic changes (Gavrilovic et al. 2022). As a result, this limits the ability of social protection responses to prioritize and address the needs of women and girls through a gender and intersectional approach. This should include considering pre-existing gender gaps (e.g., mobile phones, bank accounts, and mobility constraints) that often go unaddressed (O'Donnell et al. 2021). Research suggests that this further indicates that underrepresentation of women in decision-making leadership roles undermines integration of gender in social policy protection measures (Gavrilovic et al. 2022).

## DEMOCRACY, HUMAN RIGHTS, AND GOVERNANCE

***The coronavirus pandemic continues to disrupt political processes around the world*** – Many parliaments suspended or limited their activities, and over 100 countries restricted citizens' freedom of assembly and expression in the name of public health. In addition, authoritarian and authoritarian-leaning leaders have taken advantage of the emergency to concentrate power in the executive branch (Smith et al. 2022). Internet use and virtual participation are also associated with women's increased exposure to online abuse and harassment in politics. This can leave women feeling unsafe to engage in online discussions or forums (UN Women 2020b).

***Few analyses have probed the gendered consequences of these trends*** – In the media, the main narrative about gender and pandemic politics has centered on the perceived effectiveness of female politicians in responding to the crisis. However, the pandemic's profound political and socioeconomic effects could halt or reverse advances in women's political inclusion.

***Inclusion in COVID-response decision making and governance*** – Leadership positions and decision-making bodies related to COVID-19 overrepresented men (USAID 2020). At the same time, the pandemic and responses to it exacerbated women's political exclusion in a number of ways: governments postponed elections that would otherwise have given women the opportunity to be elected; increased childcare responsibilities accelerated women's departure from politics; political systems' increasingly relied on informal networking that reinforced male political dominance; political participation increasingly relied on online platforms that reinforced gender inequities; women were less visible in public; and governments pushed women's rights off of political agendas (Brechenmacher and Hubbard 2020).

Although many women leaders received global praise for their crisis-management performance in the past two years, women remain left out in most political and electoral contexts. COVID-19 particularly impacts women elected officials, candidates, and voters, and its backsliding effects further exacerbate inequalities and reinforce barriers. Nevertheless, several female politicians worldwide have shown exemplary leadership during the COVID-19 pandemic, making cautious but informed decisions and communicating clearly to their citizens (Taub 2020). In fact, in countries with women leaders, confirmed deaths from COVID-19 were six times lower, partly due to these leaders' faster response to the pandemic and greater emphasis on social and environmental well-being over time (UN Women 2020d). Still, too few women are managing response and recovery efforts.

**Unfortunately, there is little available data on the inclusion of marginalized groups (including women facing multiple forms of marginalization) in COVID-19 response and the impacts thereof.**

***Government Responses*** – Across the globe, feminist movements and other gender equality advocates mobilized quickly and vocally, demanding government action to mitigate the disproportionate impact of the pandemic on women and girls (UN Women and UNDP 2022). As a result, UN Women estimated that between March 2020 and August 2021, governments adopted 1,605 gender-sensitive measures (2021). Most governments adopted these measures during the first three months of the pandemic, but their implementation was often fraught with gaps and tensions (UN Women and UNDP 2022). Moreover, the response varied widely across regions. While Europe, North America, Australia, and New Zealand have led the response to GBV and unpaid care, for example, Latin America and the Caribbean has the most significant measures targeted at women's economic security (UN Women and UNDP 2022).
As governments rushed to respond, decision making was heavily concentrated in the executive branch,

frequently sacrificing consultation with parliaments, civil society, and other stakeholders on priorities and policy design (UN Women and UNDP 2022). Moreover, special task forces created to help tackle the rapidly evolving crisis relied on pre-existing, male-dominated networks. As a result, women were underrepresented in these bodies (UN Women and UNDP 2022). Nevertheless, gender equality advocates found institutional entry points for shaping the COVID-19 response in some contexts, often by tapping into long-standing advocacy coalitions and networks (UN Women and UNDP 2022). In line with pre-pandemic dynamics, strong democratic institutions, a higher representation of women in parliament, and strong feminist movements were associated with more gender-sensitive measures during the pandemic (UN Women and UNDP 2022).

***Women, peace, and security*** – Participation of women in security and peace processes in areas of active conflict or crisis was hindered. Evidence shows that COVID-19 has restricted women's participation in peace processes because of quarantines that limit their ability to attend key peace and negotiation activities (Search for Common Ground 2020). At the same time, the increased reliance on digital platforms for conflict negotiations advantaged male participation because of the existing gender digital divide (UN Women 2020d).

***Human rights*** – According to a report by Amnesty International (2022), COVID-19 regulations disproportionately impacted marginalized groups, including LGBTQI+ people, sex workers, people who use drugs, and those experiencing homelessness by exposing them to further discrimination and human rights abuses. Specifically, the report found that COVID-19 had exacerbated the negative impact of pre-existing laws and regulations that criminalized and further discriminated against and marginalized vulnerable groups. For example, the report found that groups who were already over-policed before the pandemic have experienced discrimination, unlawful use of force, and arbitrary detentions by security forces (Amnesty International 2021).

Countries' reliance on punitive COVID-19 measures has created additional obstacles to accessing essential services and support, especially for people experiencing poverty and systemic discrimination. In addition, marginalized groups were often blamed, including by public officials, for breaching COVID-19 regulations and for spreading the virus. This has, in turn, fueled violence against marginalized groups and discouraged them from seeking medical care because they fear being arrested, detained, or judged.

Although many governments adopted some form of social protection measures, countries failed to consider the social and economic realities in which they were implemented and rarely provided comprehensive support for the most marginalized communities (Amnesty International 2022).

***Anti-corruption*** – Corruption is likely to worsen gender disparities fueled by the COVID-19 pandemic. Emergency measures and income inequality are also likely to increase corruption as rich and powerful elites continue to capture political decision making and use it to protect their private interests at the expense of citizens and the public good (World Bank Group 2020). In addition, wealthy, influential individuals and corporations may benefit most from COVID-19 emergency bailout packages, which would likely reflect their best interests and further demonstrate how big money in politics fuels corruption (Transparency International 2020). With less power and influence, these packages may leave women and marginalized groups behind.

***The impacts of COVID-19-induced corruption on women are better documented than other marginalized groups*** – For example, due to the economic crisis caused by the pandemic, women are more likely to lose their jobs, income, and savings (Blundell et al. 2020). This erodes their independence, accelerating the feminization of poverty and making them more prone to giving in to corruption (Blundell et al. 2020). Secondly, women are at the frontlines of the COVID-19 health response, which makes them more exposed to the risk of contracting or spreading the virus (Transparency International 2020). Because women constitute the majority of the poor, they are also more reliant on public services and, consequently, are particularly vulnerable to corruption in the health sector. Moreover, the pandemic can have severe secondary impacts on women's access to sexual and reproductive health services, again making women vulnerable when resources are being reallocated.

## ECONOMIC GROWTH

***Overrepresentation of women in the hardest-hit sectors*** – Evidence shows that women experienced greater job insecurity, including job and income loss, during the pandemic. This was due to the majority of women working in contact-intensive sectors, which put them at a higher risk of exposure to COVID-19 (International Labour Office 2018). In low- and lower-middle-income countries, a higher proportion of women are in informal employment than men (International Labour Office 2018). This includes women migrant workers who often work in the informal sector, especially as domestic, care, and health workers, with insecure contracts for part-time or short-term work (UN Women 2020f). Women and girls with disabilities are also more likely to work in informal employment with a greater risk of unemployment and loss of income (Foreign Commonwealth and Development Office n.d.).

Women are employed in service sectors including retail, accommodation and food, and healthcare, which provide low-paying wages and poor working conditions that put women in vulnerable situations (Foreign Commonwealth & Development Office n.d.). Informal employment for women also lacks social protection and benefits, such as paid leave and the ability to work from home compared to workers in the formal sector. As a result, the pandemic's economic effects have led to a decline in women's employment by 5 percent in 2020 compared with 3.9 percent for men (International Labour Organization 2021). This increases the likelihood of women not actively looking for re-employment (International Labour Organization 2021). This reveals the lack of job opportunities for women in the formal sector, which contributes to the gender gap in workforce participation (International Monetary Fund 2021).

***Women-led micro, small, and medium enterprises (MSMEs)*** – Women in high-risk sectors who are self-employed or owners of MSMEs experienced more adverse effects than men-owned or -led MSMEs during the pandemic (International Finance Corporation and Foreign Commonwealth & Development Office 2021). Women-owned MSMEs have lower levels of capitalization and rely on self-financing due to barriers in accessing credit and loans, leading to greater financial risk than their male-owned counterparts (International Labour Organization 2020; Hyland et al. 2021). As a result, women-owned MSMEs are more vulnerable to economic shocks (International Labour Organization 2020; Hyland et al. 2021). This has led to reduced hours and size in the workforce, and a decreased market demand for their businesses compared to men-owned MSMEs, which further increases the risk of bankruptcy for women entrepreneurs (International Labour Organization 2020).

***Essential and frontline workers at risk*** – The pandemic put unprecedented pressure on women who make up the majority of essential and frontline workers, including healthcare workers, teachers, and domestic workers (USAID 2021). They account for 70 percent of social-sector and healthcare workers globally

(UNICEF 2022a). Despite their key roles in the COVID-19 response, women remain in low-paying and higher-risk jobs with low decision-making capacity, further reflecting gender disparities. This has resulted in poor working conditions, long work hours, and limited access to protective equipment, which increases the risk of infection. Evidence also shows increased exposure to violence, harassment, and discrimination for healthcare workers (International Labour Organization 2020). Women migrants who serve as frontline workers in the health sector are also at increased risk of sexual harassment and violence in the workplace (UN Women 2020e). As a result, essential female workers are subject to mental and physical exhaustion due to intense working conditions, in addition to their personal obligations at home, which sheds light on the disproportionate impacts on women.

***Income inequality*** – The pandemic had significant negative consequences on women's employment and labor participation which resulted in loss in income earnings. Women accounted for 54 percent of the overall job losses due to the pandemic (USAID 2021). This particularly impacted those represented in low-income households and informal positions due to mobility restrictions and lockdown measures (King et al. 2020). Research also suggests an increase in unpaid care work contributed to a decrease in earnings (Ogando et al. 2022). Migrant women workers in particular experienced a disproportionate loss of income (UNDP 2020). For example, evidence shows that 8.5 million women migrant domestic workers on insecure contracts faced income loss as a result of COVID-19 (UN Women 2020f). Travel bans contributed to a decrease in employment, leading to financial hardship and barriers for those who cannot return home (International Labour Organization 2020). The pandemic also exacerbated the vulnerability of rural and Indigenous women to chronic poverty, reducing their economic opportunities while increasing their workloads (UNDP 2020). As a result, women resorted to coping mechanisms to mitigate or replace the loss of earnings including asset-depleting strategies such as the sale of assets and taking out new loans, which can lead to increased debt and loss of savings during the pandemic (Ogando et al. 2022). A rise and extreme poverty and gender disparities in income inequality reveal the financial burden that women face (USAID 2022). Financial stress over income loss further correlates with the increase in tensions at home and the escalation of GBV.

## AGRICULTURE AND FOOD SECURITY

***Food insecurity*** – Women experienced negative effects of the pandemic leading to increased food insecurity being 10 percent higher in women than in men in 2020 (VanVolkenburg et al. 2022). The disruption of food supply, including food mobility restrictions and closure of markets, resulted in higher prices and a lack of food options. This led to changes in dietary patterns for women who are likely to resort to less nutritious foods and reduce their food consumption due to food shortages (USAID 2021). Loss of income from the economic downturn further increases the unaffordability of healthy diets and contributes to malnutrition and hunger for women and their households (Food and Agriculture Organization of the UN 2021). This affects nutrition and health outcomes for women in vulnerable situations, including women-headed households, pregnant women, women migrants and refugees, Indigenous women, and rural women, who are responsible for obtaining food for their families (USAID 2021). This further exacerbates pre-existing gender inequalities for women and girls who are already at higher risk of poverty and food security (Ogando et al. 2022).

***Agriculture*** – Women in the agriculture sector, including farmers, Indigenous Peoples, and entrepreneurs in rural areas who are reliant on natural resources, have also faced negative impacts of the pandemic (Woyengu et al. 2022). Women account for 43 percent of the farming workforce in developing countries and are key to the production and trade of agricultural products (Patterson 2020). The economic impacts,

combined with COVID-19 lockdown measures, reduced their ability to engage in agricultural activities and resulted in the reduction of women's agricultural food production and distribution capacities (Food and Agriculture Organization of the UN 2020). Rural women farmers are often unable to benefit from resources and services, including land, finances, markets, technology, and information (Food and Agriculture Organization of the UN 2020). In some cases, women are forced to sell goods at a lower price due to limited access to markets and transportation (Castellanos et al. 2022). Therefore, women's limited access to agricultural resources makes them less equipped than men to meet the demands of farm and food production for their families leading to a loss of income and livelihoods.

The pandemic also heightened women's vulnerability to climate change which has negative impacts on agriculture, seed availability, and food stocks that drive food insecurity (Castellanos et al. 2022). This disproportionately affects women in the poorest and most vulnerable areas who are reliant on agricultural production or subsistence farming, making it difficult for them to respond and adapt to climate change (UN Environment Programme and UN Women 2020). As a result, women are unable to carry out agricultural activities leading to reduced incomes and food consumption that put them and their families at risk (UNDP 2020).

### DIGITAL ACCESS AND TECHNOLOGY

COVID-19 necessitated a rapid transition to digital platforms. This cut across sectors, as did the underlying digital inequalities, from issues of low access and use of digital products and platforms to uneven infrastructural preparedness for digital pivots. COVID-19 exacerbated these inequalities, while newer forms of digital inequalities emerged. For example, gender inequalities prevailed in digital health innovations that the pandemic necessitated. A scoping review of 250 digital COVID-19 public health applications found that both before and during the COVID-19 pandemic, digital health applications suffered from a lack of gender equity perspective and were non-responsive to different needs of genders. Factors leading to such exclusion range from lower access and gender-blind app designs to gender imbalance in leadership and harmful gender stereotyping (Lancet Digital Health 2021).

In the aftermath of COVID-19, governments adapted and extended social protection by leveraging digital platforms. The momentum around digitization of government-to-person transfers required deliberate gender-intentionality in design and implementation to ensure women were not left behind (World Bank 2020).

Digital divides also led to unequal outcomes in labor markets. For example, gender gaps in digital literacy, internet use, and mobile phone access meant that new job opportunities in the digital economy eluded digitally unconnected or unskilled persons. A World Bank case study on its digital training programs in Uganda, Nigeria, and Rwanda suggest that unreliable digital infrastructure and restrictive gender norms were among key impediments to gender equal outcomes. Engaging young women at all stages of the project cycle; establishing linkages with local digital ecosystem stakeholders; and incorporating online safety modules into digital skills training curricula emerged as some of the key enablers of digital inclusion (World Bank Group 2022).

The 67th Commission on the Status of Women delivered by the Director of UN Women in March 2023 identified digital poverty as one that "excludes women and girls in devastating ways" and called attention to the digital divide that has "become the new face of gender inequality" (UN Women 2023).

Digital access also emerged as a predictor of child and adolescent mental health, with a study in the UK confirming that lack of access to a computer is a risk factor potentially compounding other adversities facing children and young people during periods of social isolation or educational disruption exemplified by COVID-19 (Metherell et al. 2022).

# ANNEX C: LIST OF KEY DOCUMENTS CONSULTED


Amnesty International. 2022. "Covid-19: Pandemic restrictions magnified discrimination against most marginalized groups." (Link).

Amnesty International. 2021. "There is no help for our community: The impact of States' Covid-19 responses on groups affected by unjust criminalization." (Link).

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# ANNEX D: QUALITATIVE ASSESSMENT TOOLS

## D1. SEMI-STRUCTURED KII/SMALL GROUP DISCUSSION GUIDE - USAID MISSION

Thank you for making time for this interview. The COVID-19 Unintended Outcomes Assessment, funded by USAID's Bureau for Policy, Planning and Learning (PPL), was designed to determine the extent to which USAID's programming, financed by COVID-19 funds, reflected the Agency's commitment to inclusive development and gender equality, and to identify programmatic recommendations towards mitigating harm and exclusion in current and future programming.

The assessment will assess the extent to which inclusive development principles were considered in COVID-19 program design and implementation to identify:

1. Inequalities of USAID's programming financed by COVID-19 funds
2. Unintended outcomes (both positive and negative) of USAID's programming, financed by COVID-19 funds, on underrepresented and marginalized groups.

We would like to obtain your explicit permission to conduct this interview and to record this conversation in order to be able to refer back to it during our analysis. My colleague _____ is also on the call today/here and will be taking notes. The notes will be used to develop a briefing and report on the interviews without attribution. The notes will serve as the interview transcript, which will not be published. The transcript will only be shared with our assessment team and the team members in PPL/LER who are overseeing this work. Transcripts will not be shared with leadership. We will not refer to you by name in any published documents without your written consent. Do you consent to participating in this interview?

### LOI 1: DID USAID'S PROGRAMMING TO ADDRESS COVID-19 INCLUDE GENDER AND INCLUSIVE DEVELOPMENT CONSIDERATIONS?

**[For leadership/key informants with knowledge of the country portfolio as a whole]**

1. In light of COVID-19, the USAID [insert country name] Mission/CO might have had to develop new activities, or prioritize /deprioritize/ pivot /adapt its existing activities. Can you tell us a bit about how those decisions at the country portfolio level were made? What were the key considerations underlying the decision-making process on how to utilize/deploy USAID COVID-19 funds between 2020 and 2022?
   Probes:
   a. Any analytical /diagnostics work or consultations done, or existing evidence relied on, including gender and ID-related, to inform decisions – if no; why not
   b. USG policies and/or guidance, including gender and ID-related, referred to, and in what way – if no; why not
   c. Main stakeholders involved in decision-making in the CO/Mission, and how they were engaged (including both internal and external)
   d. Nature of engagement specifically with CO/Mission gender and ID focal points during the decision-making process – if no; why not
   e. Any engagement externally (government/CSOs)

2. How did COVID-19 funding decisions at Mission/CO level (e.g., program pivots, discontinuation, added funding, etc.) affect programs addressing marginalized and underrepresented groups [Clarify, as needed, on what/who these groups are in USAID definitions generally, and contextually. Get respondents perspectives on who these groups are from their experience of implementation in-country]
   Probes:
   a. Effects on portfolio balance of activities (i.e., how was programming previously addressing marginalized and underrepresented groups affected due to COVID-19 related to the portfolio)
   b. Impact from the perspective of inclusion within programs/activities (i.e., program/activity coverage of underrepresented/ marginalized groups due to COVID-19 related changes to activities)

3. From your perspective, at the level of country portfolio, which factors / determinants influenced (positively/negatively) the extent/degree of gender/ID integration into the Mission's COVID-19 related funding & programming decisions?
   Probes (explore each in as much detail as possible):
   a. Organizational factors (staffing, resourcing, culture, org priorities, technical capacity, availability of technical guidance, etc.)
   b. Country context factors (political-economy, socio-economic, gender & ID context, activities of government or other development partners)

4. [*As applicable*], as a result of the Mission's efforts to integrate gender and ID considerations into programming that received COVID-19 funds, what were successes that are worth highlighting? Are there gender-equitable and inclusive results that you did not see despite gender/ID integration into COVID-19 programming? If yes, why did this happen?

**[For key informants at the Activity level with knowledge of sampled Activity]**

5. How did you address gender and inclusive development considerations in design, implementation, and MEL of this Activity, given differential (or disproportionate) vulnerabilities to – and impact of – COVID-19 and its adverse effects?
   Probes:
   a. Gender/ID analysis for the Activity, or use of existing analysis /evidence
   b. Degree and extent of use of Gender/ID Advisor in design and implementation of Activity
   c. Nature of engagement, if any, with underrepresented and marginalized groups
   d. Activity partnerships that are specifically geared to address gender/ID
   e. How gender/ID is integrated within Activity MEL (e.g., sex disaggregated data)
   f. Programmatic learnings on gender/ID from AMEL (or otherwise)

6. What are the types of structural inequalities or barriers that hinder marginalized and underrepresented groups' access to and/or participation in relevant activities? How did you address structural inequalities/ barriers?
   Probe, *as applicable*:
   a. How did you specifically approach equitable *participation* of vulnerable/ underrepresented people in this Activity – not just quantitatively (i.e., representation), but also qualitatively (i.e., participant experiences, responsiveness to unique needs of people, etc.)
   b. How did you ensure equitable *benefits* from participation in the Activity, i.e., how did you ensure vulnerable/ underrepresented people, who face structural disadvantages, derived the same benefits from the Activity as others?
   c. Perspectives on the following USAID (ADS) domains as they relate to the degree of gender/ ID integration in the Activity's design and implementation *(note: not all domains may apply to all activities, use discretion on probes based on desk review of activity)*
      iv. Laws, policies, regulations, and institutional practices
      v. Cultural norms and beliefs
      vi. Roles, responsibilities, and time use
      vii. Patterns of power and decision making
      viii. Access to and control over assets and resources
      ix. Personal safety and security

7. How did you address the key dimensions of gender-responsive and inclusive development, in response to gender and intersectional vulnerabilities to COVID-19- both first and second order effects?
   Probe, *as applicable: (note: not all domains may apply to all activities, use discretion on probes based on your review of activity)*
   a. Laws, policies, regulations, and institutional practices
   b. Cultural norms and beliefs
   c. Roles, responsibilities, and time use
   d. Patterns of power and decision making
   e. Access to and control over assets and resources
   f. Personal safety and security

8. [*if applicable*] What kind of gender-equitable and inclusive results were you able to achieve as a result of your efforts to integrate gender/ID in your Activity?

9. [*if applicable*] Were there intended gender/ID responsive outcomes that you still could not attain despite efforts to integrate gender/ID in your Activity? If yes, why did this happen?

10. Drawing exclusively from your experience of implementing this Activity (which received COVID-19 funds), what in your view are the key determinants of successful integration of gender/ID in an USAID Activity?
    Probe, *as applicable*:
    a. Key barriers to gender/ID integration faced by Activity
    b. Key enablers that helped with gender/ID integration

### LOI 2: WHERE HAS THE AGENCY'S RESPONSE TO COVID-19 YIELDED UNINTENDED OUTCOMES (BOTH POSITIVE AND NEGATIVE)? WHAT WAS THE PATH/LINK BETWEEN THE AGENCY'S COVID-19 INTERVENTIONS AND THE UNINTENDED OUTCOMES?

**[For leadership/key informants with knowledge of the country portfolio as a whole]**

11. Now, we would like to get your views on *outcomes* of the portfolio of USAID COVID-19 response interventions in this Mission. Were there outcomes that you were surprised to uncover, i.e., you did not intend for them to occur, or were not expecting to see? *Mention following domains in sequence, ensuring to spend sufficient time exploring each:*
    (As needed, remind the respondent that we are interested in UOs of USAID activities, not the pandemic)
    a. Outcomes related to intra-household power dynamics (decision-making)
    b. Outcomes related to civil participation and leadership, from the gender/ID perspective
    c. Outcomes related to digital access and use, from the gender/ID perspective
    d. Outcomes related to safety and security (including GBV)
    e. Outcomes related to mental health, from the gender/ID perspective

12. If the above response dwells mostly on positive outcomes, probe on negative outcomes using an appreciative tone. And vice versa
    a. e.g., The USAID Mission operated in trying circumstances during an unprecedented crisis and delivered significant results. Were there still any negative outcomes of USAID COVID-19 related interventions that surprised you?

13. You said: [summarize the UOs discussed above]. What specifically about, or in, the portfolio of USAID COVID-19 related activities in the Mission do you think influenced this particular outcome for program participants? (Ask separately for all UOs)

[For key informants at the Activity level with knowledge of sampled Activity]

14. Now, we would like to get your views on the outcomes of this USAID Activity. Were there outcomes that you were surprised to uncover, i.e., you did not intend for them to occur, or were not expecting to see? *Mention following domains in sequence, ensuring to spend sufficient time exploring each:*
    (As needed, remind the respondent that we are interested in UOs of USAID activities, not the pandemic)
    a. Outcomes related to safety and security (including GBV)
    b. Outcomes related to mental health, from the gender/ID perspective
    c. Outcomes related to intra-household power dynamics (decision-making)
    d. Outcomes related to civil participation and leadership, from the gender/ID perspective
    e. Outcomes related to digital access and use, from the gender/ID perspective

15. If above response dwells mostly on positive outcomes, probe on negative outcomes using an appreciative tone. And vice versa
    a. E.g., [Insert name of USAID program/activity] operated in trying circumstances during an unprecedented crisis and delivered significant results. Were there still any negative outcomes of this Activity that surprised you?
16. You said: [summarize the UO discussed above]. What specifically about, or in, the USAID Activity do you think influenced this particular outcome for program participants?

## LOI 3: WITH THE BENEFIT OF EXPERIENCE AND HINDSIGHT, WHAT CAN/SHOULD BE DONE MOVING FORWARD TO ENSURE SIMILAR FUTURE PROGRAMS ARE INTENTIONALLY AND PROACTIVELY INCLUSIVE?

[For leadership/key informants with knowledge of the country portfolio as a whole]

17. Drawing from your experience of the Mission's COVID-19 response activities, what do you think can be done differently to improve the degree of gender/ID integration in similar programs and crisis conditions in the future?
    Probe:
    a. Organizational aspects at any level (policies, funding, staffing, capacities, culture, etc.)
    b. Country contextual aspects, if any
18. Drawing from your experience of the Mission's COVID-19 response activities, what do you think can be done differently in the future to address or mitigate harmful unintended outcomes particularly on women and underrepresented groups?
    Probe:
    a. Organizational aspects, at any level (policies, funding, staffing, capacities, culture, etc.)
    b. Design & implementation aspects
    c. Contextual factors (political-economy, socio-economic, gender & ID context, activities of government or other development partners), if any

19. What have been the key learnings for this Mission with respect to gender/ID integration in USAID Activities – as well as mitigating negative unintended outcomes on women and underrepresented groups – particularly in crisis/pandemic response?

**[For key informants at the Activity level with knowledge of sampled Activity]**

20. Drawing from your experience of this USAID COVID-19 response Activity, what do you think can be done differently to improve the degree of gender/ID integration in a similar activity in the future?
    Probe:
    a. Organizational aspects, at any level (policies, funding, staffing, capacities, culture, etc.)
    b. Country contextual aspects, if any
    c. Thematic aspects /unique sectoral perspectives, if any

21. Drawing from your experience of this USAID COVID-19 response Activity, what do you think can be done differently in the future to address or mitigate harmful unintended outcomes particularly on women and underrepresented groups?
    Probe:
    a. Organizational aspects
    b. Design & implementation aspects
    c. Country contextual aspects, if any
    d. Thematic aspects /unique sectoral perspectives, if any

22. What have been your key learnings with respect to gender/ID integration in USAID Activities – as well as mitigating negative unintended outcomes on women and underrepresented groups – particularly in crisis/pandemic response?

## D.2 KII GUIDE - IMPLEMENTING PARTNERS

Thank you for making time for this interview. The COVID-19 Unintended Outcomes Assessment, funded by USAID's Bureau for Policy, Planning and Learning (PPL), was designed to determine the extent to which USAID's programming, financed by COVID-19 funds, reflected the Agency's commitment to inclusive development and gender equality, and to identify programmatic recommendations towards mitigating harm and exclusion in current and future programming.

The assessment will assess the extent to which inclusive development principles were considered in COVID-19 program design and implementation to identify:

1. Inequalities of USAID's programming financed by COVID-19 funds
2. Unintended outcomes (both positive and negative) of USAID's programming, financed by COVID-19 funds, on underrepresented and marginalized groups.

We would like to obtain your explicit permission to conduct this interview and to record this conversation in order to be able to refer back to it during our analysis. My colleague ____ is also on the call today/here and will be taking notes. The notes will be used to develop a briefing and report on the interviews without attribution. The notes will serve as the interview transcript, which will not be published. The transcript

will only be shared with our assessment team and the team members in PPL/LER who are overseeing this work. Transcripts will not be shared with leadership. We will not refer to you by name in any published documents without your written consent. Do you consent to participating in this interview?

**BACKGROUND**

1. Can you tell me a bit about the program/Activity?
   a. When did it begin?
   b. What are its overall goals and objectives?
   c. What is your role?

**LOI #1:** Did USAID's programming supported by COVID-19 funds intentionally and proactively include gender and inclusive development considerations? If so, how, in what ways did the programming respond to the needs of those groups? To what extent and what worked well? If not, why not, and what were the effects and challenges?

1. Did the program/Activity identify underrepresented and marginalized groups at risk for being adversely impacted by COVID-19?
   a. How did the program/Activity go about identifying underrepresented and marginalized groups?
   b. Which key groups were identified?
   c. Were any groups missed?

2. If applicable, please describe how the needs of underrepresented and marginalized groups were integrated into the program/Activity design and provide specific examples.
   a. Did the program/Activity conduct or utilize a recent gender or ID analysis to inform the program/Activity design? If so, how was the analysis integrated into the design? If not, why not?
   b. How were gender and/or inclusive development considerations reflected in program/Activity documents such as work plans, MEL plans, results framework, etc.?
   c. Was the gender or ID analysis required by the Mission as part of the SOW to inform the program/Activity?
   d. What resources were allocated for gender and/or inclusive development short-term technical assistance and activities? If none, why not?
      v. Was this a sufficient level of resource to effectively integrate the needs of marginalized groups?
      vi. Was the relevant expertise available?
   g. Did the program/Activity conduct other assessments or analyses to determine the most pressing needs of marginalized populations (e.g. contextual analyses or rapid needs assessments)?

3. What were the key determinants of successful integration of gender/ID in the program/Activity?
   a. What were the key barriers to gender/ID integration in the program/Activity?
   b. What were the key enablers that helped with gender/ID integration in the program/Activity?

4. Did the program/Activity engage local civil society organizations (CSOs) or community-based organizations (CBOs) in order to identify and mitigate access barriers for marginalized groups?
    a. Which local CSOs or CBOs were engaged, if any?
    b. During which phase(s) of the program/Activity were local CSOs or CBOs engaged (planning, design, implementation, MEL, etc)?
    c. How did local CSOs or CBOs influence the program/Activity, if at all?
    d. Did the influence of local CSOs or CBOs effectively improve access for marginalized groups?
    e. How could local CSOs or CBOs have better been included in the program/Activity?
    f. If relevant, what challenges did you face engaging with CSOs or CBOs in the program/Activity?

5. How and to what extent did the program/Activity engage with underrepresented and marginalized groups during their planning, design, implementation and MEL phases?
    a. What forms of engagement occurred if any? Were they direct or indirect?
    b. To what extent did this engagement influence the program/Activity? Please include any specific examples.
    c. During which phase(s) of the program/Activity was engagement most effective and influential (planning, design, implementation, MEL, etc)?

6. How did the program/Activity that received COVID-19 funds seek to ensure underrepresented and marginalized groups' equitable access to and benefit from programming?
    a. Did the program/Activity identify existing power dynamics (decision-making) between groups/communities or within households? If so, how? Were there any surprising dynamics that were uncovered? If so, please describe.
    b. If applicable, did the program/Activity seek to transform power dynamics that prevent underrepresented and marginalized groups from benefiting from the Activity's programming? If so, how?
    c. What worked well and what were the challenges in ensuring equitable access to/benefit from the program/Activity?

7. How did/does the program/Activity monitor and evaluate outcomes among underrepresented and marginalized groups?
    a. Were there any specific challenges in monitoring and evaluating outcomes among these groups?
    b. How far were results reported disaggregated by sex and age?
    c. Did monitoring and evaluation lead to any benefits or adaptation of the program/Activity?

**LOI #2:** Where has the Agency's response to COVID-19 yielded unintended outcomes (both positive and negative)? What was the path/link between the Agency's COVID-19 interventions and the unintended outcomes?

8. How, if at all, did the program/Activity monitor for unintended outcomes on marginalized groups?
    a. Across any of the following topics? Intra-household power dynamics (decision-making), Civic participation and leadership, Access to digital technologies/virtual platforms, Mental Health, Safety and Security (GBV)?

9. What, if any, are the positive unintended outcomes on marginalized groups that emerged as a result of the program/Activity? Were there any that surprised you? Please explain how these emerged and provide specific examples:
    a. At the project participant level?
    b. At the organizational/operational levels?

10. What, if any, are the negative unintended outcomes on marginalized groups that emerged as a result of the program/Activity? Were there any that surprised you? Please explain how the unintended outcomes emerged and provide specific examples:
    a. At the project participant level?
    b. At the organizational/operational levels?

11. To what extent could each of these unintended outcomes be directly attributed to the program/Activity or to other actions (or inactions) supported by USAID?
    a. What specifically in the program/Activity led to each of these unintended outcomes?
    b. Could the program/Activity have been designed differently to mitigate negative unintended outcomes?

12. Did the program/Activity exacerbate any social and/or civic exclusion or heighten vulnerabilities of already-marginalized groups (women, migrants, persons with disabilities, rural populations, etc.)? If so, please explain how.

13. How did the program/Activity seek to address and mitigate unintended outcomes impacting inequities and marginalized groups?
    a. Which mitigation efforts were successful or unsuccessful?

**LOI #3:** With the benefit of experience and hindsight, what can/should be done moving forward to ensure similar future programs are intentionally and proactively inclusive?

14. What are lessons learned from the program/Activity related to gender and/or inclusive development integration under pandemic or similar crisis conditions? Please provide examples of successes or challenges.
    a. What went well that should be repeated or built on?
    b. What could be improved?

15. What could have been changed to ensure the integration of gender and/or inclusive development and address the needs of marginalized groups in dealing with second-order effects of COVID-191? How would you do this differently for future programs/Activities?
    a. What recommendations do you have for other programs/Activities?

16. What learnings from your current program/Activity would you apply to avoid or mitigate harmful unintended outcomes for future programs/Activities?

17. Before we close, are there any questions that I should have asked you, that I have not asked? [And please discuss them…]

18. Other comments:

## D.3 SEMI-STRUCTURED KII GUIDE - USAID BUREAU

Thank you for making time for this interview. The COVID-19 Unintended Outcomes Assessment, funded by USAID's Bureau for Policy, Planning and Learning (PPL), was designed to determine the extent to which USAID's programming, financed by COVID-19 funds, reflected the Agency's commitment to inclusive development and gender equality, and to identify programmatic recommendations towards mitigating harm and exclusion in current and future programming.

The assessment will assess the extent to which inclusive development principles were considered in COVID-19 program design and implementation to identify:

1. Inequalities of USAID's programming financed by COVID-19 funds
2. Unintended outcomes (both positive and negative) of USAID's programming, financed by COVID-19 funds, on underrepresented and marginalized groups.

We would like to obtain your explicit permission to conduct this interview and to tape record this conversation in order to be able to refer back to it during our analysis. My colleague _____ is also on the call today/here and will be taking notes. The notes will be used to develop a briefing and report on the interviews without attribution. The notes will serve as the interview transcript, which will not be published. The transcript will only be shared with our assessment team and the team members in PPL/LER who are overseeing this work. Transcripts will not be shared with leadership. We will not refer to you by name in any published documents without your written consent. Do you consent to participating in this recorded interview?

## LOI 1: DID USAID'S PROGRAMMING TO ADDRESS COVID-19 INCLUDE GENDER AND INCLUSIVE DEVELOPMENT CONSIDERATIONS?

[For leadership/key informants with knowledge of the Bureau portfolio as a whole]

1. In light of COVID-19, the USAID might have had to support development of new activities, or prioritize /deprioritize/ pivot /adapt existing activities. Can you tell us a bit about how those decisions at the Bureau level were made? What were the key considerations underlying the decision-making process on how to utilize/deploy USAID COVID-19 funds between 2020 and 2022?
   Probes:
   a. Any analytical /diagnostics work or consultations done, or existing evidence relied on, including gender and/or inclusive development-related, to inform decisions – if no; why not
   b. USG policies and/or guidance, including gender and/or inclusive development-related, referred to, and in what way –if no; why not
   c. Main stakeholders involved in decision-making (in USAID Washington, CO/Missions, other internal and/or external stakeholders) and how they were engaged
   d. Nature of engagement specifically with regional gender and/or inclusive development focal points during the decision-making process – if no; why not

2. How did COVID-19 funding decisions at the Bureau level (e.g., program pivots, discontinuation, added funding, etc.) affect marginalized and underrepresented groups
   [Clarify, as needed: Definition People who are typically denied access to legal protection or social and economic participation and programs (i.e., police protection, political participation, access to healthcare, education, employment), whether in practice or in principle, for historical, cultural, political, and/or other contextual reasons. Such groups may include, but are not limited to, women and girls, persons with disabilities, LGBTI people, displaced persons, migrants, indigenous individuals and communities, youth and the elderly, religious minorities, ethnic minorities, people in lower castes, and people of diverse economic class and political opinions. ADS 201]
   Probes:
   a. Effects on portfolio balance of activities (i.e., how was programming previously addressing marginalized and underrepresented groups affected due to COVID-19 related to the portfolio)
   b. Impact from the perspective of inclusion within programs/activities (i.e., program/activity coverage of underrepresented/ marginalized groups due to COVID-19 related changes to activities)

3. From your perspective at the Bureau/Agency level, which factors / determinants influenced (positively/negatively) the extent/degree of gender and/or inclusive development-related integration into the USAID's COVID-19 related funding & programming decisions?
   Probes (explore each in as much detail as possible):
   a. Organizational factors (staffing, resourcing, culture, org priorities, technical capacity, availability of technical guidance, etc.)
   b. Contextual factors (political-economy, socio-economic, gender & ID context, activities of government or other development partners)
   c. Other factors?

4. [*As applicable*] as a result of the USAID's efforts to integrate gender and inclusive development considerations into programming that addressed COVID-19, what were the successes that are worth highlighting? Are there gender-equitable and inclusive results that you did not see despite efforts to integrate gender and/or inclusive development into COVID-19 programming? If yes, why did this happen?
5. How did USAID programming apply gender and inclusive development considerations in support of design, implementation, and MEL of activities in the region, to mitigate the impact of – COVID-19 and its adverse second order effects?
   Probes:
   a. Gender/inclusive development analysis for the activities, or use of existing analysis /evidence
   b. Degree and extent of use of Gender/Inclusive Development Advisor in design and implementation of activities
   c. Nature of engagement, if any, with underrepresented and marginalized groups
   d. Activity partnerships that are specifically geared to address gender and/or inclusive development
   e. How gender and/or inclusive development is integrated within activities' MEL
   f. Programmatic learnings on gender and/or inclusive development from MEL (or otherwise)

6. What are the types of structural inequalities or barriers that hinder marginalized and underrepresented groups' access to and/or participation in relevant activities? How did USAID programming address these inequalities/barriers during the COVID-19 crisis?
   Probe, *as applicable*:
   a. How did USAID specifically attempt to ensure equitable *participation* of vulnerable/ underrepresented people in activities– not just quantitatively (i.e., representation), but also qualitatively (i.e., participant experiences, responsiveness to unique needs of people, etc.)
   b. How did USAID ensure equitable *benefits* from participation in activities in the region, i.e., how did you ensure vulnerable/ underrepresented people, who face structural disadvantages, derived the same benefits from activities in the Region as others?
   c. Perspectives on the following USAID (ADS) programming dimensions as they relate to the degree of gender and/or inclusive development integration in activities in the region design and implementation *(note: not all domains may apply to all activities, use discretion on probes based on desk review of activities in the Region)*
      i. Laws, policies, regulations, and institutional practices
      ii. Cultural norms and beliefs
      iii. Roles, responsibilities, and time use
      iv. Patterns of power and decision making
      v. Access to and control over assets and resources
      vi. Personal safety and security

7. Drawing exclusively from your experience of supporting USAID activities (funded by COVID-19 funds), what in your view are the key determinants of successful integration of gender and/or inclusive development in an USAID Activity?
   Probe, *as applicable*:
   a. Key barriers to gender and/or inclusive development integration faced by Activity
   b. Key enablers that helped with gender and/or inclusive development integration

**LOI 2: WHERE HAS THE AGENCY'S RESPONSE TO COVID-19 YIELDED UNINTENDED OUTCOMES (BOTH POSITIVE AND NEGATIVE)? WHAT WAS THE PATH/LINK BETWEEN THE AGENCY'S COVID-19 INTERVENTIONS AND THE UNINTENDED OUTCOMES?**

8. Now, we would like to get your views on *outcomes* of the portfolio of USAID COVID-19 response interventions. Were there any USAID activity outcomes that you were surprised to uncover, i.e., you did not intend for them to occur, or were not expecting to see? *Mention following domains in sequence, ensuring to spend sufficient time exploring each:*
   (As needed, remind the respondent that we are interested in UOs of USAID activities, not the pandemic)
   a. Outcomes related to safety and security (including GBV)
   b. Outcomes related to mental health, from the gender and/or inclusive development perspective
   c. Outcomes related to intra-household power dynamics (decision-making)
   d. Outcomes related to civil participation and leadership, from the gender and/or inclusive development perspective
   e. Outcomes related to digital access and use, from the gender and/or inclusive development perspective

9. [If above response dwells mostly on positive outcomes, probe on negative outcomes using an appreciative tone. And vice versa]
   a. e.g., USAID operated in trying circumstances during an unprecedented crisis and delivered significant results. Were there still any negative outcomes of USAID COVID-19 related interventions that surprised you?

10. You said: [summarize the UOs discussed above]. What specifically about, or in, the portfolio of USAID COVID-19 related activities do you think influenced this particular outcome for program participants? (Ask separately for all UOs)

### LOI 3: WITH THE BENEFIT OF EXPERIENCE AND HINDSIGHT, WHAT CAN/SHOULD BE DONE MOVING FORWARD TO ENSURE SIMILAR FUTURE PROGRAMS ARE INTENTIONALLY AND PROACTIVELY INCLUSIVE?

For the next set of questions, we want you to draw from your experience of USAID's COVID-19 response activities,

11. What do you think can be done differently to improve the degree of gender and/or inclusive development integration in similar programs in future crises?
    Probe:
    a. Organizational aspects
    b. Regional or technical contextual aspects, if any
    c. Other aspects

12. What do you think can be done differently in the future to address or mitigate harmful unintended outcomes particularly on women, girls, and underrepresented groups?
    Probe:
    a. Organizational aspects
    b. Design & implementation aspects
    c. Country contextual aspects, if any

13. What have been the key learnings with respect to gender and/or inclusive development integration in USAID Activities – as well as mitigating negative unintended outcomes on women, girls, and underrepresented groups – particularly in crisis/pandemic response?

14. Before we close, are there any questions that I should have asked you, that I have not asked? [And please discuss them…]

15. Other comments:

## D.4 SEMI-STRUCTURED KII GUIDE - EXTERNAL STAKEHOLDERS

Thank you for making time for this interview. The COVID-19 Unintended Outcomes Assessment, funded by USAID's Bureau for Policy, Planning and Learning (PPL), was designed to determine the extent to which USAID's programming, financed by COVID-19 funds, reflected the Agency's commitment to inclusive development and gender equality, and to identify programmatic recommendations towards mitigating harm and exclusion in current and future programming.

The assessment will assess the extent to which inclusive development principles were considered in COVID-19 program design and implementation to identify:

1. Inequalities of USAID's programming financed by COVID-19 funds
2. Unintended outcomes (both positive and negative) of USAID's programming, financed by COVID-19 funds, on underrepresented and marginalized groups.

We would like to obtain your explicit permission to conduct this interview and to record this conversation in order to be able to refer back to it during our analysis. My colleague ____ is also on the call today/here and will be taking notes. The notes will be used to develop a briefing and report on the interviews without attribution. The notes will serve as the interview transcript, which will not be published. The transcript will only be shared with our assessment team and the team members in PPL/LER who are overseeing this work. Transcripts will not be shared with leadership. We will not refer to you by name in any published documents without your written consent. Do you consent to participating in this interview?

### LOI 1: DID USAID'S PROGRAMMING TO ADDRESS COVID-19 INCLUDE GENDER AND INCLUSIVE DEVELOPMENT CONSIDERATIONS?

1. [Ice-breaker, for context] Tell me/us a bit more about your involvement in COVID-19 responses here.
    a. Are you [is your organization] most involved in addressing its primary/direct effects on the population (in terms of morbidity and mortality), or the indirect, or "second-order effects" of the pandemic [By "second-order" effects, I mean the many kinds of indirect effects or changes that happened because of the COVID-19 and efforts to prevent its spread, such as effects of school closures, or stay-at-home orders, or effects of disruptions in supply chains]?
    b. Where have you seen the most significant second-order effects? [Probe: which sectors, or for which populations, or geographic areas, have you seen the most significant effects, positive or negative?]

2. Has _____ [respondent's organization] played a role in responding to second-order effects of the COVID-19 epidemic [here/in this country/in this area]?
    a. If so, how would you describe _____'s role?

3. What is, or what has been, the main work of _____ [the National COVID-19 Task Force - Insert correct term prior to interview]?
    a. What would you say are the National Task Force's main accomplishments?

4 Which sectors [or combinations of sectors] have been most affected by the COVID-19 pandemic?
    a. How are those sectors responding to the challenge? [Through what processes or programs?]

5. Are you familiar with USAID-funded programs to support responses to the COVID-19 epidemic here [in this country/region]?
    a. If yes, how have you/[how has your organization engaged with USAID or the COVID-19 responses funded by USAID? [Were you involved in selecting or designing programs; in implementing programs? In evaluating programs?]
    b. If yes, how different are they from other donor-funded interventions?

6. Which population groups have been most affected by the COVID-19 pandemic and its second-order effects [in this country/region]? I am not asking about which groups had the highest rates of COVID-19 disease, but about the second-order effects on individuals, families and communities.
    a. [If necessary - probe:] Are there under-represented groups that have had more than average difficulty accessing information and resources to combat or recover from COVID-19's impact?
    b. Which groups? Where? (defined by age? Gender? Geographic location? Disability? SES? Sexual orientation? Occupation? etc.)

7. What were the difficulties faced by these groups with regard to the second-order effects of the pandemic? [Ask for the three most affected groups
    a. How were their needs discovered/understood,? [Their participation in assessments or design? Prior assessments? Working with related CBOs? Etc] [Discuss different difficulties for different groups]
    b. In many countries, women and girls, and other underrepresented groups have been particularly impacted by COVID-19 in a number of areas:
        i. MHPSS
        ii. Safety and security (including GBV)
        iii. Intra-household power dynamics
        iv. Civic participation and leadership
        v. Access to digital technologies
    c. Did the national program [or the Task Force] address any of these areas? Which, and how did they address them?

8. How, and to what extent were these challenges and needs taken into account in national COVID-19 responses?
    a. What national or global policies guided efforts to include vulnerable and under-represented groups in the benefits of COVID-19 responses?
    b. Did anyone or any groups express concerns about some groups being left behind? [If so, who/ which groups, and what were their concerns?]
    c. What about inclusion of groups referred to by PEPFAR as "key populations," including men who have sex with men, people who use drugs, sex workers, incarcerated people [
    d. Were outcomes for under-represented groups tracked or monitored? [Does/did national/ organizational monitoring and evaluation require programs to collect and report their data disaggregated by gender, age, and/or for other under-represented or vulnerable groups?]

9. Were USAID's programs different from other donor-funded interventions, in how they included and responded to the needs of under-represented or marginalized groups in relation to COVID-19? [ Discuss how/what/where]
    a. What worked well?
    b. What were the challenges?

10. Did USAID engage with the national and other international stakeholders to integrate gender and inclusive development in COVID-19 programming? If yes, in what ways?

11. What lessons can be learned from the ways in which USAID and other international donors addressed the second-order effects of COVID-19 on under-represented and marginalized groups?
    a. What worked well?
    b. What were the challenges?
    c. Any lessons specifically related to how USAID responded?

### LOI 2: WHERE HAS THE AGENCY'S RESPONSE TO COVID-19 YIELDED UNINTENDED OUTCOMES (BOTH POSITIVE AND NEGATIVE)? WHAT WAS THE PATH/LINK BETWEEN THE AGENCY'S COVID-19 INTERVENTIONS AND THE UNINTENDED OUTCOMES?

12. Among all the responses to the COVID-19 pandemic that you have witnessed, especially considering responses to its second-order effects, what surprised you most ?
    a. What surprised you most about responses for or among under-represented or marginalized groups?

13. What would you say are the biggest, or most important, positive changes that have resulted from responses to COVID-19's second-order effects? Were any of these unintended?
    a. What changes at the organizational level?
    b. What about the level of participants of COVID-19 mitigation efforts? [formerly known as beneficiaries of USAID-supported C19 efforts]

14. What would you say are the biggest, or most important, *negative* changes that have resulted from responses to COVID-19's second-order effects?

15. Thinking specifically about effects on women and girls, were there any unexpected or unintended effects of responses to COVID-19 for women and girls?

16. Were there unintended effects on other under-represented or marginalized people, for example, people with disabilities? LGBTQ+ people? Young people? The elderly?

### LOI 3: WITH THE BENEFIT OF EXPERIENCE AND HINDSIGHT, WHAT CAN/SHOULD BE DONE MOVING FORWARD TO ENSURE THAT FUTURE PROGRAMS ARE INTENTIONALLY AND PROACTIVELY INCLUSIVE?

17. Do you recall any particular USAID-funded COVID-19 program(s) that specifically addressed the needs of women and girls? Other underrepresented populations? And if so, how?

18. With the benefit of experience and hindsight, what can/should be done differently in the future, in the policy, planning, and implementation processes, to ensure that responses proactively include and respond to the voiced needs of women and girls, and other marginalized groups?

19. What opportunities are there to bolster gender equality and social inclusion and to address the needs of marginalized groups in future crises?

20. Before we close, are there any questions that I should have asked you, that I have not asked? [And please discuss them…]

21. Other comments:

## D.5 FOCUS GROUP DISCUSSION GUIDE

Questions may need to change based on review of country documents, nature of activity selected, and demography of sampled beneficiaries, among other variables

- How long have you been part of [name of USAID activity]?
- What are the key types of support you receive / have received from this Activity?
- What are the most significant ways in which you have witnessed/experienced changes in your life as a result of this Activity? [Probes: negative, positive]
- How did your family members and members of the community react and respond to the [positive] changes that you were experiencing by participating in the Activity?
- Were there any negative changes in your life as a result of participating in this Activity?
- Were there changes in your life / household / surroundings that you did not anticipate – or were not among things you were told to expect – when you joined [name of USAID Activity]? What were they, and in what way did the Activity cause these changes? [Probes: negative, positive]
- Do/did you see a diversity of people (such as from different communities, genders, ages, castes, sexualities) equally participating in [name of USAID activity]? (Probe: think of other people who you know are part of the Activity)
- In your opinion, are all participants equally benefiting from [name of USAID activity]? [If not], which groups are at a disadvantage, and why? In what ways are they less able to benefit?
- We would like to know of challenges, if any, you face in your everyday life (not necessarily in the context of the Activity, but generally), w.r.t.: (personalize ADS domains in accessible language)
- Existing laws, regulations, institutional practices that feel exclusionary/discriminatory to you
- Cultural norms and beliefs that negatively affect your day to day lives
- (Expected/performed) roles, responsibilities, and time-use in your everyday lives that feel disproportionate or unequal in any way
- Power and decision-making in all aspects concerning your life within and outside your house, within the community, and as an individual
- The extent and quality of access, as well as control you have over assets and resources (e.g., income, land, movable assets, credit, businesses, etc.)
- Your safety and security, in private and public spaces, within and outside the house
- Has [name of USAID activity] changed or addressed any of these challenges/difficulties in any way during its implementation? If yes, which ones and how? If not, why not?
- Has your participation in [name of USAID activity] inadvertently exacerbated any of these challenges/difficulties for you in any way? If yes, which ones and how?

# ANNEX E: ASSESSMENT SURVEY

## E.1 SURVEY QUESTIONS

1. Sex
2. USAID Country Mission/Office
3. Name of USAID activity (recipient of COVID-19 response funds) that you manage/managed from 2020 to present time. *If you manage more than one activity, please select the activity you have managed the longest and/or are most familiar with.*
4. Did the USAID activity address the following:
   - First-order effects: Direct effects of the COVID-19 pandemic, including prevention/treatment of the virus (e.g. testing, vaccinations, infections, mortality, vaccinations, oxygen provision, lock-downs, etc.)
   - Second-order effects: Indirect effects of the pandemic as a consequence of the spread of the virus (e.g., disrupted education, economic crises, household shocks, food insecurity, civil unrest, psychosocial stress among caregivers, increases in gender-based violence (GBV), etc.)
   - Both first and second-order effects
5. Which USAID sectors/themes does this activity involve? Check all that apply.
   - Agriculture, food and security
   - Democracy, governance and human rights
   - Economic growth and trade
   - Education
   - Environment, energy and infrastructure
   - Health
   - Humanitarian assistance
   - Innovation, technology and research
   - Water, Sanitation and Hygiene (WASH)
6. Name of Implementing Partner(s) for the activity. Short answer.
7. Has the Mission/Office where the activity is implemented conducted a Gender Analysis in the last five years?
   - Yes
   - No
   - Don't know/Unsure
8. Has the Mission where the activity is implemented conducted an Inclusive Development Analysis in the last five years? Please enter 'Yes' if gender and inclusive development were addressed together in one analysis.
   - Yes
   - No
   - Don't know/Unsure
9. Did the Mission/Office conduct a COVID-19 Gender Analysis between 2020-2023?
   - Yes
   - No
   - Don't know/Unsure

10. Was a USAID Gender and/or Inclusive Development Analysis used to inform the design and implementation of COVID-19 funds for the activity that you are leading/part of, or if you were not directly involved do you think it was used?
    - Gender Analysis:
        - Yes
        - No
        - Don't Know
        - Analysis not available during the time of design
    - Inclusive Development Analysis:
        - Yes
        - No
        - Don't Know
        - Analysis not available during the time of design
11. Did a USAID Gender and/or Inclusive Development Advisor provide direct inputs to the technical team to ensure gender and/or inclusive development integration in using COVID-19 funds for the activity that you are managing?
    - Gender Advisor:
        - Yes
        - No
        - Don't Know
        - Analysis not available during the time of design
    - Inclusive Development Advisor:
        - Yes
        - No
        - Don't Know
        - Analysis not available during the time of design
12. To what extent were gender and inclusive development considerations integrated into the design and implementation of the activity you are managing, or if you were not directly involved to what extent do you think it was integrated?
    - Gender Analysis:
        - Fully
        - Not fully, but satisfactorily under the circumstances
        - Inadequately
        - Did not consider at all
        - Don't Know
    - Inclusive Development Analysis
        - Fully
        - Not fully, but satisfactorily under the circumstances
        - Inadequately
        - Did not consider at all
        - Don't Know

13. Did the activity specifically target any of the following underrepresented and marginalized groups?

    Please select all that apply.
    - Women
    - Children
    - Adolescents and Youth
    - People with disabilities
    - LGBTQI+
    - None
    - Don't know/Unsure
    - Other

14. Did you observe unintended outcomes (positive and/or negative) of the COVID-19 funding for women and/or marginalized groups (listed in the previous question) across any of the following:

    Please select all that apply:
    - Laws, policies, regulations, and institutional practices
    - Cultural norms and beliefs
    - Roles, responsibilities, and time use
    - Patterns of power and decision making
    - Access to and control over assets and resources
    - Personal safety and security
    - Don't Know/Unsure
    - No

15. Please include any other issues or areas regarding gender and inclusive development and USAID's deployment and use of COVID-19 funds that you would like to discuss. Short answer.

## E.2 SURVEY RESULTS

A rapid survey was disseminated to 228 USAID ACORs who managed activities receiving COVID-19 response funds. In total, 14 respondents (seven female and seven male) participated in the survey.Thirteen of the respondents were Mission-based, and one was Washington Pillar Bureau-based. A majority of respondents (nine) managed activities addressing COVID-19 first-order effects; only one respondent managed activities focused on second-order effects; and the remaining four respondents managed activities that addressed both first- and second-order effects. Respondents managed activities across a variety of sectors: agriculture and food security; economic growth and trade; health; humanitarian assistance; and innovation, technology, and research.

Most respondents' Missions or Offices conducted a gender analysis within the last five years, while only half conducted an inclusive development analysis. Whether a COVID-19 gender or inclusive development analysis was conducted was more mixed. A total of five respondents' Missions or Offices had conducted COVID-19 gender and/or inclusive development analyses.

| Gender and Inclusive Development Analyses | | | |
|---|---|---|---|
| | Yes | No | Don't Know/Unsure |
| Mission or Office gender analysis within the last five years | 12 | 0 | 2 |
| Mission or Office inclusive development analysis within the last five years | 7 | 0 | 7 |
| COVID-19 gender and/or inclusive development analysis between 2020-2023 | 5 | 3 | 6 |

Most respondents (eight) noted that a USAID gender analysis informed design and implementation of COVID-19 funds, while fewer respondents (four) used an inclusive development analysis. Less than half of respondents shared that Gender and/or Inclusive Development Advisors provided technical inputs on gender or inclusive development integration in COVID-19 programming.

| Use of Analysis and Advisors | | | |
|---|---|---|---|
| | Yes | No | Don't Know/ Not Available |
| USAID gender analysis used to inform the design and implementation of COVID-19 funds | 8 | 3 | 3 |
| USAID inclusive development analysis used to inform the design and implementation of COVID-19 funds | 4 | 2 | 8 |
| USAID Gender Advisor provided direct inputs to the technical team | 6 | 4 | 4 |
| USAID Inclusive Development Advisor provided direct inputs to the technical team | 5 | 3 | 6 |

Most respondents (11) shared that gender was at least satisfactorily integrated into COVID-19 programming, while half of respondents (seven) shared the same degree of integration of inclusive development.

| Gender and Inclusive Development Considerations | | | | | |
|---|---|---|---|---|---|
| | Fully | Not fully, but satisfactorily | Inadequately | Not at all | Don't know |
| Extent to which gender considerations were integrated into the design and implementation of the activity | 6 | 5 | 0 | 1 | 2 |
| Extent to which inclusive development considerations were integrated into the design and implementation of the activity | 4 | 3 | 0 | 1 | 6 |

Most of the COVID-19-funded activities managed by respondents targeted at least one underrepresented or marginalized group, including: women, adolescents and youth, children, people with disabilities, and LGBTQI+ people. The majority of respondents either suggested there were no unintended outcomes (five) or they did not know or were unsure (four) about unintended outcomes of USAID's COVID-19 programming. The unintended outcomes that were observed were related to: access to and control over assets and resources; cultural norms and beliefs; laws, policies, regulations, and institutional practices; personal safety and security; roles, responsibilities, and time use; and patterns of power and decision making.

# ANNEX F: FIRST- AND SECOND-ORDER EFFECTS

The Table 5 below lists the first- and second-order effects referenced in qualitative interviews, as well as the group or groups affected.

**Table 5.**

| First-Order Effects on Groups (Referenced in Interviews) | |
|---|---|
| Effect | Group |
| Reduced access to COVID care | Transgender individuals, men who have sex with men, female sex workers, people with disabilities, remote communities |
| Increased risk of COVID (morbidity and mortality) | People with comorbidities: HIV, tuberculosis (TB), diabetes, cancer patients, pregnant women, children under 5, people with disabilities |
| **Second-Order Effects on Groups (Referenced in Interviews)** | |
| Effect | Group |
| Education disruptions | Children, LGBTQI+, youth |
| Food insecurity | LGBTQI+, women, children, youth |
| Healthcare disruption | Children, LGBTQI+, mothers |
| Increased child marriage | Girls |
| Increased early pregnancy | Teen girls |
| Increased GBV, intimate partner violence | Women, Indigenous People, LGBTQI+ |
| Increased criminalization of activities | Men who have sex with men, sex workers |
| Increased caregiving responsibilities | Women (including USAID staff) |
| Mental strain (in some cases resulting in abuse of drugs and alcohol) | Individuals with HIV, LGBTQI+, men, women, youth |
| Reduced social services | Children and women |
| Stigma and increased marginalization | Religious minorities, healthcare workers |

# ANNEX G: GENDER EQUALITY AND INCLUSIVE DEVELOPMENT RESOURCES

## POLICIES

- Gender Policy
- USAID Disability Policy
- Policy on Promoting the Rights of Indigenous Peoples
- LGBTQI+ Inclusive Development Policy
- Youth in Development Policy

## PUBLICATIONS

- Additional Help for ADS 201: Inclusive Development
- Foundational Elements for Gender-Based Violence Programming in Development
- Gender and COVID-19 Resources
- Gender Equality in Environment, Climate and Energy
- Gender-Based Violence Prevention and Response
- Guide to Inclusive Development Analysis
- Nondiscrimination For Beneficiaries: Frequently Asked Questions
- Safety/Security-Sensitive and Trauma-Informed Stakeholder Consultations With Members of Marginalized Groups
- Women's Economic Security

## MECHANISMS AND RESOURCES

- Gender Equity and Equality Action Fund
- Inclusive Development and Equitable Assistance (IDEA, USAID only)
- Inclusive Development Activity for Mission Support (IDAMS USAID only)

## TRAINING

- Gender 101 Training for Implementing Partners
- Inclusive Development
- Disability-Inclusive Development 101 E-Course
- LGBTQI+ 102: LGBTQ+ Inclusion in USAID Programs
- ID training suite (USAID only)

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